JOURNAL

OF THE
BRITISH ASSOCIATION
OF PSYCHOTHERAPISTS

Number 27 Summer 1994

JOURNAL

of

The British Association of Psychotherapists

Subscription Enquiries:

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JOURNAL

No. 27 Summer 1994

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INTRUSIVE IDENTIFICATION, THE CLAUSTRUM AND THE COUPLE*

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Introduction

In this paper I want to describe some of the impact of Donald Meltzer's recent work on my analytic therapy with couples. This kind of therapy with couples is sometimes referred to as an *application* of psychoanalysis, which no doubt it is. It is also in my view, however, a prime arena for research into the psychoanalytic process and hence into psychoanalysis itself. However, I am not so bold as to offer this as a thesis here which I would proceed to explore and defend. It may be true or it may not, or, it may need to be modified. I am more interested in it as a state of mind in which one may approach the analytic encounter with couples. It should also be said that although the clinical material in this paper is drawn from my analytic therapy with a couple, the thinking is applicable to psychoanalytic therapy with individuals, as I hope to illustrate in a subsequent paper.

I begin with an invitation to reflect on the experience of a couple I saw with a co-therapist for almost four years in psychoanalytic therapy. It is a story which had what was, from one perspective, a tragic outcome, a story no doubt familiar to all clinicians.

> Jeremy and Jenny are a young couple in their mid-thirties, both in prominent public positions in their community. He was the head master of a small private school around which village life centres. She is a teacher in the village state school. They have two young children. Although very much in the public spotlight, Jeremy has nevertheless regularly engaged in sexual behaviour that has involved visiting prostitutes and pornographic establishments, knowledge of which would (and did) ruin his career. They had also engaged in bizarre sexual events, although Jenny, consciously anyway, disassociates herself from these activities. She sees herself as 'cold' and unresponsive sexually, although intensely, intrusively curious about the terrible, secret things Jeremy gets up to.
>
> They came to therapy because of Jeremy's affair with a close woman friend of Jenny's, the discovery of which nearly destroyed Jenny. After

* Revised version of a paper presented at a Conference on 'The Leading Edge of Analytic Marital Therapy' sponsored by the Washington School of Psychiatry, Washington D.C., 3–6 March 1994.

just over two and a half years of therapy Jenny withdrew for four months, ostensibly so Jeremy could have the 'privacy' to explore his nightmare. At the end of that time she insisted we refer her to a psychotherapist closer to home as she moved toward separation from him. Six months later they were engaged in one of the most vicious custody battles I have witnessed. Jeremy was disgraced in the village, his career ruined, and then in a twist of the ironies of the court, he was awarded major custody of the children.

There are many ways to think about this story and its outcome to date, but I want to think about it in terms of Meltzer's notion of the *claustrum* and his exposition of the three major claustrum worlds. Jeremy has 'temporarily' broken off his therapy with us – to our knowledge Jenny is still in therapy with her new therapist. He wrote to us after our last session saying: 'I feel a curious sense of freedom in having escaped [the school] and for the first time in my life find myself without an institution, or a marriage, from which to draw an identity.... I don't think I could have easily chosen to leave the marriage or to leave [the school]. Perhaps what I have to continue working with is that the cost of my not being able to *choose* that [leaving the marriage and the school] has been enormous in the way things turned out.... I can't believe that Jenny has chosen to do what she has done and she inevitably will not be able to believe that I've chosen to do the things I've done. At the end both of us have become strangers and devils for one another.'

Preparing for this paper I went back to read their application form for the first time in four years. Jeremy wrote then: 'My fear of emotions and my inexperience in making relationships meant that I have treated my marriage and home somewhat as a castle, which has become claustrophobic for Jenny who finds me all consuming and allowing no space to be.'

Before exploring how the ideas of 'intrusive' projective identification and the *claustrum* can help to understand the dilemma of this couple, I want to look back to our understanding of the notion of projective identification itself. It is remarkable to observe just how central this peculiar notion has become in our understanding of the psychoanalytic process and in particular of the dynamics of the couple relationship at the heart of this process, the analyst/analysand couple. Our clinical discussions would be the poorer, indeed for many of us almost inconceivable, without the use of the notion of projective identification. Inevitably use of this notion extended beyond the analytic couple to that quintessential relationship which is a bedrock of the analytical relationship, the primitive mother/infant couple. An exploration of the dynamics of these two couple relationships has led increasingly to the use of this 'peculiar notion' in the understanding of the marital couple and the vicissitudes of that relationship, beginning arguably with the work of Dicks and others at the Tavistock almost four decades ago.

I refer to projective identification as a 'peculiar *notion*' because I want to call attention to its clinical origins, to the phenomenon Melanie Klein described as an 'omnipotent *phantasy*', on the basis of her detailed observation of the children she analysed. As I suggested elsewhere (Fisher 1994), we should not forget what a 'crazy' idea it is, the *phantasy* that I can split off 'bad parts' of myself, unpleasant and unwanted feelings for example, and put them *into* someone else. The infantile omnipotence of this unconscious phantasy stands in tension with the subsequent incorporation of the notion of projective identification into *theories* of interpersonal dynamics as a theoretical *concept*.

One reason I wish to go back to this original understanding of projective identification, particularly in thinking about our analytic work, is to suggest that Bion in his exploration and development of this 'peculiar notion' has inadvertently opened the way to some confusion; ironic since at one stage he aimed at introducing a formal language to aid in communication between psychoanalysts. There is no doubt that Bion has had a profound influence on psychoanalytic thinking and practice and that one of the areas of greatest impact has been in our understanding of projective identification. With his development of the notion of the container/contained relationship, it has become possible to speak of a process of projective identification in the interest of communication.

This development has given substance to the increasing emphasis in the past four or five decades on the *experience* of the analyst or therapist in the psychoanalytical process, i.e., the emphasis on countertransference. However, when Bion revolutionised our thinking about projective identification with this introduction of the concept of the container/contained relationship, he also introduced a way of thinking about projective identification which can imply that it is an *essentially* benign process. From clinical experience we know that, in the dynamics of the container/contained relationship, projective identification *can* function as a primitive form of communication. This is true if, but *only if*, the person acting as a container can bear to be the recipient of projective identification and still sustain an ability to think about the experience. Betty Joseph suggests that it *can* act as a communication *whatever its 'motivation'*, i.e., whether it is 'aimed' at communicating a state of mind or at entering and controlling and attacking the recipient (Joseph 1989, 175).

This concept of container/contained has so coloured our use of the notion of projective identification that Meltzer has proposed the intro-

duction of the term 'intrusive identification' to describe a kind of projective identification which is certainly neither benign nor something in the service of communication. He has gone on to describe clinically the connection between 'intrusive identification' and what he calls the 'claustrum', which in my opinion has moved our understanding of projective identification *forward* in a way which we are only beginning to appreciate. I want to call attention specifically to the way Meltzer has expanded our field of attention in connection with projective identification, something which is particularly important for our thinking about its appearance in the couple relationship and thus in the therapeutic encounter with couples as well as with individuals. He invites us to consider what he calls the 'projective' as well as the 'identificatory' aspects of projective identification (Meltzer 1992, 4).

The *identificatory* aspects concern the transformation in the self in the omnipotent phantasy of projective identification, e.g., grandiosity, psychotic depressive states, hypochondria, confusional states. The *projective* aspects concern the nature of the experiences when *inside* that phantasy world into which one has intruded, the 'claustrophobic' aspects. What is it like in there? What are the unconscious phantasies about the inside of the internal mother that result from this unconscious phantasy of intrusion *into* her?

In other words, I want to re-consider in this paper the experience of a kind of projective identification which is *not* in the interest of communication. I want to take us back to reflect on what was traditionally described in quantitative terms as 'excessive' or 'massive' projective identification, as distinct from what Bion described as a process of communication. It is true that some people view these as points on a continuum, distinguished by the degree of intensity and extent, but essentially the same psychic mechanism (e.g., Steiner 1993). It may ultimately be important to decide whether these are indeed two poles on a continuum or whether they are two quite different psychic mechanisms, but that is not something I wish to undertake here.

In publications over the past decade Meltzer has proposed a modification of our terminology moving from a *quantitative* distinction to a *qualitative* one. He has suggested, for example, a terminology which has yet to achieve widespread use, but one which I find helpful:

Projective identification – the unconscious phantasy implementing the non-lexical aspects of language and behaviour, aimed at communication rather than action (Bion).
Intrusive identification – the unconscious omnipotent phantasy, mechanism of defence (Melanie Klein).

Claustrum – the inside of the object penetrated by intrusive identification.
Container – the inside of the object receptive of projective identification. (Meltzer 1986, 69)

With this terminology in mind, although without adopting it rigidly, I want now to consider some aspects of the experience of intrusive identification and the claustrum with reference both to the couple relationship itself and to analytic therapy with couples and with individuals. In other words I want to look at what we might think of as 'claustrophobic' experiences in relationships. Another Kleinian writer who has developed similar ideas is Henri Rey. He observed:

> Claustrophobic persons are afraid to be in an enclosed situation, they develop extreme anxiety or panic and want to get out. The 'situation' may be a room, a traffic jam, a marriage. When they are not contained they become agoraphobic and develop anxiety or panic (Rey 1988, 218).

It should be obvious that when we include 'marriage' in this list of situations, we are in an arena which is broader than 'claustrophobic' in the usual psychiatric sense. More importantly I want to take us beyond simply the claustrophobic anxiety which makes one want to escape. I will explore the experiences, perceptions, and even beliefs when one feels trapped in the claustrum. In particular I will illustrate in our experience with Jeremy and Jenny the three primary types of claustrum experience resulting from the omnipotent phantasy of intrusion into the major 'compartments' of the internal mother: the maternal head/breast, the maternal genital, and the maternal rectum.

I want to emphasise here that Meltzer's exposition of intrusive identification and the claustrum is part of what is, in my view, an elaborate and revolutionary reformulation of psychoanalytic theory, integrating the clinical insights of Freud, Klein and Bion in a way that is more coherent than might be apparent in the isolated reading of any one of his books or papers. Although I shall illustrate some of these ideas with our work with Jeremy and Jenny, I am aware how strange these ideas may sound when first encountered. I think that is because they challenge some of our basic assumptions, particularly about 'unconscious phantasy' and the 'internal world'. Meltzer suggests that having worked with children makes it easier to appreciate the literal and concrete nature of the internal world. I sometimes wonder if working with couples allows a similar experience because of the enactment which takes place in their relating *in the consulting*

room. One of my colleagues observed that 'marriage is about doing not thinking', which has an element of truth in it.

When it comes to a different way of thinking, it is not a matter of merely defining one's terms, although I shall try to be as clear as I can. Perhaps I exaggerate the difficulties just because I myself have only slowly made sense of some of Meltzer's thinking. In the end my intention in this paper is quite limited. I do not intend to 'explain theories', only to give you some idea of how I use the notions of *intrusive identification* and the *claustrum* in my analytic work. If I succeed in interesting the reader in pursuing any of these ideas and joining me in the exploration of their clinical use, I shall be more than satisfied. We are after all only just beginning to discover how to make use of these ideas.

In the clinical setting the notions of *intrusive identification* and the *claustrum*, I suggest, can give new insight into the intense dynamics with the very disturbed couples who more and more are turning to therapy in desperation and crisis, at least that is my experience at the Tavistock Marital Studies Institute. These are couples with whom it feels almost impossible to think for ourselves because we feel drawn into and trapped in their claustrum world with them. It is not so much that we are the 'recipients' of this intrusive projective identification, as that we are *in the presence* of their intrusive identification with their internal objects which is so profoundly powerful that we feel no option but to be claustrum dwellers with them in the nightmare worlds in which they are trapped.

The geography of the internal world

Before I illustrate some specific aspects of the nature of the claustrum experience with this couple, I think it is important to remind ourselves of one of the basic assumptions of Kleinian and post-Kleinian thinking, the concrete nature of the internal world as well as its 'geography'. It is one of my hypotheses about analytic work with couples that the therapeutic task can in some sense be thought of as what Meltzer (1967) has described as *the sorting geographical confusions*. This spatial notion of 'geography' for the locating of the self in relation to its various objects is particularly helpful in thinking about a central dynamic in any couple relationship, the awareness and acceptance of the separate existence of the other. This awareness and acceptance is based, I am suggesting, on the ability to make a distinction between

the internal and external world, both of the self and of the object. In other words the ability to sort out 'geographical confusions'.

We might link this with the notion of the process of 'separation and individuation', to use Margaret Mahler's more familiar terminology (Mahler, Pine and Bergman, 1975). The success of this process is critical to a sense of self and thus to the ability to sustain an intimate relationship. It is precisely this sense of self which is so dramatically lacking in many of the couples who have come for help with their relationship, couples characterised by what we might term 'narcissistic relating' (Ruszczynski 1994). One could say that the central arena of interest for post-Kleinian thinking has been what are generally termed 'narcissistic object relations'. This is one reason I find the post-Kleinian approach so important as a framework for analytic work.

One way of understanding the central issue in narcissistic object relating is to keep in mind this spatial reality of the internal world in unconscious phantasy. It is interesting to note that John Steiner, for example, in his new book describes what he calls 'psychic retreats, refuges, shelters, sanctuaries or havens' as 'states which were often experienced *spatially* as if they were places in which the patient could hide' (Steiner 1993, xi, my emphasis).

Central to this approach is the spatial quality of experience in unconscious phantasy, i.e., that the 'internal world' and 'internal objects' necessarily have a psychic reality which is 'spatial'. In trying to understand this way of thinking, it is essential, though difficult, to keep in mind the concrete nature of the internal world, internal objects and their 'geography'. As I have said it is perhaps helpful to keep in mind that in large part this Kleinian approach arose out of analytic work with children and it is in the reports of work with children that one can see most clearly this very concrete nature of unconscious phantasy revealed. Referring to the contributions of Bion and Esther Bick, Meltzer has suggested that their work has thrown 'a new light on the suggestion, implicit in all of Melanie Klein's work, that the internal world of objects is experienced in an absolutely concrete sense in the unconscious, and is primary for the establishment of the emotional meaning of our intimate relationships' (Meltzer 1986, 102).

However, it should be noted that this is actually not an unfamiliar notion, nor one confined to a Kleinian approach. For example Joyce McDougall has suggested the evocative expression *Theatres of the Mind* in her description of the 'internal stage' as a setting for the tragedies (and of course comedies as well) of the internal world. (McDougall 1986) In her vivid imagery McDougall captures the

picture of the concreteness of the internal world, even though she herself may understand it more as a metaphor. We also see it in a lively way in dreams, both in our own personal experience and in the dreams which couples as well as individuals bring to the analytic experience. They give us an intimate access to the life of the internal world whether or not we view them as Freud did as the *royal road* to the unconscious.

In a recent publication Meltzer has further suggested that this 'phantasy-geography' has a number of areas which may be distinguished from each other: the external world, the womb, the interior of external objects, the internal world, and the delusional world (geographically speaking 'nowhere') (Meltzer 1992, 57). The most critical 'arena', however, is the interior of internal objects, and thus our primary interest will be in 'intrusive' projective identification with internal objects and more specifically with the internal mother.

The geography which is *central*, therefore to the 'phantasy-geography' of the self, and thus to that of the couple relationship, is the geography of the internal regions, or as Meltzer has it, the 'compartments' of the internal mother. The conception of the inside of the internal mother (and critically, the means by which this conception is arrived at) forms a template for all intimate relationships. Thus in his exploration of the 'projective' aspects of projective identification, Meltzer is suggesting that the *mode* of entry *in phantasy* into the mother's body determines the quality of the experience of the phantasy of the nature of what is found *inside her body*.

One of the most important points I wish to make in this paper is to highlight the fundamental difference between a genuine intimacy with the other and a 'pseudo-intimacy' which is a narcissistic form of relating. The former is based on the reality that the other is known *only* from the outside. The latter is based on the phantasy of getting *inside* the other. Meltzer invites us to consider the difference between the picture of the inside of the internal mother which results from the use of *imagination* and the one which results from the phantasy of omnipotent intrusion. The imaginative 'knowing' of the other, inspired by an imaginative 'knowing' of the internal mother, is constructed necessarily out of elements of experience of the external world, respecting the privacy of the interior of the mother. It is characterised by an attitude which Bion has brought into our vocabulary from his reading of John Keats. Keats described this attitude of mind as *negative capability*, 'that is, when [one] is capable of being in uncertainties, mysteries, doubts, without any irritable reaching after fact and reason'

(Bion 1970, 125). No matter how intimate the 'knowledge' of the other, it is always characterised by uncertainties, mysteries and doubts.

We know, however, that in many couples there is a sense of *certainty* in the so-called 'knowledge' of the other, a 'certainty' often characterised by boredom and complacency, or persecution and tyranny, depending on what is omnisciently 'known'. This certainty, resulting as it does from a phantasy of omnipotent intrusion, is characterised by what Meltzer elsewhere called 'the delusion of clarity of insight' (Meltzer 1976). We have all seen it many times in therapy.

The interior regions of the internal mother

We come now to the heart of this paper. This omnipotent 'knowledge' of the internal mother and consequently of the 'interior' of the other in an intimate relationship, creates the sense of living, through intrusive identification, in what Meltzer has described as a *claustrum*. He notes that, when the part of the personality 'ensconced' in the claustrum gains control of consciousness, marked changes occur:

> First of all the experience of the outside world becomes dominated by the claustrophobic atmosphere, meaning that the person, in whatever situation he finds himself, feels trapped. Job, marriage, holiday, on trains, buses or lifts, in personal or casual relations, in restaurants or theatres – in every area there is a tangible atmosphere of catastrophe immanent and 'No Exit' (Sartre).
>
> Second, in response to this hovering sense of immanent catastrophe, the picture of the world becomes compartmentalised and stratified.... Furthermore all organisation is seen as stratified, hierarchic and therefore in a sense political, whether it be family, extended family, work place.... (Meltzer 1992, 119)

My interest here is in the claustrum experience in the relationship of the marital couple as well as in the analytic relationship of patient and therapist. Rather than talking about this experience in general terms, I want to explore some of the more specific characteristics of this 'claustrum' experience. As I have already indicated, Meltzer divides the 'compartments' of the internal mother into three: the maternal head/breast, the maternal genital, and the maternal rectum. Correspondingly he describes three types of claustrum experience. In this paper I can only allude to aspects of these three types, touching briefly on each with some material from the therapy with Jeremy and Jenny.

The *first* 'compartment' is what Meltzer describes as the maternal

'head/breast'. Seen from the 'outside', i.e., through the use of imagination, the primary quality of this region of the internal mother is 'richness', having the nuances of 'generosity, receptiveness, aesthetic reciprocity; understanding and all possible knowledge; the locus of symbol formation, and thus of art, poetry, imagination.' However, 'experienced' from the inside influenced by the motives of intrusion, Meltzer suggests a very different picture:

> Generosity becomes *quid pro quo*, receptiveness becomes inveiglement, reciprocity becomes collusion, understanding becomes penetration of secrets, knowledge becomes information, symbol formation becomes metonymy, art becomes fashion. (Meltzer 1992, 72f.)

Jenny and Jeremy lived in just such a 'claustrum' in their relationship with each other and with their therapists.

> I have already told you a bit about the desperation which brought Jeremy and Jenny to therapy. The 'breaking of his boundary' with Jenny's friend, to use his phrase, was only the last and the most unbearable of Jeremy's sexual 'adventures'. He regularly kept his 'adventures' secret from Jenny until a point when he would share with her what he had done 'as a gift' to demonstrate his wish to be intimate with her. He cannot understand why she does not appreciate such *poisonous* 'gifts', and is genuinely bewildered by her angry, sometimes violent response. The secrecy feels essential to him because it is part of his 'privacy', his need to discover himself and his 'path'. He feels her curiosity as intolerably intrusive, as if she was determined to 'get right inside him'.
>
> Jenny on the other hand feels shut out by Jeremy and yet, ironically, experiences him as 'having no boundaries'. She had in fact encouraged his association with her friend so that Jeremy could learn to be intimate, to have a friend, without 'losing his boundaries'. It is as if she lives out her sexuality through Jeremy's escapades, needing to know about them almost as if to recover something of herself.
>
> I want to focus here not on the sexuality, however, but on the dilemma which confounds this couple, the distinction between privacy and secrecy. Each feels desperately intruded on by the other, he by her relentless 'curiosity' and she by the damaging 'gift' of his telling of secrets. After a year of therapy it transpired that the affair was still going on, although Jeremy had implied in the sessions that it was over without ever saying so explicitly, i.e., strictly speaking he had never lied. Jenny was ferociously angry with my co-therapist and me. We were caught in the dilemma of either having interrogated Jeremy to clarify what was happening, something we felt we could not do, or colluding with him in his deception. Jenny was in a sense right. We had indeed 'turned a blind eye' (Steiner 1993).
>
> One of the most disturbing aspects of being with Jeremy was the intense way he would hold your gaze with his penetrating eyes for what seemed an infinity. Only after two years was I able to gather my courage and say

to him that it was 'as if' he wanted to get right inside my head. He responded almost matter-of-factly that this was indeed what he was doing. He could only 'understand' by trying to get right inside us to see what we saw. We understood this with them as Jeremy's 'magical world', the world of oneness he had with his intrusive, narcissistic mother, and which he and Jenny tried to re-create. But when either tried to get inside the other, it was felt as an intrusive, persecutory attack forcing the other either to escape into 'secrets' or 'emotional deadness'.

As Meltzer has described, we were drawn into a claustrum world in which 'receptiveness' had become 'inveiglement', 'reciprocity' had become 'collusion', and 'understanding' had become the 'penetration of secrets'. Many times I felt confused and unhelpful to them because I felt that I could no longer think clearly about the difference between privacy and secrecy, even concerning the 'privacy' of my own thoughts. To think Jeremy ought to be honest with Jenny was to collude with his poisonous 'gifts' and to join in an aggressive, damaging attack on Jenny. But to think he should keep things to himself meant we colluded with his perverse and destructive deviousness. My co-therapist and I were often filled with curiosity about what he actually got up to, as he tantalised us with hints of ever darker perversities.

The *second* 'compartment' of the internal mother is the maternal 'genital'. Meltzer notes that one characteristic of claustrum dwellers is the 'obsessive interest' in other compartments and their dwellers. I also find that, especially with couples, one can see the movement from one region to another. This was particularly true of Jenny and Jeremy who from the beginning of therapy presented us with a disturbing picture of sexual adventures which stood in tension with the public positions they both held in the community. Meltzer gives us a vivid picture of this 'claustrum world' they inhabited:

> Seen from the interior through the eyes of the intruder, it is a Mardi Gras, a festival of priapic religion where the beauty of femininity has the irresistible power to produce the erection that is irresistibly fascinating and craved by every sense and orifice.... Whether the burning desire is to *be* the irresistible phallus or to have absolute power over it, the essential object is the erect penis. (Meltzer 1992, 88, 89)
>
> From the time they met, Jeremy and Jenny inhabited an intensely sexualised world which distorted every dimension of their relationship. At university Jeremy seemed to cope with his tendency to sexualise all contacts with people by an extreme asceticism, sleeping on a bare floor, eschewing all 'luxuries', having, Jenny said, only one change of clothing. Their sexual relationship was the only one she had ever had and throughout their marriage she oscillated between an almost exhibitionist sexuality and a withdrawal into an emotional coldness which disappointed him

and sapped her self-confidence. They told us, for example, of dancing nude with another couple which included intercourse while dancing in the presence of the other couple. This did not seem to them sexual freedom, but rather the only alternative to Jenny's 'coldness' which Jeremy experienced as her being 'hard', almost as if she had adopted his early 'asceticism' as a way of escaping this claustrum.

During the therapy this dynamic was enacted with us. Jenny adopted an 'ascetic' solution, keeping herself from emotional entanglement with either my co-therapist or me, wary of 'dancing' with Jeremy in our presence. She repeatedly complained to us that *we* avoided a more personal relationship with them because, she insisted, of the *rules* of therapy. We were *not allowed* to show our feelings. Our attempts to interpret her internal rules against intimacy were met with a 'stone wall', even after one outburst when I suggested she was 'playing with fire' in her flirtatious interaction with a colleague. I had simply 'broken the rules'.

Jeremy on the other hand formed an intense attachment to us which always had the undertones of the dilemma for him. How could he be intimate without it becoming sexual. This was enacted outside the therapy as a 'mafia' of women (their term), who saw themselves as 'agents' of the therapy, were engaged to watch over him virtually 24 hours a day to ensure that he did not 'break his boundaries' in any of his attachments outside of the marriage – including with an elderly male teacher who loved to 'kiss and touch' him. Of course the inevitable happened and one of these women enlisted to help Jeremy keep his boundaries became his lover. It was the last straw for Jenny, leading to her 'demonic' attack on him and the marriage.

Jeremy lived in a 'Mardi Gras' of sexuality which he desperately longed to escape. He continually tried to involve himself with someone who could help him 'keep his boundary', although inevitably they were drawn into this claustrum world as if there were no alternative. Jeremy told us he did not want a sexual relationship with these women. What he wanted was 'to get right inside their womb'. Unconscious sexual phantasies about my co-therapist and me seem to have been displaced to the female 'mafia' drawn in to protect him between sessions and ultimately acted out with them. At one point when my co-therapist referred to her and me as a 'couple', Jeremy was speechless. He could not think what we were, but we certainly were *not* a couple. Being a couple in his mind could only be experienced in terms of his sexualisation of intimacy. He struggled to comprehend how there could be any other kind of intimacy in our co-therapy partnership with each other or in our relationship with him.

In one session late in the therapy, when we were seeing Jeremy on his own, he excitedly told us how he had managed to be 'intimate' with Lillian, an elderly, loyal and devoted former member of his staff, telling her everything. The sexualisation of this 'intimacy' was painfully obvious and he was crushed when we pointed out that it seemed this woman had been 'seduced' into his claustrum world, age being no barrier to sexual phantasy, an idea which seemed to shock him. Was there no one who could bear being in the presence of an intrusive projective identification

> with the internal mother without joining him as a claustrum dweller seeking 'to be the irresistible phallus' or 'to have power over it'. Was Jeremy condemned to this claustrophobic world? We had a picture of this nightmare in dreams, for example in Jeremy's dream of himself as the 'buried man'. In this dream his hand was sticking up above the ground, this buried man, who would not stay buried nor could escape.

One could say that Jeremy and Jenny 'escaped' that world (insofar as they ever did) only to find themselves in the *third* 'compartment' of the internal mother, the maternal rectum. It is with dwellers in this 'claustrum' that one finds the most profound disturbances, disturbing for the patient or the couple and for the therapists as well. I should say here that during the therapy with this couple for the most part we did not have the benefit of an understanding of the claustrum experience, having read Meltzer but not really having this way of thinking inside us. It was only in supervision with Dr. Meltzer that I began to appreciate how much sense it made of our experience with this couple. With this same co-therapist I am now seeing another couple who are, if anything, more ensconced in the claustrum than were Jenny and Jeremy. Although we see and experience the mutual intrusive projective identification in their relationship and with us, there is a profound difference in our capacity to think about this experience and boldness in our willingness to interpret it to them.

Our experience over three years with Jeremy and Jenny bore out Meltzer's observation about 'a slippery chute from head to rectum as voluptuousness leads to eroticism and on to sado-masochism' (Meltzer 1992, 91). My co-therapist and I were not prepared, however, for the depths of sadism and masochism which emerged in the crisis in the last summer of therapy with Jeremy alone. Jenny had withdrawn from the marital therapy and we had referred her for individual psychoanalytic psychotherapy nearer to her home as she began the process of separation from Jeremy. We had heard of crises of physical violence between the couple throughout the time we saw them together, most often with Jenny attacking Jeremy, one time hitting him so hard she broke her forearm. Life in the world of the rectum is life in an atmosphere of pervasive sadism and a hierarchic structure of tyranny and violence. In this world there is only one value, that of survival. Intrusion into the maternal rectum by stealth or violence leads to a view of a world of Bion's Basic Assumption Groups. Most shocking for the therapist working with an individual or a couple whose internal world takes on this claustrum quality is the degradation, not just of behaviour, but even more disturbing, of concepts and even the ability to think as a basis for action. In Meltzer's words:

Truth is transformed into anything that cannot be disproved; *justice* becomes talion plus increment; all the acts of *intimacy* change their meaning into techniques of manipulation or dissimulation; loyalty replaces *devotion*; obedience substitutes for *trust*; *emotion* is simulated by excitement; guilt and the yearning for punishment takes the place of *regret* (Meltzer 1992, 92, my emphasis).

I do not need to detail the degradation to which the relationship between Jeremy and Jenny sank in the last term of the therapy. We do not know how much she spent for lawyers and court costs, though it must have been at least as much as he spent; tens of thousands of pounds, which neither had nor could imaginably afford. We heard about it only through Jeremy's experience, but it was not difficult to imagine Jenny's nightmare which mirrored his. It was unbearable to sit with him in his violent despair, recounting one insane brutality after another as the inexorable legal process turned every humane gesture into a degrading attack.

Jeremy said it was the legal process that turned 'justice' into 'talion plus increment'. But I think even the family court setting, intended to be benign, was transformed into the claustrum world which Meltzer describes in the intrusive phantasy of the maternal rectum. It was difficult not to think that Jenny's new therapist and my co-therapist and I were being drawn in to be partisans of these protagonists in a world where 'truth' had been transformed into anything that could not be disproved, where all 'acts of intimacy' had changed their meaning into techniques of manipulation or dissimulation.

We saw Jeremy only once after he unexpectedly won the court battle. He recounted a recent village event in which a member of his staff, who had taken Jenny's side, had thrown a glass of red wine over him, staining his shirt. With satisfaction he told us of his 'revenge'. He went to her home, gathered up some dog shit from the green opposite and presented it to her, throwing a glass of *white* wine over her so as not to stain her dress. We interpreted his feelings towards us. Our holiday breaks had meant that we were largely unavailable at the time of the court case. Our 'deserting' him could have only one meaning *unconsciously* in his claustrum world i.e. 'he who is not with me is against me'. He felt 'stained' by our 'betrayal' but trying to hold back, he acted out his feelings with this other woman to keep from 'staining' us. He agreed that in some sense his gently breaking off therapy at that point, although necessary for him in order to establish a new home for the children, was also an attempt to protect us from a 'shitty' ending.

When I think of the two small children at the centre of this battle and read Meltzer's concluding words to a chapter on 'Life in the Claustrum', I am filled with a profound sadness.

> Somehow they are able to produce an atmosphere of hostage-holding, even if one cannot quite detect the identity of the hostage. It is always one's loved ones, in the last resort the children. (Meltzer 1992, 95).

Conclusion

In conclusion I want to make a brief comment on technical considerations in working with one's countertransference when in the presence of intrusive projective identification, i.e., when one is working with a couple or an individual imprisoned in a claustrum. What sense can we make of the experience? I don't know what we should say 'metapsychologically', but experientially it feels as if one were also a claustrum dweller. We begin to think and act as if the world we inhabit *is* the claustrum world in which the patient lives. It is a world into which the patient draws significant others and which we sometimes see a couple share. Being able to think about what is presented and experienced in the consulting room this way, I find, helps me to step back from this claustrum world and the limited options it presents. It also makes it possible to interpret in a different way.

The details of this world, most of which 'seem' full of meaning, invite earnest therapists to try to make sense of them in their eagerness to be helpful. However, this does not take account of the world in which the patient or the couple is living. For the head-breast dwellers interpretations can be seen as an invitation for them to join us, intruding into our minds to see the world through our eyes. This can seem momentarily gratifying, although with couples it often means one partner joining us to be an 'extra therapist' for the partner. But therapeutically it is inert, enacting a comforting sense of 'oneness' which soon becomes the suffocating attempt at fusion it really is (Morgan 1994).

For the dwellers in the 'Mardi Gras' world of the maternal genital, interpretations within the claustrum can be experienced either as seductions or as evidence of having been seduced. We are all too familiar with patients with whom we struggle to be able to say anything which is not one or the other, aware that we are being drawn into a claustrophobic 'eroticism' in spite of ourselves.

Most disturbing for us as therapists, however, is that claustrum of the maternal rectum with its sado-masochistic perversion of truth and fairness. In an earlier paper I have discussed the dynamics of what I called the 'false self couple', the dynamics of the 'impenetrable other' (Fisher 1993). In this relationship there is only the tyrannical self and the compliant object, or the compliant self and the tyrannical object, a dynamic into which therapists too can be drawn, feeling caught in the dilemma of having either to 'back down' or to triumph (Daniell and Fisher 1994).

What is required is not interpretation *within* the claustrum, but interpretation of the dilemma of living in that world, what Meltzer has called 'an invitation to come out of the claustrum', in an attempt to convey that there is indeed a world outside the claustrum, a world of humane values, of respect for the mystery of the other, a world in which there is to be found devotion, truth, intimacy, privacy, regret, a world beyond the 'narcissistic object relations' of the claustrum.

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NOTE: I would like to express my appreciation to Ms. Mary Morgan, Senior Marital Psychotherapist, Tavistock Marital Studies Institute, for her permission to use material from our shared co-therapy experience. As always in co-therapy, the ideas arose in the shared experience and thus the 'ownership' of the ideas belongs to the co-therapy partnership. In the same spirit I would like to acknowledge the couple from whom we learned so much through their sharing of their experience with us.

A HEROIC JOURNEY – TO A SCHIZOID COMPROMISE?*

KERRY THOMAS

Introduction

This paper is based on work, in Cambridge, with a mid-life male patient whom I shall call John, who came to me specifically for a Jungian analysis. The paper focuses on the first two years of the therapy. These two years were a committed contract period during which he came three times a week. This was followed by a further six months of once a week therapy. I used both archetypal psychology, and object relations theory in an attempt to understand John's difficulty in separating from his mother. There is a paradox underlying the work. From the outset I felt that I knew John very well and in writing about him I experience a subjective sense of certainty. But, at the same time, I am aware that in a fundamental sense I know very little. Is the journey he undertook a healthy, if delayed, life-journey of emerging consciousness? Or is it a jumbled and blocked developmental journey from his real mother and her representations in his inner world? At the end of the work I didn't know how far he had separated from me. In particular, I didn't understand the meaning of the end of the contract period or the end of the therapy. This knowing and yet not knowing must lie in a mix up between the two us, but it is also a fact that he brought me virtually no information about his external world. We worked almost entirely without context, using the relationship in the room, and his dreams.

Background - the hero

John's referral papers arrived with a warning: 'This patient might be a risk because he has already seen nine therapists.' The last of these therapists reported, 'John is struggling for control over a woman and afraid of his explosive rages.' I was surprised by the quiet, articulate

*Reading-in paper for Associate Membership of the BAP. Awarded Lady Balogh prize in February, 1993.

man who arrived. He was approaching forty five years, a blond man who sometimes looked a little feminine. His face could change rapidly between that of a beautiful boy, and an old man. I felt that he engaged with me almost at once, perhaps when I interpreted his fear of the rigidity of the time schedule and contract. He made a commitment to the work in the second session and I learned most of what I know about his history and current life in the next few sessions.

John is a first surviving son, brought up in close contact with cousins, Susan who was two years older and Mark, two and a half years younger. John's father was an alcoholic and John's early memories are overshadowed by angry quarrels between mother and father. Mother nagged and shouted and sometimes lashed out physically. Father wept and drank, dried out and returned to the bottle. John was frightened by mother's anger and the viciousness of her words and disgusted by father's weakness. As mother terrorised father so Susan terrorised John; and mother 'hovered' without intervening. 'But,' he said 'everyone loved little Mark. He was *my* baby. I remember hugging and kissing him and looking after him.' John remembers his mother not showing affection and being preoccupied with financial survival. The ethos was 'pull up your socks, be a big boy and get on with it, we all have to share the burden.' When John was about nine, mother took the children away from father and they moved from the East Anglian coast to a small Suffolk town. One of John's strongest memories is of the final separation, leaving father in the garden of a clinic. Father wept and begged mother to let him stay with them. After the age of fourteen John never again saw his father, who died a bankrupt alcoholic. But the rows didn't end. Mother quarrelled with her sister, John's aunt, and with Susan. And through adolescence into early adulthood Susan persecuted John. There were physical fights and he remained afraid of her. He said of women's words 'they get inside you, they make you helpless, they can kill; women's words are like weapons.' Yet here he was, committed to working with a woman for two years.

Very soon John's resistance set in and I was left with a man who brought me nothing about his external world and very little more about his earlier life. He told me he was feeling disillusioned with the therapy; it wasn't Jungian. He said he felt trapped and when the bad appears he usually escapes. He receded into long silences and he began to bring his recurrent dream about a journey. He described this as 'one of my recurrent dreams about travelling, about making a significant change of some kind although I am never quite on the journey.'

He brought this dream, the same structure with small variations, with increasing frequency throughout the therapy, more than twenty times in all. Usually, much of the dream was taken up with the frustrations and anxiety of trying to get his belongings together and packed up in time to catch a plane or a bus or a ship. There was often the anxiety of having to leave behind some important possession and there was always time pressure which he experienced as coming from an unknown source outside himself. Usually he didn't want to leave the place he was in; often it felt like the right place, or home, or paradise. In the dreams he had very little idea of where he was going but knew that he had no choice, the journey was inevitable. He always woke without having met the deadline.

At first I saw John's struggle to get his things together and move on as a metaphor for our work, his resistance, and his feeling in the transference that I was mother expecting too much and pushing him on too fast. When I interpreted the dream in relation to the therapy, he told me firmly that it couldn't be so because he had been having the dream for years. I wondered if the dream might also represent his passage through the stages of life, in a more general sense. He came to therapy wanting what he called an intellectual quest that would give him a new direction and help him find what he called 'my real self'. He presented himself optimistically, as a man who was re-assessing his life, withdrawing a little from the outside world rather as Jung described in 'The stages of life' (1930–31). I wondered if the sense of pressure in the dreams was the passage of time and acknowledgement of the approach of death (Jaques, 1965). Or perhaps the journey was one of deintegration-reintegration and lifelong individuation, driven by the Self and experienced in the dreams as the compelling sense of inevitability (Fordham, 1957).

John told me in those early sessions how he had become disillusioned with his career. Against his mother's wishes he had studied humanities and quite enjoyed teaching, but he wanted 'a higher profile job'. He had forced himself, in a counter-phobic way, into the 'City' and in the money world achieved a behind-the-scenes kind of stardom in a job which consisted of doing the impossible and making sense out of chaos, under time pressure and anew each day. Each day he felt that he was starting again in his struggle to achieve; he could not hold on to the good he had already done. He felt that all this had been to please mother but she had never been impressed. He said, 'My job was a sort of mistake, although it brought money. The only part of my life that felt real was rushing home to look after my daughter,

Lizzie.' He told me that he had already done a lot to change his life, rebuilding it around the arts, friendships and time put aside for his analysis. When he began therapy he had already given up his stressful job and was doing only a limited amount of freelance work. Was John an animus-dominated man being rescued in mid-life by the contra-sexual parts of his personality? This didn't seem like the whole story. There was too much heroic striving and frustration in his history and too much anxiety and stuckness in the recurrences of the dream. I began to think of the recurrent dream as an heroic journey.

In these recurrent dreams, in the heroic tradition, John is reluctant and preoccupied with the preparations for a journey whose destination and outcome is unknown, and compelled by a mysterious force. The hero is a symbol of nascent consciousness (Jung, 1956). But the emergence of consciousness implies a loss, loss of the comfort of oneness with the unconscious matrix. This struggle is represented in myth by the hero killing the dragon, that is, the mother who might pull the separating child or adolescent back into an incestuous and regressive union. The few facts I had about John's childhood certainly suggested that his real mother provided a powerful negative imago, at very least a reinforcement of the negative maternal archetype. Jung described this negative mother as '...a terrifying and inescapable fate' (Jung, 1938, para 158), that is, a projection of the fear of being drawn back into the matrix. In a paper on the Oedipus complex in adolescence, Gee suggests that the constellation of the [negative] archetypal mother 'may represent the young man's resistance to the separating effects of consciousness' (1991, p 205). So perhaps John was not very far along the developmental road, still in the midst of an adolescent battle with the dragon. Perhaps starting therapy was his attempt to collect his possessions, that is, become conscious of his shadow, leave the heroic position and begin the rest of life's journey. This view fitted with John's main, overt reason for starting therapy.

He told me that his 'idyllic' relationship with his little daughter was shattered as she changed from a child into a woman. Lizzie was seventeen when the therapy began. Perhaps John had been able to maintain his hero identity by projecting his shadow aspects. While older women took the projections of his rage, it seemed to be Lizzie who carried his weak and powerless part, the other pole of the hero archetype. So, by mothering the child Lizzie, he was able to stabilize the precarious hero who was struggling in the 'City'. Together they created an equilibrium. But then, in adolescence, Lizzie began to defy him and express her anger, becoming a dragon/mother/cousin just like

all the other women in his life instead of the perfect, innocent female he thought he had created. When they quarrelled he felt out of control, but disowned the anger: 'it is like a tool I pick up off a shelf when I am threatened, but not a part of me.' But he also said, 'When the verbal anger began again after I thought I had organized my life to remove it, I knew something was wrong.' John had glimpsed his own part in the conflict and his shadow, i.e. his hero identity was threatened. This was what triggered his search for therapy.

Gradually, I learned a little more about John's past attempts, in the external world, to leave mother, and control or leave relationships with women. He told me that he almost had a breakdown when his first lover was unfaithful, and that he had, in effect, used Lizzie's mother as a surrogate mother. He persuaded her against an abortion and when they parted after an eighteen month affair in the USA, John kept Lizzie. Contact with Lizzie's mother was lost. He has never again cohabited. He described his relationships with women as either intense sexual encounters which ended in disaster – betrayal or abandonment – or as unimportant. He decided to avoid close relationships with women and have only 'partial ones, without commitment'.

The beginning of therapy – the baby

Oedipus was abandoned by his real parents and later rejected his adoptive 'good parents' whilst striving to demonstrate his omniscience and independence. But this heroic activity served to return him and bind him to his 'bad parents'. Jung believed that the Self would eventually heal whatever damage abandonment inflicted. Gee (1991) suggests a less extreme, but still positive view that some degree of early abandonment, or sense of abandonment, can stimulate the hero archetype. A child who feels abandoned might be stimulated to become a precocious hero, even as early as the oedipal stage. This could have happened to John who once said, 'I never felt like a child but a little, aggressive adult.'

At the start of therapy, when John told me about the changes he had already made in his life, he said, 'So you see, I am feeling strong and self-sufficient and I don't really need therapy.' Omnipotence, omniscience and pseudo-independence are at the core of the hero archetype, but in the shadow is a dependent baby, and in the first session after John made his commitment, a frightened, angry, abandoned baby appeared in a dream. He said, 'It was a dream like no

other I have ever had ... it was a dream within a dream ... it was a kind of therapeutic setting and there was a [female] therapist and I was being prepared for sleep. And in this sleep I dreamed I was on the couch and I was a baby, and I was uncomfortable and crying because I had been left. Then, in the dream within the dream, I woke and the therapist wasn't there and at the same time I actually awoke.' He said that the therapist was obviously warm and caring and wanted to be there when the baby woke up. 'When the baby woke up alone, that was the ordinary state of affairs and it didn't feel bad. ... the baby had been lying on the couch like a real baby, with wet nappies, kicking its legs and screaming. I'm pretty sure that I actually cried, although that wasn't the feeling when I woke up. When I woke up I felt good and the strongest feeling was a sense of creativity, that I had had such a creative dream, one that I couldn't have had with my conscious mind. ... therapy should be creative like that, a beautiful thing. I don't want to put that on you as a burden, rather it is something that we do together. I had thought I wouldn't tell you about the dream because I felt I couldn't do it justice.'

With the baby, John's defences and schizoid aspects of his personality appeared in a way that was typical of what was to follow. The dream and his telling of it contained a denial of misery and of the fact of abandonment. He denied the absence of the therapist, and idealized her. And in a grandiose intellectualization he idealized the therapeutic process and inflated his own unconscious creativity, revealing a split between his conscious and unconscious mind. The dream within a dream seemed to be a way of distancing himself from the baby and the work. He revealed his need to control what he brings, and to control me and what I might be allowed to do in the therapy. He wanted us to be equal, two mothers/analysts doing it together. And he revealed his anxiety about the constant benchmark; can he do it well enough? The dream also showed an unconscious regressive pull, but signalled that he wouldn't let it happen, or not in my presence. This dream proved to be a harbinger of the importance of the denied baby, and of John's defences and his resistance.

In the room

For John, the first two years of his therapy turned out very like his journey dream. He felt frustrated but compelled, and frightened but heroic. He would wake at 5 or 6 a.m. on the mornings of his sessions,

worrying about not having good material to bring. But he felt he had to come on time, and never ask for changes in times, and he had to fulfil the contract. These anxieties remained throughout the therapy. But whilst he seemingly complied, he resisted the process. I had little or no idea what was happening in his life, or even how he spent his days. He admitted censoring his material. 'I don't want to bring everyday things, trivia and gossip. My analysis should be about more "lofty" matters.' A ritualistic defensive pattern emerged. He would begin, lying stiffly on the couch, in silence for six or seven minutes and then either express his anxiety about the process or about bringing material that would satisfy me; or he would bring a predigested dream which he would describe without affect but in elaborate language and detail as if he were describing a painting from a distance. Indeed he was often an observer within the narrative of the dream. Sometimes he seemed to be filling up the sessions with dreams to prevent us talking about anything else and if the dream revealed material that he didn't want to deal with, he would attack the dream himself, before I could say anything.

Much of the time he was distant and affectless and the few people from his outside world who found their way into the room, usually as associations to figures in dreams, were nameless and shadowy. His dreams were the most alive part of therapy and they became a vital language in which we could communicate about his inner world and about what was happening between us. For example, he dreamed of a colourful and happy wedding that was taking place in a country churchyard, where he was on the fringe of the crowd. He turned away and realised that the meadow came to the edge of the sea where there was a storm. A little way out there was an empty boat and two men were in the water. A big wave delivered the men to his feet. One was all right but the other was unconscious. John, with the help of a technician, resuscitated the drowning man and John woke with a sense of joy. This dream illustrates some of the splits in his inner world; between a good and happy place where people or parts of people can be joined, and the dangerous, stormy sea where parts of him reside in different figures, one of which is half-dead. But his heroic coping-in-the-technical world part pulled off a miracle, with the help of his observing self, in which he resides.

He had many such dreams and sometimes continued to work with an interpretation for several sessions. Often the dreams came in a series and we worked co-operatively, signalled by an almost imperceptible softening of his tone. At these times there was a warmth and

rhythm between us that was like his description of music, being held by the body of voices in a chorus. These were the best of times and I felt he must have begun well with his mother. But, as a child, he had had difficulty doing things alone. He would feel as if he had 'lost the rhythm and been dropped'. Something must have gone wrong very early. In the therapy too, the closeness would suddenly be lost. Sooner or later he would retreat.

Throughout the two years we oscillated between productive dialogue with some small changes, a recognition of defences and some acceptance of work in the transference, and attack and retreat. He attacked the process: 'I've kept a copy of Masson's *Against Therapy* beside my bed since we began. I know what it is about but I dare not read it... I do believe in the process but I don't want to feel duped'. He kept track of anti-psychoanalytic articles and book reviews in the press, particularly those which concerned sexual exploitation in therapy. He fought implacably against transference interpretations for a long time and his most dramatic retreats were when my interpretations implied a closeness between us. Sometimes he would half accept, saying 'I understand what you are saying and I know about the process from my reading, but I can't feel it.' Sometimes the attacks were clearly directed at me but completely unconscious. He dreamed of a woman harpist (harping, or a harpy, perhaps) 'who was so preoccupied with some technical aspect of her instrument that she destroyed the music and turned the whole performance into a farce, a pantomime.'

John defended himself against my interpretations in a characteristic way. At first he would nod and then elaborate, intellectualizing and gradually turning my meaning until he had reached a denial. Often it was more complicated and he would come back eventually to the original meaning. I realised that he was unaware that what he was delivering were essentially two contradictory messages. For example, after each holiday break he would return telling me how well he had done without me, and how he didn't need or want to come back. But threaded through this there would be a quite separate, overt acknowledgement that he is better because of the therapy, that there are changes in him, but he can only experience the benefit when he is away from me. I learned to pull out the opposing strands and hold on to them long enough to show him what he was doing, but it was difficult and exhausting and could feel the meaning evaporating as I almost lost the capacity to think. When I could hold the strands for long enough and get them into words, he could sometimes 'see' the contradictions. But then he would distance himself, saying, 'Well if

you say so' or deny one or other of the meanings, usually the more positive aspect. Holding on to the good in his therapy was difficult and dangerous for John.

I often felt him pushing me away and distorting any understanding that might threaten his attempts to keep us apart. But sometimes there was a breakthrough. Once, in the context of his fear of women, he brought a dream in which he was lying face down on a bed with his mother lying on top of him. 'She was pinning me down with a masculine grasp.' I made a transference interpretation using some of his own, earlier words about seeing me as strong enough to stop his intellectualizing. He came to the next session with a quiet but insistent, intellectual assault on the use of transference. 'Since last time I have been thinking about how I just can't take the things you say about our relationship, especially the last dream. I can see that it was my mother; clearly it was my mother in the dream. And I can see that the dream relates to the way I relate to other women. I can't make the leap to connect it with my relationship with you.' There was a pause. Then he said, 'I just can't feel it. I can see that you see it and that you believe it but I just can't get any feeling of it at all. I can't accept that it is about the relationship in the room.' There was another short pause and he added, 'I don't know whether all this means that there actually isn't anything in it or that it just isn't working between us.' He continued, 'I know I find it difficult to hold things together and I've been having this argument in my mind; it's been going on since the last session.' I reminded him of how, last week, he had been afraid to ask me about taking two sessions off. He said, 'Yes, but that felt more like work, like wanting to be reliable and do the right thing.' I said, 'That's one aspect of your relationship with your mother that you do experience in here.' He said 'I haven't come to therapy to work on our relationship, but to work.' I said, 'You have come to work on relationships and this is the one we have here, the one most alive.' He continued to argue, for about fifteen minutes in all, and then stopped, saying, 'I don't know if I have made myself clear. I don't know if I have got across what I am trying to say.' I said, quietly, 'Yes, I think you have.' And then there was a heavy silence for a minute or two. Then he said, in a softer tone 'Now I feel I've been heard and understood.' He was silent for a while. Suddenly he broke the silence: 'Now I feel I have pushed you away and it is safer. But your silence makes me think I have hurt you, damaged the process.' I said, 'You have argued your point about transference intellectually but then experienced it, right here in the room.' He

nodded and said, 'Yes, and I have the sense of having done something wrong, which is very familiar. And that I have to repair the damage, and somehow a pressure to over-compensate. But I had to say what I said.' After another pause he said, 'If you are right then it requires a level of trust that is unique'.

My countertransference feelings were difficult to understand. I could hear his attacks and later read them on the pages of my notes, but I almost never felt their impact. John felt to me like a precious, small boy, somewhere between four and perhaps nine years old. With only one or two exceptions I remained a patient, loving mother, interested, even engrossed in this special child. It was as if I had become just what he said he had wanted and never had. He told me, 'I never felt loved for myself, just a little boy sitting in the corner.' With this phrase, John expressed a feeling that is almost exactly what Fairbairn described as a precondition for the development of a schizoid personality. But John also told me that he had always felt that he knew he was the special one for his mother, it felt like a secret between them, but something she couldn't tell him. He seemed to have re-created this in me. Eventually, he confessed to another schizoid attribute. He said that he had always had a deep down sense of knowing, of always being right. And I realized that there was a similar omniscience in my countertransference, that from the beginning I had felt I understood him. Some unconscious identity seems to have begun between us almost instantaneously and I think this was what enabled him to commit himself at once to therapy with me. I think he idealized the 'analysis' and perhaps part of me too, but that in this there was a degree of mix-up between us. As I began to see these dynamics more clearly, I realized that the splits and internal objects I was experiencing in projection in the transference and countertransference mapped on to Fairbairn's description of the inner world of schizoid patients (Fairbairn, 1952a and b).

The schizoid inner world – a cast of characters

Fairbairn's theory of normal psychic development grew from his work with the dreams of schizoid patients where he found split-off ego fragments and internal objects interacting as if characters in a play. His model of the inner world has similarities with Klein's psychic reality and multiple internal objects, but there are significant differences. Klein's belief in the death instinct gave us babies that are driven

by innate aggression, hate and envy. Whilst Fairbairn also emphasised the negative, he believed that the primary motivation in development is object relating and that it is an infant's *actual* experiences of frustrating and depriving objects in the environment, subsequently incorporated into his inner world, that leads the differentiation of internal structure, rather than innate unconscious fantasies, or archetypes.

According to Fairbairn, in the early oral phase an infant defensively internalizes his original object (usually mother) *insofar* as he experiences her as unsatisfying, and to achieve some control over bad aspects of the environment, including the 'normal' frustrating experiences of separation and hungry emptiness. But the infant is then faced with a persecuting internal version of the same mixture of satisfaction and frustration. What follows is not a two-way split into good and bad but a three-way split, promoted by the infant's original, unitary ego. A central core of the conscious ego remains attached to an idealized and de-sexualized version of the original object, mother, from which both the rejecting and the exciting aspects have been split-off. The rejecting parts of mother, the antilibidinal object, are attached to a corresponding split-off ego fragment which Fairbairn called the antilibidinal ego or 'internal saboteur'. The exciting parts of mother, the libidinal object, are attached to a corresponding split-off ego fragment, the libidinal ego. These two split-off pairs of part-object plus ego fragment are then repressed by the central ego. Fairbairn proposed that the internal saboteur (the antilibidinal ego), because of its attachment to the rejecting parts of the inner mother, joins up with the central ego in a further hostile repression of the especially dangerous libidinal ego. Guntrip, who worked with severely regressed patients, believed that this led to such levels of internally generated anxiety, primarily experienced by the libidinal ego as persecution, that the libidinal ego splits for a second time, to create in addition, a regressed ego fragment which pulls constantly towards 'passive, dependent, security' (Guntrip, 1968a, p. 74).

For Fairbairn, it was separation anxiety that was the 'earliest and original form of anxiety' and it was abandonment, in varying degrees, that led to the initial defensive splitting. I learned that John was suddenly weaned at two or three months for 'medical reasons'. For Guntrip, withdrawal into an inner world was increased by tantalising non-satisfaction of needs and the impingement of a hostile world such as quarrelling parents. John experienced his female cousin Susan as a tantalizing persecutor and his mother as 'hovering' but not protecting him. And he certainly lived in a noisy, verbal battleground. Fairbairn

believed that these early structural splits in an infant's psyche are not necessarily pathological, and that an infant can move on to a less rigidly split endopsychic structure providing that later developmental stages ameliorate rather than reinforce the splits. But if the oedipal stage and adolescence are also problematic, rather like the cumulative trauma described by Khan (1974), then the split structure becomes pathologically rigid; the structure of the schizoid personality.

Throughout childhood and adolescence John seemed to have experienced his family in a way that reinforced the early splits in his inner world and kept him tied to both the idealized and the rejecting internal mothers, constantly reexperienced in projection and projective identification in his external relationships and in his therapy, where I experienced the same cast of characters in the transference and countertransference. Part of me became an idealized, intellectual mother/analyst, safely desexualized. His antilibidinal object was projected into the constraints and demands of the therapy and into another part of me. His libidinal ego, the baby of the harbinger dream, the weak and helpless shadow of the hero, was largely kept hidden and what was particularly frightening for John was any experience of closeness with me that might engage the dependent baby and even pull it back into a regression. This fear was the main feature of the therapy and, I believe, the reason for John's massive resistance (Guntrip, 1968b, p. 196).

John's resistance was the result of continuous sabotage by his antilibidinal ego, a constant attack on his despised weak part. But the crux of the struggle, as I understand it, was that in John's case, the libidinal ego was more than just a needy baby. What was notable about John's case was that in his family there seems to have been a basic confusion between child and adult and between male and female. I believe that these mix-ups pushed him into an early and confused oedipal stage, precocious pseudo-independence, and a diffuse gender identity. There seems to have been early projective identification with father, a mix-up between John's own baby part and his father's childlike personality. The result was that John's libidinal ego, massively repressed now in the light of his real father's real rejection by mother, became associated with not only a dependent, hungry infant but also with an addicted, sexually hungry, and ultimately abandoned man. In the effective absence of a father, John identified with mother in both her idealized, feminine aspects, and as an angry, rejecting, and animus-driven replacement for father. In each case these identifications were made with archetypal intensity. John said, 'I had to be like mother because

the only alternative was to be like father.' By this he meant, in his own words, 'drunk, out of control, disgustingly weak, weeping like a child, and begging not to be sent away'. John remembers, from before he was three, being a good mother to his baby cousin Mark. But he also remembers being a bad mother at a very early age. He recalled taking responsibility for finding empty drink bottles, shouting at his father but hearing himself speaking his mother's angry words. In adolescence, without a father to help him modify or separate from these internal versions of his mother, John had an unrealistic masculine model, his mother's animus, to fuel his heroic imago. And as a young adult he maintained his maternal identifications. He projected the negative mother into his own mother, his female cousin and his lovers whilst enacting perfect motherhood with Lizzie, and searching for a perfect woman partner to take the projection of his ideal.

The intensity of John's internal struggle with his repressed, sexualized libidinal ego (baby/father/husband) is illustrated by a dream: 'There was homosexual man, older than me, on my back, clinging and clutching and I couldn't get him off. I couldn't get him off without help and there were TV camera's there and I appealed to the public through the cameras to stop this "rape". But it didn't help. There was also a shadowy nurse figure. The man was addicted to pills and the nurse thought that the man might be induced to take an overdose and fall asleep and then I could get him off. But this didn't happen and in the end time took over and the man fed himself the pills to self-destruct and fell on the ground. There was something about this man that made me think of my father, but I couldn't really say what. I was frightened as a child by my father's weakness but mother described him as insistently heterosexual, and sexually needy.' This dream reveals John's unconscious fear that he might be homosexual, a topic beyond the scope of this paper. It also shows his attempts, in the external world, to compensate for his needy part by making himself heard with public success. In this dream I am a nurse/therapist, someone he wishes would help him kill off his addicted, sexualized baby/father/husband. The dream also reveals the pull of regression. What John most feared was that this sexualized baby/father/husband would get into the room and he would lose control. Once or twice it did.

Very close encounters

About six months into the therapy, and again a year later, something happened which had a different quality from all our other interactions.

The second of these episodes occurred after a real event disturbed the container. John arrived at my house for his session, early in the morning, at the same time as an elderly man who was carrying bags and suitcases. In the session that followed John seemed to be 'relieved', but did not mention the encounter. He brought a dream to the next session. In this dream he and his female cousin were having sexual intercourse, fully clothed, on a sofa. The explicit purpose of this frightening and exciting intercourse was therapeutic; it was so that they could get it out of the way and then get on with their relationship. During the act they confided in each other about their jealousy of the other's sexual partner. His cousin's partner in the dream was a man with John's own name. My attempts to interpret this dream in the transference and in oedipal terms led to a series of dreams, brought to the next few sessions, in which his cousin damaged his property and perhaps his body. She killed a favourite plant, and she stood over him close to a large pair of scissors. She literally cut communication with the outside world by pulling the tape out of his telephone answering machine and she sat in his flat, knitting, and preventing him from making outgoing phone calls.

For several sessions John seemed to be in a borderline state. His arguments with me seemed to be aimed at destroying meaning and he concretized my words with a quiet intensity which felt like both fear and anger. I felt attacked and frightened. The room felt as if it was full of dangerous fragments and a sense of imminent disintegration. John felt that I was robbing him of the work he had already done himself on his relationship with his cousin, and that I was destroying all the good work he and I had done together. He felt that the therapy had already ended. After a few sessions I began to feel irritated and then angry and experienced him like an angry adolescent. It was as if I had 'become' his cousin Susan.

This episode lasted for about two weeks. The extent of my anxiety about John was revealed in a dream. I dreamed that John was my patient in a hospital setting and that he had come at the weekend for an emergency appointment. He was seen, not by me but by the duty psychiatrist. During this period, although John didn't accept my interpretations, he did stay with the powerful feelings and kept coming to the sessions. The terror subsided but we both felt irritable and gridlocked. We came out of the episode when I showed him how he always attacks the links when we approach this area, admitting that I didn't understand exactly what 'this area' is. He welcomed the interpretation 'because I don't want you to get off your pedestal'.

Perhaps this meant that I had resumed my role as an idealized, out of reach, intellect. I said, 'When I am "off my pedestal" the battles feel real'. He agreed. Soon afterwards he was able to say that he 'half sees' the process, and is 'beginning to see that all this is the essence of the work'. He told how much of his time he spends asleep and that his legs 'go weak'. He began asking himself, 'Am I on the right journey?' Around this time I appeared in his recurrent journey dream as a travelling companion, this time as a safe colleague.

Understanding the borderline episodes

In our 'very close encounters', John turned everything around, dreamed of cut communications, lost the 'as if' quality of the work, and words seemed to become things in themselves. I felt that we were approaching a psychotic part of John's personality (Bion, 1958, 1959). If, in these episodes, he was indeed attacking the K links, what was it he couldn't bear to know? I can speculate.

The borderline episodes seemed to occur when there was a possibility that in the transference I might become a libidinal object, triggered either by an oedipal replay or (in the first such episode) by mention of Susan in an erotic context. Both of these might represent later developmental repeats, in the oedipal stage and adolescence, of his experience with the early, *oral* libidinal object but now in its more sexualised forms. I am not clear about the significance of his cousin, but I do know she attacked him verbally and physically and frightened him until they were young adults; in adolescence, at least, it is likely there was a sexual element to this aggression. Perhaps *she* carried the projections of the most frightening, sexual aspects of the negative mother. Was John cutting the links because he couldn't think about the possibility of an exciting object joining with the other two split-off versions of his internal objects (idealized and rejecting objects), parts of me in the transference? Was it that he couldn't bear these parts coming together internally, and in one person, in the transference, in the room?

Or was John unable to think about threesomes? Perhaps the glimpse of 'father', the accidental intrusion of the external world, turned me into a sexual object and part of an oedipal triangle. This would resonate with his libidinal ego in its most powerful form, that of father already weakened and about to be rejected, and carrying the projection of John's own baby self. In this way father was both rival and self,

husband and child, inextricably mixed into the most frightening combination of dependency, sexuality and potential abandonment.

Or was the terror about a forced emergence of two out of the illusion of oneness? During these episodes John seemed to be experiencing my words like missiles that threatened to annihilate him, just as he had said before of women's words. Perhaps he was experiencing my attempts at verbal interpretation like Bion's 'mutilating attacks' on his projective identification with me. Did 'father' returning home with his suitcases trigger John's powerful memory of father returning from the drying-out clinic? He remembers, at age three or four, opening the front door, and realising that father was already drunk. John called upstairs to tell mother 'He's drunk again.' The reappearance of father threatened the oneness of the idealized, safe, non-sexual couple in a state of projective identification. In Meltzer's metaphor (1976) this, and my verbal interpretation, could be seen as forcing an exit from the secure omniscience of the head-breast, a forced recognition of difference. John says of his mother, 'She would tell me things about myself, that I knew were not so, that I was irresponsible, and like my father, and I would feel wiped out as if I had lost my sense of identity.' One way to understand the power of the idealized head-breast mother is that John had to creep inside her defensively, had to become mother and look out through her eyes in order to avoid the gender war zone and the danger of being dropped for ever. I see now that he spent a large part of his therapy looking out through my eyes and being his own analyst; our unconscious identity and our mutual sense of omniscience persisted throughout. If he does have to come out of my head and 'down off my pedestal' then we are separate, one becoming two. What follows then is the frightening possibility and the implications of two becoming one-sexuality, rivalry, identifications with father and finally, failure and abandonment.

According to Kernberg (1975) it is only in the areas of 'close personal involvement' that borderline patients lose the sense of boundaries between 'self [ego] and object images' (p. 39). And this is how it was with John. Kernberg also describes what I understand as John's cumulative trauma and the sexualization of his early libidinal ego: '... I suggest that what is characteristic of the borderline personality organization, ... is a specific condensation between pregenital and genital conflicts, and a *premature* development of oedipal conflicts from the second or third year on (p. 40) ... In the case of the boy, premature development of genital strivings in order to deny oral-

dependent needs tends to fail because oedipal fears and prohibitions against sexual impulses toward mother are powerfully reinforced by pregenital fears of the mother, and a typical image of a dangerous, castrating mother develops...' (p. 41).

This sounds close to the idea of negative archetype of mother being evoked by something akin to precocious stimulation of the hero archetype.

The end of the contract

Towards the end of the two year contract period, John voiced a paradox. He said that for him it would be a move towards health if he left at the end of the contract and got away from mother's demands. He said he couldn't afford therapy any more and it was imperative that he spent the time looking for paid work. But he also said that if he left it would be like running away as he always does, and he would feel a failure. Most of the depression and anxiety about the ending seemed to be put into me. I was sad and felt not good enough. I was anxious about John and I began to see that the two year period of therapy might have been a controlled regression, away from the pressure of full time work, safely conducted in the privacy of his flat, and away from me. I tried to think of a way that would enable him to continue therapy. I suggested that it is his compliant self that brings him to the sessions and that this part of him has used the rigid schedule and contract as a structure, an external force, to fight against and prevent another part of him, what he calls his real self, from getting engaged in a journey of increasing awareness. In the next session John described a dream. He had brought an idealized version of his real mother, 'beautifully dressed and I was proud of her', to visit his bad mother, in the form of a (real) bitter ex-landlady who shouted at him on the door-step about his cowardice in not revisiting her. In the dream he then brought the two 'mothers' together in one room and watched them talking to each other. I was encouraged by this dream and wondered if he might be able to let go of the demanding three times a week mother and make use, perhaps better use, of a less rigid, once a week object.

I offered John the possibility of continuing at the reduced fee, once a week but open-ended so that he would eventually have to negotiate a real ending. In the following session he told me that he had felt that

this was a wonderful gift and that he had experienced warmth in the room in recent weeks. He also said, 'I had the journey dream again and actually got all my things together in time. But then I had to question affection from women and spent hours turning it into something bad, wondering what was in it for you.' He was aware that he was attacking the good, but in explaining this to me he began to attack again. The internal saboteur took over. I think that as he approached awareness of his need for the gift and for affection, his hunger was projected into me and women in general and he then attacked the devouring, seducing, mother. He said, 'It always feels as if they only want a part of me, not *me*. It's sex they want and the problem is that it will go in the end and so it feels like a baby who is left... it (sex) makes me feel good and alive and then just when I've become dependent on it, it will go, just when I had become addicted.' John had the journey dream several times more, getting his things together but now responsible not only for his possessions but for other people, dependent children and a 'crazy withdrawn aunt'. The main feeling now was not frustration and anxiety but the burden of the things; 'they are all so heavy'.

It took John nearly a month to accept my offer of once a week therapy. When he did, I felt optimistic that we had achieved something that allowed him to separate a little from his negative, internal mother. But then I saw that his decision could be interpreted as a typical schizoid compromise, half in and half out of his therapy. I began to accept the reality of how little I knew about him, his current life and what the end of the contract really meant. I began to question: 'How ill or how well is he? Is he taking another step on a more or less healthy journey of individuation? Is he finally leaving the hero behind and moving towards acceptance of limitations, dependencies and sadness. Or has he settled down into a schizoid equilibrium, neither with mother nor separated, the best he can manage? Or is he becoming his father, withdrawing from the external world, sinking into unemployment, poverty and regression?

Summary

During the contract period of the therapy I think we did make a small impact on John's defences and resistance. At the beginning of the therapy he was dimly aware of the presence of the helpless baby but

fought against anything that might imply dependence on me. Most of the time he could barely work in the transference and when he did, it was with his negative experience of the demands of the therapy and therapist. Very occasionally he managed to work overtly with positive aspects of the transference but this invariably led to a retreat. The background of idealization remained almost unrecognized although it flickered into life when we approached the ending of the two year contract. Very gradually over the two years he had begun to own some of the aggression around him and acknowledge that he might never be rescued from his loneliness by a perfect woman. And he had begun to recognise that he doesn't 'know' how old he is. He had a significant birthday (45), a few months before the end of the two year contract, and an old man appeared in his dreams alongside a young one. In one dream this old man was left lying on a bed whilst a young man with superhuman strength went on his way, reluctantly and carrying a sofa with him. The hero cannot experience despair, dependency needs or the destructive side of his aggression, so it seemed that John might finally be giving up his preoccupation with the hero archetype.

In my attempts to understand John, I used both Jungian archetypal and object relations approaches. Pulling the strands together, I found a surprising amount of commonality between these two ways of thinking. There is in each a notion of early abandonment leading to precocious pseudo-independence. This might be some kind of false self, or splitting, followed by idealization of an ego-object fragment, or a defensive projective identification with mother to maintain omniscience, or early elicitation of the hero archetype. In each there is a weak and perhaps highly eroticized baby/child who has to be protected and denied, and a regressive pull back into mother to be resisted. But, despite these similarities, the two approaches have rather different implications for health.

Given my continuing confusion about how well or how ill John was, it became crucial that I remain aware of the possibility that I might use theory, unconsciously, to deny his inability to move on and the limited use he had made of the therapy. I found that when I tried to think about where John might be on his journey, I could be much more optimistic using the Jungian approach. It provided a sense of forward movement, the compelling force of John's recurrent dream, the drive of the Self towards bringing shadow parts, or split-off parts, into consciousness. But when I looked from the object relations vertex it seemed much less likely that he would be able to reintegrate the splits in his inner world and move on.

Postscript

John continued his therapy for six months beyond the two year contract, coming to one session per week. At first he held on tightly to the negative mother, saying he still felt he had to bring good material, only now it had to be three times as good since he was here only once a week. He was, however, able to let himself be depressed and his age become a major theme. The recurrent dream changed. He managed to get his 'things' together in time and moved on to the actual journey, showing concern for the dependents who were travelling with him, perhaps an indication that he was indeed reaching the depressive position. I began to think that he had been in a long, heroic adolescence, a defensive reaction to condensed and jumbled-up developmental phases, but was now working this through in the context of mid-life and the approach of death.

We had agreed, after the end of the contract period, that the end of the therapy would be negotiated and that he would need to experience a real ending, rather than a flight, his usual pattern. Sometimes he talked about ending the therapy, but did so in the same way as he had all along in that he has continually to fight the temptation to run away. He brought this up again in the last session before the three week Easter break. Halfway through this holiday he wrote, enclosing a cheque, to say that he would not be coming back. I wrote back, asking him to try to return for one session to talk about the ending. He declined: 'What would concern me about that is precisely what has been at the centre of my struggle over the last two and a half years. Other endings and other 'goodbyes' would be talked about and not the ending of a professional arrangement. The relief and sense of wholeness that I now feel when I don't have to struggle with the dilemma of transference is such that I can hold on to the good from the therapy in retrospect and I don't want to cast doubt on that.'

With this letter in front of me I could no longer entertain the more positive view of the therapy. At the moment of writing to me John seems to have been just where he was at the outset. In Jungian terms, he was just as engaged in the heroic struggle to be independent and to escape from mother as at the start of the therapy. However, either in keeping with my sense of 'knowing' this patient from the beginning, the projective identification between us, or as a defence against his attacks in the letter and the relatively small impact the therapy seemed to have had, I found myself engaged with a fantasy. This fantasy *could*

account for John's final retreat, within the object relations interpretation of his libidinal ego that I had already committed to paper.

John did not write to end the therapy as soon as the break began. Nor did he write just before he was due to return. He wrote in the middle of the break and within forty eight hours of the publication, in a newspaper that I know he commonly read, of an article 'against psychotherapy.' This was not a general onslaught but one of those that focuses on the prevalence and the terrible dangers of seduction of the patient by the therapist. Unusually, it concerned a female analyst, accused in the USA of seducing and then abandoning an adolescent, alcoholic, male patient. The abandoned patient committed suicide. The parallels between John's history, my understanding of his resistance as reflecting the power of his libidinal ego (in my own, earlier words 'associated with not only a dependent, hungry infant but with an addicted, sexually hungry and ultimately abandoned man') and the timing of the article and John's flight is compelling. But, of course, I will never know.

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ENACTMENT AS COUNTERTRANSFERENCE*

STANLEY RUSZCZYNSKI

Preamble

In this paper I want to reflect on a particular but, in my view, fundamental aspect of the concept and the experience of countertransference. What I want to state is very simple and familiar, but like anything else that gets taken for granted its value may become forgotten and it may therefore come to be misused or even abused.

I will take it as read that, both theoretically and clinically, there is agreement that the psychotherapeutic process rests on the analysis of the transference-countertransference relationship, the understanding of which leads to insight, the mediation of internal object relations and therefore psychic change. There are now probably few psychoanalytic practitioners who would not acknowledge the potential clinical usefulness of the psychotherapist's countertransference experience, alongside, of course, that of the patient's transference. The clinical debate tends to be about 'transference interpretations only' v. 'transference, non-transference and other agents of psychic change', rather than whether transference analysis is important or not.

The clinical focus on the transference-countertransference relationship, as well as the debate about transference and extra-transference interpretations, is as alive in psychoanalytic work with couples as with individuals. In the former, however, the transference-countertransference field is substantially more complex, given that not only are there two patients in the room at the same time, but also that the couple will have their own 'transference-countertransference' relationship to each other as well as that in relation to the marital psychotherapist (Ruszczynski, 1992, 1993).

Be it with couples or with individual patients my understanding is that an analysis of the nature of the transference-countertransference relationship gives access to the internal world and object relations of the patient, and (in addition) with couples, to their shared internal world which informs the nature of their interactions with each other.

*Presented at a Conference 'The Leading Edge of Analytic Marital Therapy' at the Washington School of Psychiatry, Washington D.C. 3–6 March 1994

I will leave aside the interesting debate about how much this same access to the internal world may be gained through an analysis of the nature of the couples' 'transference-countertransference' to each other as opposed to that in relation to the marital psychotherapist.

Precisely because of its clinical usefulness, however, I have sometimes wondered whether we are inclined to forget just how subtle and complex the concept of countertransference actually is. The literature on the subject is vast and it is not possible to give that literature proper recognition in a brief paper. Perhaps this volume of writing reflects the complexity of the concept and the debates and discussions around it; but it must also reflect the centrality of the understanding of the transference-countertransference relationship in the psychoanalytic process.

Contemporary psychoanalysis increasingly acknowledges the interactive nature of the psychoanalytic endeavour and recognises that the analyst or therapist is an active participant in the process and will therefore, inevitably but unpredictably, get caught up in it. Segal, amongst others, reminds us of the unconscious pressures we will all be put under by our patients to participate in their phantasies and internal object relations (Segal, 1977). This *experience* we have, as a result of the ways in which we are *consciously and unconsciously* affected by our patients, is what now so much informs our clinical work. However, as Segal points out, 'countertransference is the best of servants and the worst of enemies' (Segal 1977) and, in my view, we need to constantly remind ourselves of both of these aspects of the concept.

Introduction

I have recently noticed in the psychoanalytic literature, particularly though not exclusively in American writings, that, over the last few years, a number of authors have taken a special interest in the analyst's and therapist's *enactments* in the psychoanalytic process (e.g. Chused, 1991; Jacobs, 1986; McLaughlin, 1991; Panel Discussion, 1989; Renik, 1993a, 1993b; Viedermann, 1993). As McLaughlin (1991) points out, the word *enactment* seems to have crept into the psychoanalytic literature with some uncertainty about quite what is being referred to.

Although most of these authors have related enactment to the transference-countertransference matrix in the psychoanalytic process, definitions of the concept and its understanding differ from writer to

writer. Appropriately, it is sometimes linked to the concept of acting-out, though the somewhat pejorative way in which that concept tends to be understood is avoided. In the panel discussion on the topic held by the American Psychoanalytic Association in 1989, the reporter of the discussion, Morton Johan, concluded that, '...Full agreement on a definition (of enactment) is not yet at hand. It was agreed that interactions occur in almost all psychoanalytic situations (more in some and less in others), which should be denoted by the term enactment. These enactments derive from unconscious sources in both patient and analyst. Enactments are those moments, from brief and single moments to prolonged and/or multiple time periods, during which *the patient's action, in the service of transference resistance, interacts with the analyst's resistance'* (Panel Discussion, 1992, my emphasis).

I was struck by this conclusion, primarily because of the emphasis placed on *transference resistance* in both patient and analyst, which brings it very close to the concept of acting-out. Does enactment really relate purely to resistance, to an avoidance of gaining access to the unconscious internal world? Sometimes, of course, it may well do so, hence the value of the original understanding of acting-out *by both patient and therapist*, as an avoidance of acknowledging the transference-countertransference relationship.

However, may enactment not also be considered to be an unconscious repetition, in the transference-countertransference relationship, of dynamic aspects of the internal world of the patient? Does enactment then refer to a complex unconscious *engagement* between patient and therapist, substantially created by the patient in the course of living out his internal object relations in the context of his relationship to the psychotherapist? In other words, are we talking about anything other than the transference-countertransference relationship?

I was therefore led to wonder whether that which these (and other) authors are struggling to delineate, as they discuss the concept of enactment, has actually *always been at the heart of the psychoanalytic process*: an unconscious living out of the patient's internal object relations, in the here and now of the psychotherapeutic encounter.

In what follows, therefore, I will briefly trace a development of the concept of countertransference which emphasises its *unconscious* aspect and which roots the countertransference experience in the understanding that, as psychotherapists, we are by definition affected by our patients as a result of the dynamic effect of unconscious communications. I want to suggest that some form of *enactment* is always, and

necessarily so, at the heart of the countertransference experience. This is because the psychoanalytic dialogue between patient and therapist takes place not only in spoken words but in the experiences unconsciously enacted between them. That which I wish to restate is simply that by definition *countertransference is unconscious*, to both patient and therapist and therefore, the meaning of the title of this paper, *enactment as countertransference*, will emerge. In keeping with what I am presenting, I hope that what I will say will be evocative rather than prescriptive or definitive.

My approach is not new, and is only one interpretation of the development of the understanding of the psychotherapeutic relationship amongst others which have developed simultaneously. I can best outline that which I have found of value in my own attempt to understand my clinical work with individuals and with couples. I would indeed add that my psychoanalytic experiences with couple relationships as well as with individual patients has *obliged me* to constantly address that which Owen Renik has called the 'irreducible subjectivity' of each of us (Renik, 1993b), be we patient or psychoanalytic practitioner.

Paula Heimann's contribution

Paula Heimann's paper 'On Countertransference' (Heimann, 1950) marked a watershed in the development and understanding of countertransference, particularly in relation to its clinical usefulness. Freud had already recognised that, '...everyone possesses in his own unconscious an instrument with which he can interpret the utterances of the unconscious in other people' (Freud, 1913).

Freud did not develop this idea any further, and his references to countertransference were always in relation to arousal of pathological feelings in the analyst in response to the patient's material. This being his understanding, Freud recommended that analysts return to psychoanalysis every five years or so to protect themselves and their patients from their countertransference (Freud, 1912, 1937). Earlier, however, Freud had suggested that what was required was *self-analysis* (Freud, 1910), unknowingly perhaps coming close to what later came to be elaborated as the now contemporary understanding of the clinical requirement that the therapist constantly monitor and take account of the experiences he has in his relationship to his patient.

Heimann's revolutionary suggestion was that the feelings which the

psychotherapist experiences towards the patient are one of his most important tools for analytic work. She refers to countertransference as a research instrument and suggests that the psychotherapist's unconscious understands that of the patient. Though Heimann tends to focus on conscious and preconscious feelings – what she calls the therapist's 'emotional response' – she makes a further point. She writes, '...Often the emotions raised in (the analyst) are much nearer to the heart of the matter than his reasoning, or, to put it in other words, *his unconscious perception of the patient's unconscious is more acute and in advance of his conscious conception of the situation*' (Heimann, 1950, my emphasis).

What I want to draw attention to is this emphasis on the fact that as therapists we will be affected by and respond to the patient and that this takes place *before we become consciously aware of it.* This seminal paper emphasises that what is being described is fundamentally something which is unconscious.

It is this that I primarily want to restate. I say restate because I am only saying what we all know: countertransference, by definition, is an unconscious phenomenon and we do an injustice to the concept and its clinical usefulness by our readiness to sometimes so easily talk and think that what we rationally and consciously feel in relation to a patient is necessarily countertransference. It may be intuition, empathy or sensitivity (to use only some of the positive possibilities), all of which are very useful and necessary, but it may not be countertransference.

Projective identification

The basis for Heimann's understanding of countertransference was the concept of projective identification which had been introduced four years earlier by Klein (Klein, 1946). Nearly 50 years later the understanding of projective identification has substantially developed but it continues to be a complex and controversial notion.

Projective identification, as originally delineated by Klein, refers to an unconscious phantasy, rooted in the paranoid-schizoid position, whereby parts of the self and internal objects are split off from the psyche and projected into an external object which then becomes possessed by and identified with that which has been projected. Klein's understanding was that this was a defensive process whereby unbearable aspects of the self were in phantasy expelled from the subject.

Klein was, of course, aware of the complexity of the idea she was putting forward, and in a footnote to her 1946 paper, she adds: 'The description of such primitive processes suffers from a great handicap, for these phantasies arise at a time when the infant has not yet begun to think in words. In this context...I am using the expression "to project *into* another person" because this seems to me the only way of conveying *the unconscious process I am trying to describe*' (Klein, 1946, my emphasis).

What I want to emphasise here is the understanding that the process of projective identification is not only an unconscious mechanism but that in some way the projection *enters* the object. We may speculate that this is what Heimann had in mind when in her 1950 paper she writes that 'the analyst's counter-transference.....is the patient's *creation*, it is part of the patient's personality' (Heimann, 1950). What is therefore being described is an unconscious engagement between the therapist and the patient, driven by the patient's defensive attempt to deal with unbearable aspects of the self by locating them in the therapist. This is of course an omnipotent phantasy but its description by Klein enabled those who subsequently developed her work to further investigate the nature of the dynamic unconscious.

Projective identification as unconscious communication

Bion, and then Rosenfeld in particular, developed this idea substantially by suggesting that the process of projective identification may not only be used for defensive purposes, but also as a form of communication. In summary, the view which they, and subsequently others, developed, was that the person doing the projecting acts in such a way as to evoke, in the recipient of the projection, feelings appropriate to those being projected (Bion, 1959; Rosenfeld, 1971). The recipient, therefore, becomes unconsciously identified with that which has been projected and is in some part influenced in his thinking, feeling and/or behaviour.

Hence the concept of projective identification provides a vital conceptual bridge between an individual psychology and an interpersonal psychology because, an awareness of this mechanism permits us to understand interactions which occur *between* persons in terms of dynamic conflicts occurring *within* individuals. The recipient of the projective identification now has potential knowledge of some aspects of the person doing the projecting.

In parentheses, it is perhaps clear from the above, why the concept of projective identification, and its counterpart, introjective identification, is central to psychoanalytic work with the couple relationship. Further it shows how in working clinically with the couple relationship, the therapist has direct experience of observing the ways in which aspects of the couples' shared internal world get enacted, via these projective and introjective mechanisms, in what takes place between them, as well as between them as individuals and as a couple, and the marital psychotherapist.

Interpersonal Interaction

Joseph Sandler also refers to the interpersonal element in the analytic process and writes that, unconsciously, 'The patient attempts to *prod* the analyst into behaving in a particular way' (Sandler, 1976, my emphasis). He describes an intrapsychic role relationship in the analytic situation whereby unconsciously the patient casts himself in a particular role and casts the analyst in a *complementary* role. This actualisation in the transference gives access to the patient's internal object relations and Sandler advocates that the analyst practice what he calls 'free floating responsiveness' (Sandler, 1976), as well as 'free floating attention', which may enable him to identify with the role being demanded of him. He adds however that the analyst, '...may only become aware of (his role responsiveness) through observing his own behaviour, responses and attitudes, *after these have been carried over into action*' (Sandler, 1976). It is this 'action' which actualises the patient's unconscious internal images which he unconsciously 'prods' the therapist to participate in through some sort of unconscious enactment.

Those of us who work analytically with couples are familiar with this process of enactment in as much as this is one way in which one can conceive of the nature of the couple relationship. As Robert Gosling puts it, 'Falling in love is perhaps one of the most striking examples of transference' (Gosling, 1968). In a couple relationship, each partner is to some degree unconsciously reacting to the other as if the other were a figure from the past or trying to get the other to behave like someone in their internal world. This mutual process of projective and introjective identification produces an unconscious enactment of shared internal object relations which is the focus of the clinical work with couples.

Many authors writing clinically about the psychotherapeutic relationship have contributed to the literature on countertransference, but most influential perhaps in the tradition which I am outlining have been the writings of Grinberg, Money-Kyrle, Racker and Segal. All in their different ways emphasise the ways in which the therapist gets caught up in aspects of the inner world of the patient.

Racker distinguishes concordant countertransference, characterised by the analyst's identification with the patient, from complementary countertransference, in which the analyst identifies with the patient's internal objects (Racker, 1968). This corresponds to some degree with Money-Kyrle's normal countertransference differentiated from what he calls a deviation from the normal countertransference (Money-Kyrle, 1956). Both authors suggest that the latter of their two categories refers to a more problematic countertransference.

Grinberg's contribution is to introduce the concept of projective counter-identification, which refers to the analyst's difficulty in maintaining his analytic stance because his internal world becomes very confused with that of the patient (Grinberg, 1962).

Segal, in a way, summarises this attempt to describe the complexity and invasiveness of the countertransference experience when she emphasises that, as she puts it, the patient *does things* to the analyst's mind. She emphasises that, 'The major part of countertransference, like transference, is always unconscious. What we become aware of is its conscious derivatives' (Segal, 1977).

Brenman Pick (1985) adds a further significant contribution. She follows Strachey's view that a deep transference experience is disturbing to the analyst (Strachey, 1934), and warns us to be careful in our attempts to differentiate between countertransference as a tool in psychotherapy and pathological countertransference responses. She writes: 'Whilst this differentiation is an essential part of our psychoanalytic endeavour, ... how problematic the clinical reality is. For there is no absolute separation, only a relative movement within that orbit' (Brenman Pick, 1985).

The transference of total situations

This recognition of the patient's capacity to arouse thoughts, feelings and actions in the therapist, emphasises the complexity of the process being described. But it also indicates the unconscious communication *as well as* the unconscious defensive manoeuvres inherent in the process

of projective identification. There is therefore a direct relationship between projective identification, transference, countertransference and enactment: the transference-countertransference relationship can be understood as *always* to some degree including an unconscious enactment.

Clinically, the therapist is never able to be other than a participant in the psychoanalytic process since he will be made use of in certain unconscious repetitions of the patient's internal object relationships. Contemporary psychoanalysis is based on a struggle to make theoretical and clinical sense of this irreducible intersubjectivity of the therapist and the patient, be that in the context of individual or couple psychotherapy. Working with couples in psychoanalytic psychotherapy is a particularly useful arena in which to study the interplay between the intrapsychic and the interpersonal, because, as I said earlier, the intimate couple relationship may be most usefully understood as based on a mutual projective identification whereby intrapsychic dynamics inform the interpersonal interaction (Ruszczynski, 1992, 1993).

The work of Betty Joseph (1989) focuses in particular on the patient's unconscious *use* of the therapist in the psychotherapeutic process. Probably in her writings more than in any other we read about the ways in which the therapist is constantly caught into the internal world and object relations of the patient and how inevitably the transference-countertransference relationship becomes an arena for new enactments of the patient's familiar earlier primary object relations. Following Klein, Joseph takes the view that transference needs to be understood in terms of *total situations* transferred from the past into the present. She writes:

> 'Much of our understanding of the transference comes through our understanding of how our patients act on us to feel things for many varied reasons; how they try to draw us into their defensive systems; how they unconsciously act out with us in the transference, trying to get us to act out with them; how they convey aspects of their inner world built up from infancy – elaborated in childhood and adulthood, experiences often beyond the use of words, which we can only capture through the feelings aroused in us, through our countertransference' (Joseph 1985).

Hence we no longer have a picture of a patient misperceiving the therapist, as in the original definition of transference. Now we understand the patient as *doing things* to the therapist – projecting *into* the therapist in a way which affects the therapist. If this process of projective identification is successful, even if only fleetingly, we must be talking about some form of enactment of an internal object relation-

ship evoked by the patient and responded to by the therapist. As Brenman Pick puts it, '.....insofar as we take in the experience of the patient, we cannot do so without also having an experience' (Brenman Pick, 1984). By definition this experience must be, at least initially, an unconscious experience, and therefore an enactment, which only subsequently may become conscious and so available for analysis.

Towards processing the enactment

All communication has a projective element in it, so the therapist is always to some degree acted upon by the patient. The issue is whether the therapist can develop and maintain a capacity for scrutiny of and reflection on *his* unconscious enactment as well as that of the patient and also, perhaps most crucially, an enactment of the patient and therapist jointly in some form of therapeutic *folie à deux*. It is this monitoring of the therapeutic experience which may eventually give access to the otherwise unconscious aspects of the patient's internal object relations, now enacted in the patient-therapist relationship.

An understanding of this reflective capacity was developed by Bion in his delineation of the now familiar concept of the container-contained (Bion 1959, 1962). What is particularly relevant to the point I am trying to emphasise is Bion's insistence on the *reciprocity* of the container-contained relationship. *Meaning can only be generated via this reciprocity*. If the analyst is *not* fully available; if the analyst, as Bion puts it, is preoccupied by memories and desire, the patient may unconsciously experience being rebuffed or resisted by the analyst, and his projective identification as communication takes on a more and more forceful quality, with the more evacuative defensive aspect taking precedence over the communicative aspects.

I will now present two vignettes of clinical work, one with a couple and the other with an individual patient, and hope to illustrate something of what I have been sketching out about countertransference and the therapist's unconscious enactments.

Clinical vignette 1

I had been seeing John and Mary twice weekly with a female co-therapist with whom I work fairly frequently. The couple are both in their middle 40s, with three teenage children. He is a senior teacher

and she a nurse. They were referred to the Tavistock Marital Studies Institute by a family therapist whom they had consulted because of their concern about one of their sons who had been stealing persistently from within the family home.

We knew that Mary had been sexually abused by her elder brother, in her very early teens, and that her parents had not been able to talk to her about this when it was eventually uncovered. Mary has a psychiatric history which includes a number of psychotic episodes which have resulted in hospitalisations. We also knew that John had been his mother's favoured elder son, but that he was jealous of his younger brother who he felt was free from the burden of fulfilling his mother's aspirations and expectations of him. However, he felt that he could not protest at his own trapped position as he was deeply anxious about maintaining his mother's affections.

In the sessions John and Mary were a very depressed and silent couple, colourless in both manner and dress. They made very brief comments and rarely engaged in a dialogue with each other or with us. The sessions became dominated by disturbing silences. The couple's repeated complaint was that each felt that the other was disinterested and distant, though we witnessed that in their interaction they *both* subtly maintained the other's distance from themselves by deflecting any possible approach made by the other. Exactly the same dynamic took place in relation to any comments made by my co-therapist or myself.

Initially, the couple said that they had only come into marital psychotherapy because of the suggestion made by the family therapist. This passivity seemed to be a theme in the ways in which they related and very quickly they fell into a very tense and disturbing deadness between them. This deadness quickly gathered in my co-therapist and myself and we too became somewhat lifeless and stuck, unable to think or say very much.

In our co-therapy discussions outside of the consulting room, which always take place when working with a couple so as to attempt to process the experiences in the session, we further reflected the couple's frozen relationship in our own interaction. We found ourselves trapped in this state and even though intellectually we could identify what we were enacting we could neither understand it nor escape from it. We were in the grip of something powerful and unconscious, and our conscious and intellectual awareness of it did little to aid either our understanding of it or our ability to free ourselves from it. We were

being invited to experience something in the most potent way; by living it out.

In one particular session, about six months into the therapy, I found myself feeling particularly uncomfortable and immobilised. At points in the session I felt that I had some interesting and relevant thoughts but they quickly became stifled and lost. Alternatively, I felt that I had something to say but found that I could not bring myself to say it. Increasingly I felt that something was oppressing me and stopping me coming alive. Again, I was not aided in understanding this phenomenon in our post-session co-therapy discussion and again, both my co-therapist and I ignored this strong emotional reaction even though consciously we would both agree that its understanding could be therapeutically very useful.

In the next session I began to develop a thought that I was remaining silent because I believed that if I *were* to speak I would find myself in open conflict with my co-therapist: she would openly disagree with me, and this would be extremely damaging to us, to the couple and to the therapy. Initially, this thought froze me even further, and I felt a sense of hopelessness and helplessness. Momentarily, I concluded that I could no longer work with this co-therapist and certainly could not be of any use to this couple. It was as if simply having the thought of speaking out produced a sense of destructiveness and despair.

Now, however, I came to realise that actually I have often worked with this particular co-therapist and I knew that if and when we do have disagreements or issues to debate, we always do so outside the consulting room, in our own discussions. This is in the service of processing our experiences so as to analyse what may be being unconsciously projected into us from the couple. My terror that we would fight destructively was anomalous. I then realised that not only were we, as the co-therapists, reflecting the nature of the couple's relationship, but that I was caught in an enactment based on an unconscious anxiety, now come into consciousness, that if I were to speak up and engage more in the consulting room, I would provoke a destructive fight which would break up the relationships we had.

I also found myself reflecting on the couple's histories. Both had, for very different reasons and in different circumstances, the experience of very difficult issues not being talked about and of themselves not being able to talk about them. Both could entertain phantasies about the destructive and disruptive potential of speaking their mind. It was as if survival depended on a profound splitting off of part of their experience.

I made an interpretation to the couple along these lines: I wondered whether the way in which they remained so uninvolved, hardly being able to engage with each other or with us, was because of a profound anxiety about the response they might get which would be an aggressive one and highly dangerous to the relationships tentatively maintained, with each other and with us. At the extreme, I suggested, this might even include disengaging from their own thoughts and feelings within themselves.

Initially the couple appeared not to understand. For a moment, I felt that what I had said was provocative and destructive of their ways of managing themselves, and I began to wish I had not spoken. However, Mary then said that she was very reluctant to speak her thoughts because they would have to include just how angry she could be with her husband, and that when she had spoken in the past he had angrily dismissed her comments because they were not real but only a product of her psychiatric illness: it was her 'madness' which was speaking, he would say. In this way she felt that she was 'robbed' of her thoughts and feelings and then attacked by them. She felt herself indeed 'go mad' when this was said to her and it was therefore safer not to speak out and to stop thinking.

John gently nodded in some apparent agreement or understanding. He then said that he felt very frightened to talk about his thoughts and feelings about himself and his wife because if he did talk more about his anxieties, he was terrified that he would come to realise that he could feel just as disturbed as his wife obviously felt, and this he felt to be unmanageable. He too, John said, found that he tried not to think that which he found himself thinking.

Each of them, therefore, was describing an evacuative projective identification, into the other, of their own feared anger and madness which then had to be kept in the other. This resulted in the other then having to be kept at some distance and not engaged with. This is an illustration of the way in which Klein originally defined the concept of projective identification: a mechanism employed for defensive purposes, expelling unmanageable aspects of the self into an external object.

The enactment in which my co-therapist and I got caught up was in projective identification with the couple's defensive reaction to their feared internal object relationship which suggested that a more real, communicative, open exchange would lead to disastrous and destructive consequences. Coming more alive, engaging more with each other would herald conflict, anger and madness. By projecting this dynamic

into the experience of the therapy and into the therapists, an unconscious enactment was created which eventually allowed the containing capacities (in Bion's terms) of the therapists to metabolise their experience and offer some insight which addressed the internal object relations.

The use of this reflection in the relationship of the marital therapist couple, of unconscious aspects of the internal object relations of the patient couple, has long informed the clinical practice of psychoanalytic psychotherapy with couples (Mattinson, 1975; Ruszczynski, 1993). Elsewhere, I have referred to it as 'the marital countertransference' (Ruszczynski, 1992). Unconsciously, aspects of the couple's shared internal world get enacted, through projective and introjective identification, in the relationship between the two marital co-therapists. The processing and understanding of that enactment, when it becomes available for conscious scrutiny, gives access to that which is being projected and hence constitutes a valuable insight into the internal dynamics of the patient couple's shared internal object relations. An interpretation of the nature of this internal object relation may mediate the internal images and free up the external relationship from some of their constraints and anxieties.

Clinical vignette 2

I have been working with Tony in psychoanalytic psychotherapy, three sessions weekly, for twelve months. He is a highly successful doctor, aged middle 40s, married and with two grown-up children. He was referred for intensive individual work with a presenting symptom of premature ejaculation, which a number of years of sporadic marital and sex therapy had not been able to deal with.

Tony is the eldest of three children, brought up in America where his now elderly parents continue to live. His siblings live with their respective families in distant parts of the world. He remembers a materially comfortable life, but also recalls feeling that his parents were very close to each other but ignored their three children. This picture is complicated by another image of Tony being mother's support and solace whilst father was away from home on business. It is as if Tony experiences himself as Oedipally excluded or as seductively and triumphantly included, but used. Tony deals with this Oedipal confusion by splitting off his angry and insecure feelings and promoting a very benign image of himself, primarily to himself but also to others,

by being constantly available to anyone who may need solace. This subversive care-giving allows Tony to identify with being taken care of. Any direct awareness of his own sense of deprivation and neediness is met with horror and terror and is immediately split off and denied. The sense of murderous outrage it produces is felt to be unbearable.

The events I want to refer to centre around the recently diagnosed life-threatening illness of Tony's mother. With her having become seriously ill, Tony has become the focal point for numerous phone calls from his father and siblings all seemingly looking to him for support. The sessions with me have become filled with accounts of these telephone conversations.

Initially there was a sense of Tony feeling powerful and strong: he was the one holding the family together in the face of a crisis. However, Tony's sense of frustration and impotence grew as he came to experience that not only could he not allay the family anxieties but that his own seemed not to be recognised at all. His initial sense of potency quickly disappeared and he felt useless, frustrating and frustrated. (This is parallel to his sexual dysfunction which is tht he is always able to achieve an erection, but finds himself ejaculating very quickly, leaving himself and his wife frustrated and often angry. Their capacity to recover from the let-down is non-existent, and they are unable to continue with any other form of shared intimacy.)

I also began to feel increasingly frustrated – the material of the sessions was becoming repetitive and I felt impotent to say anything of use. I felt that something was expected of me, sometimes with some desperation, though it was not at all clear what this was, and though I could be aroused by this expectation I was not able to provide it.

In one session Tony reported with some anger and guilt, that he was now leaving the telephone answering machine permanently switched on so that when his family, particularly his father, called, he did not have to respond immediately and he then delayed calling back. I interpreted that perhaps he felt that I too was storing up his messages to me and not getting round to responding to him. Tony acknowledged that he did feel desperate in the face of his mother's illness and his family's demands on him, but could only go on to say rather rationally that he knew that there was nothing I could really do about the situation. Immediately after that session I realised that I had finished the session a few minutes early. I was quite shocked; I have a habit of glancing at the clock on my desk before stopping a session but had failed to do this on this occasion with Tony. On reflection it felt as if, like Tony's premature ejaculation, I was also coming to an end too

soon, as if I could not hold the tension of the session. Inevitably, I also wondered about my own transference to the constant barrage of material about the anxieties and concerns about a dying mother. Was I getting rid of Tony because the material was simply too painful?

In the following session I found an opportunity to comment on Tony's growing sense of frustration and impotence and how he might want to get rid of his father's and siblings' phone calls as a way of ridding himself of the feelings of failure being produced in him. And of course, his mother's illness left him feeling that he could do nothing for her either and perhaps he wanted to rid himself of this sense of impotence too. My not offering him any response to his plea to me made him feel that I too was teasing him and humiliating him. (I had in mind an Oedipal scenario of the little boy both phantasising and being invited to be the strong man but quickly discovering that his potency is severely limited and feeling tricked into the situation.) However, almost as soon as I had said this, I felt flat and despondent and I immediately realised that I had made a rather impotent and frustrating statement. Far from understanding the impotence and frustration I had simply enacted it in my comments.

A couple of sessions later I again found myself finishing the session early but this time I realised that I looked at my clock *after* announcing the end of the session, rather than *before* doing so. What I was then struck by was the thought that if I could glance at my clock just as Tony was leaving, why could I not glance at it a few moments earlier, as I usually do, to ensure that I was finishing the session at the right time? I began to feel very guilty at my *cruelty*; this is what I found myself experiencing. However, I also felt that something very persecutory and cruel was being *done to me* as well: I was failing as a psychotherapist in the most basic way; I could not even keep a proper time boundary. This subsequently led me to reflect on the cruelty of not having (Oedipal) boundaries securely held.

In the following session, again largely dominated by the family telephone calls, I began to be more aware of the cruelty and abuse Tony felt. I interpreted again that he felt that I was like the telephone answering machine which took messages from him but did not respond to him. This time I added that he must feel that I was being cruel withholding my responses, just as he felt himself being cruel to his father in relation to the unanswered messages on his answering machine. Who was being cruel to whom, however, I wondered? Was it cruel to be invited to believe that he was capable of something which in fact he will inevitably fail in? Was it my failure to offer him

something in response to his material or was he inviting me into something which I was bound to fail in? Perhaps he was inviting me to know about the sense of failure and humiliation exactly as he had felt himself to be so invited in the original scenario with his parents.

Tony responded by acknowledging how difficult he finds it to express his anger or frustration even when impossible demands are persistently made of him. He then told me that on the previous evening he and his wife Lucy had had an enormous argument because he had approached her for sex and she had refused him and he had become angry, unusually so. He now felt very guilty because he knew that Lucy found his premature ejaculations extremely frustrating and so he was being cruel and unfair to ask her for sex, which he wanted simply for his own relief. However, he went on to say that actually he was angry with her because if she would occasionally initiate and show interest in sex, he would feel less guilty about his desire for sex and perhaps he would be able to maintain his erection longer before ejaculating. His premature ejaculation might be a way of quickly terminating the sex which she did not want.

I interpreted to Tony that he might feel that my silence in response to his material left him feeling that I too was deeply frustrated with him and his efforts. Rather than expressing his anger at my apparent disappointment in him, he found himself relating to me very tentatively and so not really engaging me in the way he otherwise might. If I were to be more vigorous with him perhaps he could trust me sufficiently to be more vigorous with me.

Tony acknowledged that he did fear that I was getting frustrated with him and he could well believe that as a result of this he would hold back so as to not add further to my frustration. He said that he was very familiar with this form of sacrifice. I interpreted that it might not only be a question of not further frustrating me, but that he might be holding back from a fear of attacking me for teasing him and frustrating him. I then added that this might also be a way of understanding why he so quickly loses his erection, the fear being that he might damage Lucy if he were to maintain it for any length of time. Simultaneously, of course, he did attack her by frustrating her and disappointing her. Tony repeated that he felt that Lucy's frigidity was certainly just as much an issue as his premature ejaculations. I said that this made me wonder whether he felt that I was being rather frigid in relation to the degree of anger I was suggesting that he felt towards me.

As the subsequent work has developed there is emerging a complex

dynamic of cruelty, guilt and punishment, with Tony feeling himself to be both the *victim* of the cruelty, perhaps in phantasy, a cruelty from the teasing and rejecting mother and parental couple, but also the *perpetrator* of the cruelty, perhaps a phantasied attack on the envied sexual parental couple. One can begin to see how this might be unconsciously experienced in his marital relationship and also enacted in the transference relationship to me. In the countertransference I found myself enacting the teasing and withholding object, and also the object which felt attacked for having something which he envied and therefore wanted to see spoilt: my capacity to hold the tension and time boundary of the session, and not prematurely bring it to an end.

In summary

In this paper I have emphasised that the mechanism of projective identification is, as originally defined by Klein, an unconscious defensive evacuation of unmanageable aspects of the internal world of the individual, or, of the shared phantasies of the couple.

The further *communicative* value of this process rests on the patient's capacity to evoke in the psychotherapist some form of unconscious enactment which is what fundamentally constitutes the countertransference experience. I have tried to indicate the complexity of this phenomenon, and how it may pervade the nature of the transference-countertransference interaction. Countertransference, therefore, may be thought of as the totality of the psychotherapist's reactions in his relationship to his patient, conscious and unconscious, the latter often being realised in subtle and complex enactments beyond the use of words or immediate rational awareness.

We need to remind ourselves, however, that the psychoanalytic use of countertransference and of enactments is complicated by the psychotherapist's own defensive needs, his self deceptions and his unconscious collusions with the patient to avoid reality (Steiner, 1993). Though our understanding and clinical use of countertransference has developed substantially, the original way in which Freud understood it still holds true for us all to this day. Heimann warns us that the approach she advocates to countertransference should not be allowed to become a screen for our own shortcomings (Heimann, 1950). The classic story reported by Segal (quoted in Spillius, 1983) is worth repeating. Segal tells of a supervisee of Klein's who, in the course of discussing material

from a patient, told Mrs Klein that he had felt confused and had therefore interpreted to his patient that the patient had projected this confusion into him. Mrs Klein is reported to have said, 'No, my dear, it is *you* who are confused'.

By engaging with our own confusions and entanglements in relation to our patients, possibly with the support of consultative help from colleagues, we may *eventually* be able to decipher the communicative aspect of the enactments in the countertransference, transforming, in Segal's words, 'the worst of enemies' to 'the best of servants' (Segal, 1977).

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LITTLE BOY LOST: INITIATION, FATHER AND HOMO-EROTIC COUNTERTRANSFERENCE*

'Father! Father! where are you going?
O do not walk so fast.
Speak, father, speak to your little boy,
Or else I shall be lost.'

The Little Boy Lost, William Blake.

Introduction

The problem of erotic transference is well documented in psychoanalytic literature and probably is the most frequent transference phenomenon encountered in the consulting room. It is usually evoked in the therapeutic situation which is predominately heterosexual and in this respect is unremarkable. What is rarer to find in the literature is references to homo-erotic transference, particularly in Jungian writing. This is further compounded by the lack of any real exploration of the homo-erotic countertransference. Paul's therapy presented some unusual material and situations; not only his epilepsy but his worries over his homosexuality as well as a poor sense of Self.

In this paper I will attempt to explore some of the theoretical issues around homosexuality as they emerged in the therapy. I will also attempt to show how circumcision as a manifestation of an archetypal process was present in the therapy. This paper traces almost two years of therapy in which time Paul emerged into the space inside himself and started to gain a sense of himself as an adult man as opposed to a confused boy. I also began to confront my residual homophobia and gain a vital insight into homoerotic feelings which I believe have a very important part to play in helping homosexual men, and male therapists, to come to terms with these feelings. This paper also suggests ways in which we, as men and therapists, can be comfortable in loving intimate relationships in our personal lives with male friends and remain in an intimate therapeutic relationship with homosexual men. This is vital if our homosexual male clients are to be able to exist in a homo-phobic culture such as we live in.

*Reading – in paper for Associate Membership of the BAP. October, 1993.

The referral

Paul came into therapy after suffering a series of epileptic fits. He was referred to a Hospital by his GP to look into the fits. Whilst there he asked for and was passed on to a psychotherapist as he thought the fits might be brought on by anxiety attacks, usually in the presence of violent/sexually violent images at the cinema or the theatre. He was seen by a consultant (every two weeks) for several months. During his sessions at the Hospital it became apparent to Paul that there was a multitude of questions and difficulties that needed to be explored in depth. Amongst these his homosexuality and his relationship to his mother stood out, as well as his inability to allow himself 'the time to think things through and arrive at my own conclusions.' He also explained that he wished to 'recognize the person I am....to achieve change'.

It is interesting to point out that at this stage Paul refused to take drugs but was very anxious to learn whether or not he was suffering from epilepsy. There seemed to be some doubt and it was later, during the first year of therapy, that he was actually diagnosed as suffering from a very mild form of epilepsy due to a slight abnormality of his brain, at which point he started to take the offered medication. A further complication in his life was his obvious confusion about his sexuality. He professed to being a homosexual and was in a long term relationship with Stewart. At the start of the therapy they were living separately.

Clinical discussion

Paul comes from a professional family. His mother was very dominant within the family and dealt with punishment, often using a hairbrush to chastise him. His father was emotionally distant and pursued a 'quiet life'. He recalled his childhood as being mostly concerned with hiding his emergent confusion about his sexuality from his mother and colleagues as well as being somewhat lonely. During his adolescence he engaged in some petty theft of magazines or chocolates. Apart from this he stated that his childhood was dominated by 'keeping up appearances'.

Paul is a slim boyish looking man of 28 with dark hair and eyes. He wears casual clothes which are considered fashionable within the conventions of gay culture. That is he would be recognisable by other gay

men as such, although he is at pains not to stand out generally for fear of violence on the streets from 'queer bashers'. During the first sessions it was very difficult to hear what he was saying as he tended to mumble. He seemed very anxious to please and almost too ready to agree with anything I might say. I found myself liking him from the start but was strangely untouched by his presence. It was as if his presence in the room was an apology. This produced several early sessions where I experienced a lot of sleepiness and I realised an unconscious impulse to collude with his defences.

The first problem that I had to confront with Paul was how to promote a sense of alliance with me in working with his unconscious and at the same time not collude with his need to adopt, in a defensive way, attitudes and opinions which he would have willingly used to keep me out and his defences intact. He had achieved this in his life so far by adopting other peoples' ideas and conforming to his perception of their expectations whilst suppressing his own, in the hope of gaining approval and keeping his own ideas and opinions secret for fear that they would be judged, found wanting and would result in him being humiliated. Evidence for this emerged in the first sessions as he described how his desire to attend university was manipulated by his mother. He had been turned down for an English degree at the universities of his choice, so his mother had then given him a set of courses which she had highlighted for him. He said that at the time he believed that she knew best and chose a course that she approved of. I found myself acutely aware that he needed to be approved of by me and wanted to be a 'good' patient. He still does. He rarely misses appointments and is punctual with his attendance and bills. Underneath, though, I could sense that his compliance masked a great deal of resentment which was difficult to get in touch with.

He started therapy by bringing an initial dream;

> Dream 1
> I am in a Dr.'s consulting room which is invaded by lots of people who I don't know. I feel very irritated by this and get up and enter another room. In this room I see another Dr. who examines my feet. This Dr. starts to manipulate the bones in my feet which I find quite painful. However I know that it is going to help me so I don't mind. I am still aware of a crowd of people outside of the room.

The dream gave a lot of clues as to direction of the therapy and as Jung states, 'Initial dreams are often amazingly lucid and clear-cut' (vol. 16 pp. 145); the invasion of the room/self are the part objects and 'borrowing' that Paul used to defend himself throughout his life from

his mother and his own hostility/rage. The Doctor is the therapist who by examining the feet points to the essential Oedipal nature of the problem; however there is only a thin divide between the invasive people/part objects and Paul, so the difficulties are still very present. Although Paul brought dreams to sessions on a regular basis he could not use any interpretations or associations to them at the beginning of therapy so I initially refrained from offering anything.

The second difficulty was Paul's struggle to understand why he wanted therapy. His need to understand his epilepsy was relatively easy to explore, he was obviously frightened by the fits and was anxious to find a cause and hopefully a cure. He resisted the idea that he was an epileptic and it took a year in therapy before he came to reluctantly accept this as a fact. It seemed as though the violent images that set off the fits touched upon Paul's repressed violent wishes and impulses which no doubt stemmed from his primitive rage at his mother which had to be kept secret for fear of the reprisals that might follow. Having speculated about the causes of the fits and the particular circumstances that seemed to contribute to them being activated, a further and more difficult area emerged; his acceptance or not of his sexual orientation.

Although at times he seemed certain that he was gay (I will take the term gay or homosexual to be interchangeable) there seemed to be areas of doubt which were rather puzzling. He said that he found women's bodies to be of no interest to him, in effect there was an absence of interest, not a loathing or rejection of them. He had invested more in the the male form and in sessions where this was being discussed he became more animated when talking about men. He expressed some anxiety during the early months of therapy about whether I was going to 'cure' him of homosexuality. This opened up several important assumptions; is homosexuality a pathology? Could a 'straight' man really understand a gay men? It is important to note that these questions were being asked by both of us. I explored with him his fear and how it was based upon his early experiences with his powerful mother who seemed to be intent on manipulating her son to fit some rather negative ideal that she had about men. It would appear that she did not really have any idea about how he actually existed in the world, her perceptions seeming to be based on her own rather distorted view of him. In this respect his father, who might have been of some use in the growth of Paul's sense of masculinity, was absent and probably rather weak in contrast to Paul's mother. Paul presented an interesting memory of his father being given used sanitary towels to dispose of by Paul's mother, which he did by burning them. He reported this in the

context of the mystery that surrounded all things to do with women and their bodies. He recalled being curious about the secret way in which his mother and sister would furtively disappear into chemists to buy sanitary towels which would be quickly stuffed into shopping bags so that he would not see.

On seeking to understand Paul's sexual orientation a brief look at theoretical considerations seems relevant. Freud attributed homosexuality to the individual's inability to master problems associated with the Oedipal period. He traced it, in the case of men, to an unusually intense erotic attachment to his mother and a particularly distant or hostile relationship with his father. These conditions were said to intensify the boy's Oedipal conflict with his father and consequently to maximize his fear of being attacked by him (castration anxiety). This arouses deep anxiety about the loss of the penis. It is this anxiety that Freud believed prevents the boy from being able to take woman as a love object. He is unable to tolerate the sight of female genitals because they lack a penis and therefore remind him of what could happen to him. In addition he unconsciously equates any female love object with his forbidden, erotically charged relationship with his mother; and so is likely to reexperience in every heterosexual contact the guilt surrounding his Oedipal attachment to her.

Freud hypothesizes that when the male, who is to become homosexual, discovers he cannot safely love his mother, he identifies with her and chooses to love others as she would. Quite defensively, he shifts so that he plays her role instead of taking her as a love object. Freud added that the homosexual adopts himself as the model of the kind of object his mother would prefer, and he sexually favours males who resemble himself. What is particularly important to him is that the love object should possess a penis whose presence will help him allay castration fears. Freud underscored the homosexual's exaggerated overvaluation of the penis, and indicated that what he was really seeking as a love object is a girl with a penis. It would appear that for Freud homosexual practice was abnormal in that its intention is to circumscribe castration anxiety and guilt.

In this respect Jung also seems have thought that homosexuality was abnormal but not for quite the same reasons. In Hopcke's (1988) review of Jung's writings on the subject he sums up by stating that Jung had three different theories on homosexuality: (1) that homosexuality is a result of an identification with the personal and archetypal feminine, (2) that homosexuality is the result of an incomplete detachment

from the hermaphroditic archetype of the self and (3) that homosexuality is the result of constitutional factors.

The constitutional theory by which I understand that homosexuality is biologically determined or genetic, presents therapists with a rather difficult problem; the theory that genetic predisposition can account for homosexuality is still uncertain and the complex relationship of environmental factors influencing behaviour is still far from being understood. By its very nature genetically determined behaviour is very difficult to alter by cognitive or analytic intervention. It also seems that Jung's other theories have a complex relationship with each other. If homosexuals are identified with the personal feminine, usually mother, and it is primarily she that mediates and facilitates this part of the archetypal experience, then boys will not be able to move on in individuation process until the identification with mother has been worked through.

The centrality of the mother in shaping the identity of homosexuals has been the subject of some interesting research. Evans (1969) compared homosexual and heterosexual men and found that homosexuals grow up in a family setting in which the mother is close, binding, seductive and the father is distant and unfriendly. Thompson et al. (1973) reported similar findings. Snortum et al. (1969) in looking at family dynamics came to the same conclusion as others mentioned. Chang and Bloch (1960) studied identification in homosexuals as compared to heterosexuals and found that the former identified more with mother than father. It would seem that, according to the research just mentioned and Freud's observations, Paul's history falls into these patterns. It must be pointed out that the premise that homosexuality is a pathology is still not proven and in order for the work to proceed with Paul I came to the conclusion that I could not start from a position of regarding Paul's sexuality as an illness. I found support for this position in an article by Limentani (1994) in which he states that there are many ways in which patients with latent or overt homosexuality present to psychotherapists and the complex challenge they pose. He explores the heterogeneity of the condition and shows how the analyst may be of help, whether or not there is a desire for a change in sexual orientation.

Like Hopcke (ibid.) I believe that the expression of sexuality exists on a continuum and there are many forces operating that will push or direct an individual to express their sexual needs on any particular point of the scale; in fact, because like most human expressions of drives it is fundamentally dynamic, it will move about somewhat from

either extreme. That is not to say that gay people do not suffer sexual problems or other neurotic symptoms which may or may not be sexual in content.

The centrality of mother to homosexuality is also commented on by Jung (1954) who stated, 'In homosexuality, the entire son's heterosexuality is tied to the mother in an unconscious form'. Later talking of the mother-complex he added 'simple relationships of identity or of resistance and differentiation are continually cut across by erotic attraction or repulsion'. Further evidence for the existence of a mother-complex is to be found in a dream which Paul brought after six months in therapy;

> Dream 2
> I am at home in the dining room, only it is different. There are several glass cabinets with lots of interesting objects in them. I know they belong to my mother. Although I go over to look at them I cannot recall any items. I look down the room and find that it gets darker and the walls have bookcases along them. I feel that the room becomes more 'Victorian'. As I examine the books I am aware that my mother and another person (his grandfather/her father) are present and somehow she is directing my attention to books that I do not want to look at; the ones I am interested in, I feel, she is drawing me away from. At the far and darkest end of the room I notice a small staircase between two book cases. I ascend the stairs and a bag of women's clothes falls from the top of the bookcase onto me. I know that this bag has been hidden away and is related to the two other people in some secret and sinister way; I replace the bag on top of the bookcase.

The secret bag of clothes could be a reference to the burden of mother's identity that he has to carry and hide, even from himself. In fact he did keep some clothing hidden away in which he would dress up and pose in front of the bathroom mirror. These items of clothes had holes cut in them around the nipples and genitals. That it is she who is 'directing' shows just how powerful she is in his inner world. There is also reason to think that he is trying to show me in transference terms, how he feels I, like mother, will direct him to look into areas he is not interested in but I am.

In struggling to understand homosexuality I found myself having to deal with some confusion in myself. I had taken the attitude that if homosexuality is a matter of choice in how one expresses the act of sex then any sexual behaviour would not necessarily be pathological. That is not to say that it could not be, it would have to depend on what it meant. I felt that for Paul, who tended to have long stable relationships and not engage in any of the more risky sexual practices, such as cruising or cottaging, sex was a expression of his need to be in a close

loving relationship in much the same way as heterosexuals, with the exception that he must have made a decision at some point that he was not going to be a father (at least in the short term). This rather conscious attitude on my part, which allowed Paul to feel free to explore his feelings about gay sex, was in conflict with a more unconscious part of myself that left me wondering if there was a residual hostility to homosexuality that was being activated in the countertransference. I have been fortunate to have been around many gay men and women and believed that I am relatively liberal in my attitude. I believe that this was felt to be very useful by Paul as he began the process of testing me to see how, or if, I would react to his disclosures of homosexual practices. As he became more confident, he began to disclose his fantasy around the darker aspects of gay sex.

In one such session he recounted a discussion that he had with some male friends who were condemning cottaging (the gay practice of loitering in public toilets to pick up men in a rather indiscriminate way. The term is derived from the public toilets on Hampstead Heath which were built in the style of country cottages), Paul found himself becoming quite angry and said that even if a child was exposed to this it would be the child's fault. In one way this is a surprising remark from Paul who is very mild, but it seemed to reflect his experience as a child in the way that nobody seemed to be looking after his best interest so it is not so surprising that he would not consider the negative impact on a child exposed to cottaging. Paul had himself been the subject of some interest in a toilet at the Festival Hall, which I am told is well known by gay men. Paul was accosted whilst in the toilet but became so frightened he fled. It was evident that Paul also found the darker side of gay culture exciting and would often wish that he could indulge in 'cruising' and indiscriminate sex with men in gay pubs and the like.

I found myself feeling a degree of disturbance with some of his revelations because in the sessions in which he was describing sexual activity I could detect in myself a measure of excitement. I realised that I was initially repressing my response to these feelings in me when I had a dream in which Paul made sexual advances which evoked very powerful feelings of revulsion. It was apparent that these feelings were being activated in me as a counter-transferential response. I began to realise that there was a residual part of me that wanted to reject and attack these feelings. I am not gay, but on reflection I began to sense that I had to experience these homoerotic feelings and stay in touch with them or I would be unable to help Paul internalise me as a *man*. Paul was like a baby needing to sense and feel the sensuality of being

loved by his father. It would be through this that he would be able to start a process of separation from his internal powerful mother, through being able to experience the difference of paternal feelings as distinct from maternal feelings. In a simple way Paul had never been able to grow emotionally into a man, to understand the difference between the feminine and masculine parts of himself, nor, I believe, the outside world.

The importance of this shift in attitude in myself to these transference feelings was highly significant. As mentioned earlier there is not a great deal of information on homosexuality in Jungian writings so it was of great benefit for me (and Paul) when I read Frey-Wehrlin's paper (1992) where he points out the dangers of not dealing with homosexual feelings in the therapist. The article looks at several significant male relationships in the history of the psychoanalytic movement and notes that they had a propensity to break down at moments where erotic feelings emerge between men. To further explain the process, which he feels is archetypal, he explores the relationship between Laius and Chrysippus. It was the abduction of the boy and ultimately his rejection by Laius and violent death that brought about the curse on Oedipus and the Sphinx's punishment of Thebes. It was Laius's initial indulgence in his homosexual feelings and then later rejection of them that set in motion the whole tragedy.

If the myth were not to be repeated in the therapy I, having taken the young man/Paul into therapy/my home, must not abandon him by repressing my homoerotic feelings, like Paul's father who seems to have abandoned Paul somewhat like Laius. I would have to be able to remain in a homoerotic relationship with him in order for him to work through these feelings and take his place along side me as a man without fear of owning his penis/masculinity. This also meant having to withstand his primitive desire to slay the father/me, or perhaps more importantly, that I would be prepared to be slain by him, so that he could emerge in relation to mother/women as an equal without the need to use projective identification to defend his ego from her power.

Having reached this point I was convinced that for Paul, at least, the expression of his sexuality was not abnormal; he had chosen to commit himself to a long term relationship with one man and in fact brought the usual problems that any couple would have to face and deal with in therapy, including a woman who seemed to become a rival for his partner's attention and act as a convenient source of hatred and fear for Paul to explore his aggressive and destructive feelings about women/mother. It was at this point in the second year of therapy that

another significant problem emerged which was to have profound implications for Paul and the therapy.

THE INITIATION

I'll shade him from the heat, till he can bear
To lean in joy upon our father's knee;
And then I'll stand and stroke his silver hair,
And be like him, and he will love me.

The Little Black Boy. William Blake.

As I have noted earlier, Paul's mother was probably ambivalent about Paul and his body if not unconsciously hostile or afraid of it. This was to such a degree that the fact that he had suffered Balinitus since his childhood had gone completely unnoticed. Balinitus is a condition that affects the foreskin, it is scar tissue that forms on the foreskin and prevents the foreskin from being drawn back over the glans. If this is spotted it can be easily treated or a circumcision is performed. As this had gone unnoticed by both parents, Paul grew into puberty not being able to experience a full erection because of the discomfort. He did get erections but he had to 'get rid of them' by lying on his stomach. This would reinforce very neatly his castration fears as observed by Freud. Later on his penis became associated with disease by some of his partners who refused to engage in oral sex with Paul and he did in fact suffer several infections engendered by his inability to retract his foreskin.

At this point in the therapy I tentatively suggested that he seek medical advice on a circumcision, as I realised that he had *never seen his own penis fully erect*. It seemed obvious that this fact was a mirroring of his psychic state; he, like his penis, had never been uncovered, his true self was still cloaked with the covering of his pre-pubescent 'skin', he had not yet made the transition into adult manhood. I was being used as the initiator of his adult masculinity, taking on a role that for boys is usually the role of the father.

I believe that Paul was able to approach the idea of circumcision at this time because he felt sufficiently safe within the therapy and with my ability to remain with the homoerotic countertransference I was experiencing at the time. This allowed him to face the terrors of surgery, an idea that might produce fits, and would allow him to move into adult sexual experience with the ability to sustain an erection. He had expressed a wish in several sessions to be able to penetrate his partner, in other words to have adult sexual experiences. It also seemed

to me that the circumcision had even more significance at a deeper archetypal level.

According to Seligman (1965), quoting Kirschner & Joseph (1927) one seventh of the earth's population practise circumcision. Most, but not all, are part of male puberty or pre-puberty initiation rites and have something to do with separation from the mother. More recent studies seem to confirm this. Benchekron (1982) states 'Circumcision is a rite of passage in the North African community, symbolizing the passage of the boy into manhood. Previously the male child had a life in the harem, the world of his mother, sister and aunts. Circumcision marks the transition of the male child from the mother's to the father's world. The act of circumcision is not symbolic castration but a reminder of submission to the will of a larger being, the rule of Allah. Kratz (1991) exploring rites in Kenya states that boys complete a ceremonial process by the 'trial of circumcision which gradually distances them from their childhood lives'. Jeammet (1983) comparing puberty rites in Western and 'primitive' cultures says, 'The adolescent suffers symbolic death as a child and rebirth as an adult with a definite place and role in his society.'

Paul had not had to undergo the relatively normal struggles with his emerging sexuality and so had never been able to experience his own creative powers. As I have mentioned earlier I believe he had made a choice not to become a father so the issue of procreative power was side stepped for the time being. Despite this, the unconscious drive towards adult functioning would require him to have to undergo the same kind of processes even if, as I suspect, his procreative drives were sublimated into areas of work where he could care for or contribute to the caring of others e.g. HIV voluntary work or seeking a post at a Children's Hospital.

During the months leading up to the operation Paul rarely mentioned it, partly due to the Hospital's reluctance to give him a date. I found myself becoming quite anxious to know when he was to be admitted, fearing that it would coincide with my summer break. In the event he was admitted one week after my return to work which was probably enough for Paul to feel he was not facing the ordeal totally alone. My anxiety seemed to be derived from countertransferential feelings, as if I were like a mother worrying over her child. It is with some interest that Seligman (ibid.) writes of the role of the 'Tutor' in initiation rites and like Hobson (1961) in an earlier paper, explores and comments on the practices in many cultures where young boy(s) are

taken from the mother's home to live with the Tutor who becomes not just a guide through the rites and rituals but also a substitute mother, some even don women's clothes throughout the entire period and engage in sexual acts with the boys as if they were husband and wife.

During this period Paul presented me with a series of dreams which seemed to be reflecting the process of the circumcision.

> Dream 3
> I am walking along a country lane, a black man is walking alongside me. We sit down and I can see foxes in the distance who were able to do fantastic things like levitate, they eventually end up falling on small animals and biting their heads off.

Paul's association to this dream was to link the black man to his sexuality. The Foxes seem to represent Paul's rather primitive sexuality with an interesting link to magical thinking. There was at the time, at an unconscious level, a lot of 'magical' thinking about the circumcision, that it would in some way enable Paul to take revenge on those men who had humiliated or rejected him now that he was going to get a new, more effective penis.

> Dream 4
> I am leaving the church youth club in Chester. I see a man on a bike, he looks like Jesus with long hair and a beard. He cycles past me and through a gate in the city wall. Above the gate I notice a clock. On the other side there are some dark menacing figures who might be people who live on the streets. They approach the man and start to attack him

In this dream Jesus could represent the figure of rebirth and Paul's need to emerge into a frightening world. The gate seems to be the portal, with its clock, through which Paul/Jesus has to pass in order to continue with his journey. It is interesting that as mentioned some of the circumcision rituals talk of the ordeal as a rebirth. Paul is afraid that the dark figures on the other side, which represent split off paranoid parts of himself, will attack him, thus stopping any progress. Paul's associations were to the bicycle and the church youth club, the former relating to his lonely rides on Sundays and the club was where he experienced his first 'fit'.

> Dream 5
> I am standing in the middle of Trafalgar Square. There are lots of children around me, they seem to want something from me. As they approach me I feel panic and try to move away from them but they pursue me. I try to put them off by reaching into my bag and throwing money at them hoping they will stop to pick up the money. However this does not stop them they

still pursue me. I only feel safe when I get to the edge of the square and Stewart is there.

This dream uses Trafalgar square as a symbol of the Self which contains the phallic column and the receptive fountain and is guarded by lions (primitive defences). Paul is beset by children which represent on one level split off parts of himself seeking integration and Paul's confrontation with his masculine/father self which he is still very afraid of. The use of money to try and fend off the aggressive children probably represents Paul's attempts to defend himself by locating value in external things, clothes, books etc., literally throwing money at the problem, which does not work. It is only when he moves to the edge of the square/Self and finds his partner that he felt safe. His partner of course holds the projections of himself as he has constructed them, which were initially to fend off castration anxiety.

During a session some months after the operation Paul, after a silence, in a joking way said; 'I've just had a funny idea. I imagined that my foreskin had become very hard, like a serviette ring, so I thought I would give it to my mother as a gift.' I was struck by his comments, for as part of the circumcision rituals in Ancient Egypt the foreskin would be buried and offered to the Mother Goddess as a gift, a token for giving up her hold on the boy and also as a talisman to ward off her wrath for his leaving her protection and care. It would appear that Paul had found his way to this part of the process quite unconsciously and wished to give her something to ward off what must have felt to be at a very primitive level, her response to his operation. It was significant that he did not tell either of his parents that he had undergone the operation until several months after. He perhaps also derived some pleasure in sharing a secret with me so that I was felt to be in alliance with him against their possible disapproval of his emergent sexual activity.

At about this time he began to realise just how unseeing his mother was. He attended a party where he told a friend that he had had a circumcision and why. This friend said that as a child he had suffered the same problem but he had undergone the operation when he was six, due to his mother discovering that he had a problem. Paul became very angry with his mother and the first signs of his growing inner separation began to emerge. He also started to explore connections with things and events and develop a sense of continuity. In some part this was the result of the reliability of the sessions. He brought a dream at this time;

Dream 6

I am at my Grandmother's house. It is a small two up two down house with a narrow garden. At the bottom of the garden I notice a small garden pond which has fish in it. It seems to be connected to a lake by a stream with a weir in it so that water is flowing into the pond. As I look into the distance I see that the lake is joined to the sea.

In this dream he is perhaps being presented with the dimension of the procreative couple and connectedness. The two sets, two up, two down seem to point to him seeing the relationship which produced firstly his mother and then himself. He was also able to see how all these people are connected and have relationships that go back in time and that the problems and difficulties he was having to struggle with had there roots in the past. That his life is connected and has a sequence which starts in the collective sea, is joined to a lake/his family, and finally joins the pond, himself. I felt this to be a significant dream as he now seemed to have found his connections to life and could begin to live in himself as it were, rather than through others.

During the Autumn, Paul decided that he would give up his room in the house he was living in and move in with Stewart. They had been talking about buying a flat together for some time but nothing had come of it. The decision to live together seemed to be further confirmation of Paul's ability to make choices for himself rather than wait for a consensus to build up from friends or his mother.

Towards the end of the period covered by this paper Paul began to have spontaneous fantasies in the sessions. Two were of some significance. The first he imagined was that a dark hand was emerging from the end of the couch moving up his legs. He felt that it was going to attack his penis and that he was going to have to defend himself with his penis. I asked if he felt he could do this, he replied that he thought he could by using it as a sword although he was a bit anxious in case he failed. He thought the hand belonged to his mother.

The second fantasy was inspired by the figure of a small attractive girl who he recalled came from a children's book he had read when he was young. In this fantasy she was holding a large rolling pin in the kitchen of his parent's house and started to lay about her with the rolling pin, destroying everything in her path, eventually knocking the whole house down and standing on the rubble in triumph.

It would seem that the process of Paul's growth is still at a precarious stage. He is uncertain of the symbolic power of his penis although he realises it is now potent, but it is the little girl, with whom he is still probably identified who has the power to be destructive. Paul has still some way to go before he has ownership of his masculinity.

Summary

Paul has not had any fits for over a year. The last one he experienced was during a play by Peter Shaffer, 'The Gift of the Gorgon'. It is a very powerful play which mixes Greek myth with powerful women and the need for revenge. It would seem to represent the three major themes that have influenced Paul's life. The Mythical, archetypal level found in his need to undergo the ritual circumcision and emerge from his Mother's suffocating world, to find the inspiration for a personal meaning for his life and his still largely un-expressed need for revenge on the woman who tried to stop him from becoming a man.

Over the course of two years of work together I have sensed that Paul has become more solid, perhaps even 'grown up'. He is certainly more able to see the manipulations practised by his mother (he can also see how his partner's mother behaves in a similar way) and be aware of his anger at her for the past and is able to be in touch with it in the present. He is more able to ask for, and receive, help from his partner when he needs it and does not tolerate the kind of petty abuses that are the currency of his daily work any more. His awareness of the depth of his rage is only just emerging and will, I feel, take some time for Paul to accept and integrate.

The therapy continues and he is still very committed to carrying on the work. In several recent sessions I have been able to not know what is happening and I have been led, as if he were an inquisitive child, by the hand to explore those things that he finds interesting. Perhaps he is beginning to look at the books with me/mother that in his dream he felt he was directed away from.

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RIVALRY AND THE STRUGGLE OF THE DEVELOPMENT OF THE SELF: OBSERVATIONS OF INFANT TWIN BOYS

ANNE PENINGTON

Introduction

I will outline my observations of the development of non-identical twin boys in the first year of life drawing as I do so on the theories of Bion (1962), Klein (1952) and Fordham (1989) I will focus on the experience of each baby of the other throughout the year and speculate about the ongoing influence of experiences before birth. In thinking about the very early, primitive aspects of the experience of twinship I will refer to the archetypal theory of C.G. Jung (1936). When thinking about competition between the twins at a much later developmental phase, towards the end of the first year, I will refer to the work of Anna Freud on ego-defence mechanisms. I will outline the stages of Stern's model of the development of the self as I go, as I think it provides a useful framework for conceptualizing shifts in the babies' relationship to one another.

I will also attempt to think about the ways in which shifts or changes in the development of one baby influence the development of the other.

I will compare my observations with the findings of others who have observed twins; firstly Burlingham (1952) who observed three pairs of very deprived twins in the Hampstead War Nurseries, then Piontelli (1992) who observed four pairs of twins, both in the womb, using ultra-sound techniques, and at home until the age of four, and finally Davidson (1992) whose one year weekly observation of twins was recently published in the *International Review of Psychoanalysis.*

Background to the observation

I had had a long and arduous search for a baby to observe. After looking for several months I again visited a local N.C.T. group to ask prospective parents whether they would be interested in participating in an observation. One of the men present facilitated my place in the group as I interrupted the busy chatter to make my plea. He then

enquired whether I would be interested in observing twins. His wife Sarah followed his lead and said that she would be interested in finding out more about it.

The couple welcomed me into their home when I went round for a preliminary visit a short time later. Sarah at this stage was nearly 7 months pregnant and moved about with some difficulty. They are a professional couple. Sarah, who is Irish, is in her mid-thirties and John, who is English, seems to be a little older. They live in a pleasant roomy terrace house in a suburban street not far from a park.

They quizzed me at some length about my professional background and were straight and forthright about the arrangements for the observation. Sarah for instance wanted to know whether I would require cups of tea. With two babies to manage she thought she would not be up to looking after visitors. The couple planned to refer to the new arrivals as 'the babies' rather than 'the twins'. They said that in the long-run they would need separate cots but at the beginning they imagined that the babies would want to sleep together having been so long together in the womb. John wanted to know whether I would adhere rigidly to an observer role or would respond to the babies when they started to relate more to me as they grew older. They checked whether I would intervene if I saw one being aggressive to the other. When I had been vetted as satisfactory I was told of the very important place that the cat held in the family. This was to be significant later.

In the course of the observation I learned that the couple had been married for about 3 years. I did not learn anything about the history of their attempts to have children. They did tell me at this meeting that the babies had been conceived by GIFT fertility treatment. They had known from the outset that if the treatment was successful a multiple birth was a possibility. The doctors at this stage had advised them from the scan that there were a boy and a girl in utero.

Throughout the observation the couple respected and supported my role as a student observer and would remind others that I was there to observe the babies and to learn from them.

Early days: 0 to 6 weeks

I approached the first observation with some trepidation as I had not heard from the couple when the babies were born and had needed to

make two telephone calls in order to negotiate the first observation at two weeks.

When I visited the house I learned that the early days had been very difficult. Sarah had been called into hospital for a caesarian operation when at an ante-natal appointment it had been found that Tommy, the smaller of the babies was in distress. His brother, Simon, had been in the breech position throughout most of the pregnancy. The doctor said that he thought that Simon's foot was interfering with Tommy's head. The parents identified Simon as the twin who had been the more active of the two in the womb. He was also the twin who had been thought to be a girl.

Tommy, the smaller twin had had feeding difficulties in hospital. Mother and the babies returned home after a week in hospital. Only a day after returning home mother and Tommy returned to the hospital for further help with feeding. It emerged that Tommy was feeding with the tip of his tongue touching the roof of his mouth so that the underside of his tongue effectively shielded his mouth and made it difficult to take in food. At the hospital Sarah had been issued with a breast-shield and shown how to stimulate the sucking reflex by tickling Tommy under the chin. Tommy's first experience of an object in his mouth may well have been that of his brother's foot in his mouth while in the womb, and the curling back of his tongue may have been a way of protecting himself from this intrusion.

I felt quite overwhelmed in this first observation as I struggled to observe the two babies in the company of both parents. The following is a summary of this observation. When I arrived Sarah was breast-feeding Tommy and talking to Simon who was lying by her side on the marital bed. Tommy was handed over to father to be winded once his breast-feed was finished and Sarah then breast-fed Simon. Father put Tommy down in his cot. Tommy became distressed over his gluey eye which he started to poke with his finger in a most alarming way. Simon's feed was then interrupted as he was handed over to father while mother attended to Tommy's eye. Simon sneezed, hiccoughed and expelled wind.

Both babies were sharing the breast with a rival. This is an experience which has many parallels in the animal kingdom. It would be most unlikely not to provoke an instinctual response of a basic kind associated with the survival of the fittest. In Jungian terms this kind of experience would represent the instinctual pole of an archetypal experience (Jung, 1936). How the babies experienced each other is difficult to imagine. Sarah spoke softly to the twins throughout the hour

providing, in Bion's, terms an *alpha* functioning for the infants' unformed emotional experience. Simon held himself in a tense way as he sucked noisily at the breast. Sarah said to him '*There is no need to rush; no-one is going to take it all away. Are you wondering whether your brother is getting something better?*'.

The impact on each baby of the presence of the other seems to have been mainly that of having his feeding experience interrupted as they were handed back and forth while in the process of digesting the feed. Sarah faced the dilemma of being wrong-footed whatever she did. It was impossible to spare one baby the disruption of an interruption without the other missing out on her care and attention. I felt much more tuned in to mother's patter to the babies than to that of father, which may or may not have been the experience of the infants.

Although at birth Tommy had been only a couple of pounds lighter than Simon his slow weight gain remained a source of concern for the first four weeks. These feeding difficulties could be understood in Fordham's terms as a breakdown in the ongoing, unfolding process of deintegration and reintegration (Fordham (1989). Sarah continued to both breast-feed and give him formula milk, measuring and recording his intake all the time. Tommy seemed distressed in his sleep during these early weeks. At 4 weeks I observed that *on at least three occasions Tommy screwed up his face, drew his legs up and in and forcefully pushed them away from his body. On one occasion I noticed his left hand turned outwards from his body as though shielding his face from something.* At times Tommy's face would go red and he would expel little bubbles of spit from his mouth. One of the sources of Tommy's pain seemed to be the hard faecal matter he passed which was unlike the soft stools of his entirely breast-fed brother.

The babies had been delivered two weeks before full term, which as Sarah said is 'fantastic for twins'. However in my observation at 4 weeks I recorded my impression that Tommy was not quite ready to be in the world yet. Sarah said on more than one occasion later on that she felt that unlike Simon, Tommy had not been quite 'cooked' when he came out.

At 5 weeks I learned of a remarkable development. The parents had consulted a cranial osteopath who specializes in work with very young babies. She had used her fingers both on Tommy's scalp and inside his mouth. After this Tommy had let out a long sigh and had then managed to feed from the breast without a breast shield. He was then offered a dummy which he accepted and continued to use for the rest of the first year. One could speculate that the experience of the osteo-

path placing a knowing finger in his mouth that knew and understood his pain had provided him with the experience of a good object in the mouth unlike the experience he had had in utero. In Fordham's terms the archetypal expectation of a good object in the mouth, had now been met, in contrast to the earlier experience in the womb. This marked a turning point for Tommy.

Simon's problem with wind continued to worsen and, on top of this, he developed nappy rash. He would guzzle voraciously at the breast and often held himself stiffly. I wondered whether he sensed his mother's preoccupation with his brother and over-compensated for this with the breast. He would defecate during feeds so that even when Tommy was not competing with him for mother's attention, mother was left with the dilemma of whether or not to interrupt the feed. If she had not stopped to change the nappy she would have run the risk of Simon's nappy rash worsening. Her dilemma was not just which baby to attend to, but which end of which baby! By 6 weeks Simon had developed colic which was to beset him for several months.

At 6 weeks Sarah informed me that she had been thinking about the possibility of getting someone in to help her with the babies. She articulated her sense of missing out on the time to simply be with her babies as she was so exhausted just keeping up with the physical demands. It seemed that a process was underway of coming to terms with the human limitations of what could be provided by one person caring for two babies at the same time. It was not until the babies were 25 weeks old that a trainee nanny was engaged two days a week.

It was at 10 weeks that I first observed Sarah feeding both babies at once with comfort and ease. *Simon was at the breast lying across her lap. Tommy was lying behind him and both were supported by Sarah's encircling arm. Tommy had just finished a bottle feed and the empty bottle was lying discarded on the sofa.*

I was interested during these early weeks to observe the babies' interaction with each other. At 8 weeks Sarah told me that 'when both babies were feeding together Simon was sucking at Tommy's head, and at one point their arms knocked into one another and they did not seem to notice'. At 10 weeks I observed Simon's hand touched Tommy's head several times. Later Tommy's foot touched Simon's leg...their arms touched one another's bodies several times...neither baby showed any reaction to this contact. One could speculate that this interaction reflected a predominantly benign experience of one another in utero.

In Stern's developmental framework these early interactions belong

to the phase of the '*Emergent Self*'. At this stage the infant will not have fully differentiated the bodily self of himself and his mother, and presumably by extension of this, of himself and his twin. During this phase, however, patterns of experience are being laid down from which the infant is actively forming an overarching sense of self. The next stage, the domain of the '*Core Self*', extends from 2 to 6 months. Infants sense that they and mother are separate physically, are different agents, have different affective histories and separate histories.

There was another kind of interaction which I first observed at 9 weeks. *Simon had started to make straining sounds in his sleep and his arms flayed about. Tommy (also asleep) then started to become more and more agitated and let out small expulsions of sound as though he too was straining. Seemingly in response to this Simon made louder and louder sounds (combining a high-pitched sound with chesty pushing sounds).* Sarah confirmed that she too had observed them pushing each other to a crescendo when they were half asleep. This communication seemed to be of a primarily unconscious nature. This is something I have not witnessed in young singleton siblings of a similar age and do not know how peculiar this kind of interaction is to twins.

The time leading up to the introduction of solids at 6 to 15 weeks

The experiences of the two babies leading up to the introduction of solids at 11 weeks were very different.

Simon's colic continued. At night he would often cry right through from 10.30 pm to 1.00 am. When I visited I would sometimes observe him cry in the rigid, jerky way of a colicky baby. His breathing was partially blocked both when feeding at the breast and at other times. He also had difficulty establishing a sleeping routine. These are all classic features of colic, as described in Daws' (1989) helpful book for parents *Through the Night*. In a discussion about sleep disturbance in colicky babies she suggests that as the colicky baby does not have an opportunity to learn to trust his body rhythms in taking in food and defecating there is not a secure basis for learning to trust the body's natural rhythm of waking and sleeping.

Unlike Tommy, Simon would fight against falling asleep. When I observed him in his sleep he often seemed restless and uneasy, a bit like Tommy's sleep had been during the early weeks. Simon would fall asleep at the breast and demand a feed as soon as he woke up. It seemed as though in the no-man's land between wake and sleep he

wanted the reassurance of the nipple in his mouth. I wondered whether this pattern exacerbated the pain of his colic. In falling asleep straight after a feed Simon was missing out on the mental digestion (*alpha* function) offered by mother to help with the feelings aroused by the physical experience of the feed, leaving him only the avenue of bodily expression of these feelings.

As the mother of a colicky baby Sarah had the task of detoxifying the baby's persecutory fantasies which will have been projected on to her as he inevitably sees her as the source of his pain. Sarah however had the added dimension of knowing that the baby who was behaving as though he was being poisoned was the one who was taking her milk and not the other way around.

At 6 weeks Sarah reported that Tommy was now able to root for the breast. However most of his milk intake continued to be from the bottle, and as far as I know he was not fed from the breast beyond 9 weeks. (When sharing an earlier draft of this paper with Sarah, I learned that Tommy was fed at the breast once a day up until 9 months.) His breast feeding was important to Sarah. I remember that at one point she said, when he had put on weight, that she was sure that it was the breast milk that had done it.

Simon would brook no substitute for the breast. He turned down the dummy at 5 weeks and at 6 weeks refused water from the bottle. Tommy, on the other hand, was so attached to his dummy that by 8 weeks when it dropped out of his mouth while he was in the cot he would turn his head persistently to the side and attempt to reach it until someone returned it to him.

The two babies reacted in characteristic ways to the introduction of solids. Simon reacted with caution and suspicion, in Sarah's words '*as you would expect a baby to do*'. Tommy guzzled the new solid food without hesitation and put on weight very quickly over several weeks which gave him a very swollen appearance.

At 11 weeks, three or four days after solids were first introduced Sarah developed an acute attack of mastitis. She complained that the pain in her breast was worse than anything she had experienced in her life, worse even than the caesarian. The pain was at its worst when she was either ready to feed or was feeding from the non-infected breast. Simon's colic, which had lessened slightly, worsened again coinciding with the mastitis attack. It is tempting to think about this in Kleinian terms as a somatization of the angry feeling projected onto mother's breast by the infants, or indeed a somatization of mother's own angry frustrated and needy feelings. The introduction of solids

represents a loss for a mother. For Sarah it would have meant not only a loss of the experience of being the sole source of sustenance for Simon but also of the opportunity of ever having been able to feed Tommy totally with her own milk.

At 15 weeks, the last observation before the holiday break, a tragedy struck the family. When I arrived John was looking after the children as Sarah was at the local veterinary clinic with the cat. Sad Irish ballads were playing on the tape-deck. In the course of the observation Sarah telephoned with the news that the cat had had to be put down. I recalled that the cat had been poorly when I had visited the previous week. I learned that this elderly cat had miscarried a litter of kittens and had never recovered. Sarah stayed on at a friend's house to be comforted rather than returning straight home. I felt helpless. I worried about being a burden to Sarah, my observations representing yet another demand at a time when the world was experienced as such a dangerous and persecutory place. I wondered what the cat represented to Sarah in terms of her life experience before meeting John, and the longing for children that had prompted them to start on the hard road of fertility treatment.

The period of weaning: 20 to 42 weeks

I will now follow some of the threads of the babies' development from the first observation following a five week holiday break over the summer, up until 42 weeks when Simon was finally weaned from the breast.

A feature of the twins that stuck me immediately on my return from holiday was the degree of eye-contact which was made with the adults around them. Sarah asked me how I felt about being stared at by two babies at once! This had already been established earlier in infancy. As early as 7 weeks Sarah had reported that when John and Tommy were looking at each other Tommy had started to scream as soon as John had withdrawn his gaze.

I had first observed the mutual gazing of the mother baby 'love affair' at 11 weeks. I recorded, '*While Sarah was waiting to get through on the telephone the babies engaged her with smiles and rapturous gazes. She looked from one to the other returning their smiles and talking about what she was doing.*'

At 21 weeks Simon's manner was that of the young scientist as he studied the difference between his mother's face and mine. *Simon*

looked at me, he then looked steadily at his mother's face and then turned to look at my face again. He repeated this three or four times with a good deal of concentration.

At other times the staring had a more confrontational, or even hostile, quality as though we were in a staring competition. On some occasions when one or other of the babies was upset and my face showed concern the baby would calm down as he gazed at my face. At 32 weeks Sarah told me that one of the babies had stared at someone for a full 10 minutes in a restaurant. Empty restaurants were definitely unpopular!

Tommy first engaged me in a rudimentary game of peek-a-boo at 24 weeks. Both babies engaged in peek-a-boo games, of increasing sophistication, throughout the remainder of the observation period. These games play an important part in helping the infant to develop his own sense of mastery and agency as the temporarily lost object is repeatedly recovered with delight, and eventually established as having a continuity of existence independent of the baby.

With regard to physical development Simon remained a couple of weeks in advance of Tommy. At 25 weeks Simon was able to sit unsupported while Tommy was still toppling over. At 28 weeks Simon was able to fully roll over onto his front and could work his way across the room in a prone position. Tommy did not master these feats until he was 30 weeks.

A couple of weeks after the holiday break at 22 weeks both babies came down with colds. The following week Simon's colic returned, having abated during the holiday, and he again started to wake up during the night. Sarah now clearly saw Simon as being the more vulnerable of the twins. She said, 'At the beginning it had seemed that Tommy was the baby who would need the extra cossetting but it had turned out to be Simon'. In the evenings Simon was again falling asleep at the breast. Sarah now developed a peculiar method of getting him off to sleep during the day which continued for the rest of the observation period. She would carry him around in a sling and cover his head with a cloth so as to reduce external stimulation, and would then jiggle him up and down as she walked around the house until he fell asleep. The significance of the jiggling has remained a mystery. Simon had already shown a tendency to enjoy rough and tumble play more than his brother (For example at 20 weeks he would look quite excited as he was swung around by his mother). It is possible that the jiggling resulted in some sort of physical excitation that would 'blanket out' other feelings.

As I write it is difficult to describe each baby independently of the other. The parents also compared them. As the observation progressed there was a shifting back and forth of personality characteristics the parents attributed to one or other baby. At different times one or the other would be referred to as 'the goody goody' or 'the little devil' or 'the charmer'. At this stage Tommy was seen to be the one who would be able to 'sit down quietly with a book when he grows up' and Simon the one who needs to be 'distracted'. After meal times one was the 'clean one' and one the 'grubby one'. At times of exasperation Sarah would sometimes call one the 'good one' and one the 'bad one'. The sense of the babies' not yet having a clear sense of identity was reflected in the seminar group's confusion about which was which.

There were however some enduring characteristics emerging. I was for example often struck by Tommy's high level of excitability both before and during feeds. I had observed this in early infancy during both breast and bottle feeds. Now when being fed in the high-chair by either mother or the nanny his limbs would often quiver with excited anticipation. Tommy was often observed by others to appear more 'babyish' than Simon. Although this may have been partly due to his more rounded face it may also have had something to do with his less developed capacity to contain excitement.

John and Sarah commented on a tenacious quality in Tommy. At 28 weeks when the family went to stay with a friend who had a one year old daughter, Simon would hand over anything she grabbed at whereas Tommy would not relinquish anything without a struggle. I recall the seminar group's surprise when I reported the parents' concern about Tommy being able to defend himself from Simon when they grew older as around this time Tommy's kicking was more vigorous than Simon's.

I noted Tommy's sensuality, whether he was running his fingers through his mother's hair or stroking the soft surface of a cloth or the soft toys in the cot. He developed a pattern of going to sleep with the soft furry surface of a cuddly toy touching his face or head. The presence of soft toys around him in the cot while he was asleep remained a feature for the rest of the observation period.

An enduring characteristic of Simon's behaviour was an intolerance of substitutes for the breast. He turned down later offers of a dummy. At 4 months and again at 6 months he again turned down the bottle. This discriminating quality, an insistence on the 'original model', seemed to be reflected in his object relationships. For example, at 22 weeks Sarah left the babies in the care of a minder for half an hour

while she went for a swim. Tommy greeted her return with excitement and smiles whereas Simon started to cry as soon as he saw her. Much later at 40 weeks, following an interruption in contact with both the nanny and myself, Simon demonstrated an age expectable 'stranger response' and took his time before smiling at either of us. Tommy on the other hand smiled straight away.

From about 6 months on Simon often seemed quite subdued. In retrospect it seemed that he had been starting to engage with the 'depressive position'. This involves an increasing synthesis of love and hate in relation to part objects as mother is experienced increasingly as a whole object in her absence. The infant suffers from intensified depressive feelings 'since it is the loved person (internalized and external) who is felt to be injured by aggressive impulses' (Klein 1948 p.35).

At 22 weeks *when mother lifted Tommy to change his nappy leaving Simon on the floor. Simon's face crumpled and he became increasingly grizzly. When Sarah returned her attention to him he actively engaged her both verbally and with his eyes.* At 24 weeks *'Simon started to whimper when Sarah left the room, then immediately made eye-contact with her when she returned...he seemed much more subdued than Tommy.* At 30 weeks when Sarah was teasing him by calling him a name in a sing-song voice Simon's face crumpled and the corners of his mouth dropped slightly at the edges and he was frowning. I thought that he looked depressed. Sarah tried to jolly him out of it saying 'I was joking. It was only a joke'. He remained downcast.

At 29 weeks it seemed as though there was the beginning of a shift. I had observed as the two boys were fed breakfast by the nanny and had then been sitting on the end of the parents' bed as the two babies slept. Although it had been some time since I had observed Simon on waking I was aware that this had often been a difficult time for him. As a younger baby he had cried immediately on waking. Now *Simon awoke and studied the fabric of the cot blanket which he grasped in his hands...he fixed his gaze on the animals pictured on the fabric lining the inside of the cot, then again turned his attention to the cot blanket which he grasped with both hands and moved around in front of his face. Sarah came in and with an exclamation of surprise and pleasure made contact with Simon. I leant back on the bed wishing very much not to intrude on this private and intimate moment. Sarah was oblivious to my presence but made contact with me with mild surprise when she withdrew from her reverie.*

At 31 weeks the balance shifted between the babies. Up until then Simon's sleeping at night had been very patchy but from this point

on he generally slept through the night. On the first of the two nights when Simon slept through Tommy awoke at 4.00 am ready for 'a conversation'. Tommy continued to sleep poorly. At 40 weeks Sarah reported that Tommy no longer dropped off to sleep immediately but cried when he was put down. He also started to cry in his sleep as Simon had done earlier. It seemed that Tommy, the baby who had previously made do with substitutes, now felt more free to make demands on his parents. It also seemed that he was actually experiencing more distress.

The sleep deprivation that the parents experienced understandably caused a great deal of distress. However it seems unlikely that the babies' sleeping would have been such an issue for them without its having some roots in their own personal histories. Mother mentioned once that her husband had told her that she sometimes slept with her eyes open. She reported early in the observation that she had observed Simon sleeping with his eyes half open. At 49 weeks I observed Tommy, after a period of very exciting play with the nanny, sleeping with his eyes open, the eye-balls rolled back until the pupils were nearly out of sight.

The age of 7 to 9 months marks the beginning of a surge forward in development. Stern (1985, pp.27) describes this time as the beginning of the developmental phase which he calls the *Sense of Subjective Self*. 'Self and other are no longer the core identities of physical presence, action, affect and continuity.' New capacities include 'the capacity for sharing a focus of attention, the attributing of intentions and motives to others and apprehending them correctly, and for attributing the existence of states of feeling in others and sensing whether or not they are congruent with one's own state of feeling.' Burlingham (1952 pp39) observed a shift in the relationship of twins to each other at around 7 to 8 months, noting that it was at this time that 'the twins first seem to take notice of each other's presence.'

Mobility is also starting to take off at this time. When Simon first started to crawl he could only make progress in a backwards direction, but by 35 weeks was crawling forwards with ease. In this observation I watched as Tommy rocked backwards and forwards rooted to the spot as he struggled to crawl. Tommy was much more mobile by 39 weeks and was crawling fluently by 40 weeks. The parents were concerned about how difficult it was for Tommy not to be mobile when he saw his brother moving about. This view was echoed by Burlingham (1963). She emphasized the important place of differences in physical development in rivalry in twins. She drew attention to the ego-defences

used to cope with the painful feelings of rivalry. Although these defences were identified in slightly older children, for example at 10 months in the case of girl twins, I think that it is possible to see the beginnings of the defences of 'copying' and 'identification' in the material here. These defences can be understood in Anna Freud's terms as a 'reaction formation' against competition (Freud, A. 1937).

A rudimentary form of copying seemed to be taking place at 29 weeks. *Simon's grizzle turned into a steady low-key whine... a little while later Tommy started to grizzle in the same way. The abrupt way he started to grizzle and then looked around left me with the impression that it was a deliberate copying rather than the primarily unconscious communication I had witnessed earlier.*

I first had a clear sense of the two competing for my attention at 30 weeks. *Both babies stared at me and started to make vocalizations. The more I looked at one the more I felt an imperative to look at the other. Sarah acknowledged my unspoken dilemma saying, 'It's difficult to know which one to look at.'*

At 32 weeks Tommy seemed to abandon the competitive position and opt for identification with his brother's experience. The nanny was playing a game with Tommy which involved holding her fingers up in the air with an attitude of suspence before relieving the tension by tapping her fingers on the feeder tray. *She then turned to play this game with Simon. Tommy looked at her with an engaging smile as though trying to divert her attention. He then joined in with Simon's smiling at the finger tapping part of the game. When the nanny had finished the two babies looked at each other and smiled.* It was as though Tommy was prepared to go only so far in his competition with his brother at that time.

The beginning of the development of the ego opens up for the infant the possibility of using ego defence mechanisms rather than 'defences of the self' the sole option to which it has recourse in the early days of development (Fordham, 1974). I am thinking here of the way one infant would cry in a total and abandoned way while mother was attending to the other when they were tiny.

The outside world was now starting to impinge more on Sarah, and at 35 weeks she returned to part-time work two days a week. The babies were cared for by the nanny one day a week and by an older woman who was familiar to them on the other day. Although until then Simon had been having a feed from the breast at lunch time, he now for the first time accepted a feed from the bottle. This was given to him by the nanny.

At 40 weeks both cots were finally moved from the parental bedroom to the nursery.

Simon's weaning was speeded on by the arrival of his teeth and the associated biting. As with other physical developments Simon was a few weeks ahead of Tommy. Simon's first tooth appeared at 30 weeks and by 39 weeks he had both some upper and some lower teeth. Tommy's first tooth did not come through until 33 weeks and he had to wait until he was nearly one year old before more arrived. At 39 weeks I learned from Sarah that Simon had bitten both herself and Tommy on the ear, leaving bite marks on Tommy! When Simon latched his mouth onto Tommy's head in this observation Sarah quickly removed him.

Understanding of language had also progressed. At 40 weeks mother called them both separately by name from the bathroom. Each baby responded to the sound of his own name and crawled out from the nursery into the corridor to join mother. Simon managed this more confidently than Tommy who hesitated at the nursery door and needed further encouragement from mother.

A baby's recognition of its own name opens the way for the use of language in mediating experiences of self and other. In Stern's model the *Sense of a Verbal Self* starts at between 15 and 18 months but I will not elaborate on that here as this period is not directly relevant to this observation.

The final weeks: 43 weeks to 52 weeks

In the observation at 42 weeks Sarah told me that two days previously Simon had had his last feed from the breast. She said, 'Hurrah, a bottle-fed baby, good for him and good for me.' It turned out to be the beginning of yet another difficult period for everyone.

What particularly struck me in this observation was the degree to which Simon's aggression seemed to be directed towards his brother's head. The parents were reading holiday brochures and the two babies were vying for my attention from the playpen. *Simon manoeuvered himself around and placed his hand on Tommy's head, using it much as he might have used a piece of furniture to support himself. Tommy screwed up his face and looked uncomfortable as Simon pressed his hand down on his head. Father lifted Simon away and moved his hands to the bars encouraging Simon to hold on to them instead. He said in a mildly cross way that Simon 'must not do that to Tommy'. Simon immediately*

started to cry and I thought he looked a bit hurt and distressed. The cry was very brief and within a minute or two his hand was back on Tommy's head. Father said firmly, 'No Simon, you mustn't climb on Tommy'. Again Simon cried as his hands were moved back to the playpen bars. Tommy continued to engage me. He soon held out a plastic cup towards me through the playpen bars. It was done in a vague way and he did not seem bothered when I did not take it.

Three weeks later when the nanny called out to Sarah that Tommy was hitting her leg as though it was a drum, Sarah told me that Simon had been using Tommy's head like a 'drum and a rattle'.

Tommy became very sensitive to any knock to his head, and would sometimes cry when it seemed that here had been hardly any knock at all. Although he sometimes pulled Simon's hair (and his mother's hair) this did not distress Simon in the same way that Tommy was distressed by Simon's hitting. I was reminded of the doctor's speculation towards the end of the pregnancy that Simon's foot was interfering with Tommy's head, and wondered whether an early sensitivity was being reactivated by the current assault from Simon.

I was also reminded of the work of Piontelli (1992) who observed twins both in utero and up to the age of four. She concluded that characteristic patterns of relationship behaviour between twins are established *in utero*. Twins that come to mind are the 'kind twins' who stroked one another in the womb, and then at the age of 1 year were observed to stroke one another through the flimsy film of the net curtain. The 'fighting twins' fought for space in the womb and then were very jealous of one another as children.

The increase in Simon's level of aggression can be understood as both a stirring up of oral drives associated with the arrival of his teeth, and an increase in aggression associated with the loss of the breast. The nourishing breast had gone at the time he had started to bite, which could have fed into unconscious fantasies of the power of his own destructiveness, and increased persecutory and depressive anxiety. In Kleinian terms an absent breast will be experienced as a bad breast, the first persecutory object (Klein 1952). It may be that Tommy's head also stood for the bad breast. Tommy for his part was having to cope with a very real persecutory object in his external world, namely Simon.

At 43 weeks both babies again became ill, this time with gastroenteritis. (The previous major bout of illness was chicken-pox at 32 and 34 weeks for Tommy and Simon respectively). The gastroenteritis lasted for over a week. Simon was in an acute state of distress during

the first part of the observation at 44 weeks. At first it seemed that his distress could be contained by either looking at mother's face or being held in her arms. As the observation progressed his crying became more acute and urgent which reminded me of the distressed abandoned crying of the early observations. *Sarah held him naked next to her body until he pulled himself back and in a standing position surveyed the room and the painful tummy that was causing him such distress. He rubbed his tummy with his hands.* Simon's intimacy with his mother was interrupted by her handing him over to the nanny to change his nappy. My thoughts returned to the interruptions to continuity so prevalent in the early observations. *Now as his crying subsided and he looked up from his mother's body his glances towards me were hostile and suspicious. I felt that any look from me was experienced as intrusive and persecutory.* I had perhaps become the bad-breast object. *Sarah remonstrated, 'come on Simon...it wasn't Anne who gave you a tummy-ache'.* In subsequent observations Simon looked at me in a suspicious manner when he had just woken up. Later on in the observation at 44 weeks I observed Simon squat down on the floor and withdraw into himself in a quiet way for a few moments. Contrary to mother's (and my) expectation he had not been filling his nappy at that time. It seemed that Simon was beginning to develop an inner mental space where thinking and processing of affects might be possible as his ego capacities strengthened and developed.

In the seminar group we wondered what the psychological contribution to the current bout of illness might be. It seemed likely that in Simon's case the affects were most probably about the pain and rage of loosing the breast. However in Tommy's case it might be that he was somatizing undigestable feelings about the fear and pain associated with the attacks from his brother. If this were the case, the presence of the same symptoms from different causes would add to the confusion for a mother struggling to decode the distress of two infants at once.

Simon continued to be the better sleeper of the two, on occasion waking Tommy at night with his crying. Simon continued to be jiggled about in the sling next to Sarah's body in order to fall asleep. Tommy had until now always been able to fall asleep on his own. At 44 weeks Sarah told me that Tommy would now no longer fall asleep without being carried. In this observation while Sarah jiggled Simon to sleep in the sling the nanny vigorously rocked Tommy back and forth in her arms. This pattern continued until the end of the observation period. Even more odd was the news at 50 weeks that Simon had now

started to use a dummy. I have wondered whether this was to please mother or was an imitation of Tommy.

Speech was developing quickly and again Simon was a little ahead of Tommy. At 48 weeks Sarah told me that for the first time they had been able to tell her something she did not know already. While taking them out for a walk in the stroller both had cried out 'woof woof' before Sarah actually spotted the dog they had seen. Simon joined in with 'woof woof' while Sarah told me this story.

The beginnings of co-operative play were in evidence. A few weeks previously Sarah told me that she had found the telephone off the receiver and when she picked it up she had found the emergency services at the other end of the line. The two had evidently dialled '999'! In a follow-up observation at 1 year 5 weeks I heard that the boys had together pulled out some things from behind the fridge. On a less dramatic note, I observed the two babies roll the clothes basket back and forth in the nursery on several occasions and sometimes tussle over it.

In the observation at 1 year 5 weeks competition between the two was more clearly in evidence. Once contact with me had been reestablished the two vied for my attention: Tommy offering me cups of tea from the tea-set and Simon following his lead and offering me the plastic telephone receiver.

At 50 weeks Tommy seemed driven by his needs for reassurance from Sarah and his rivalry with Simon. Simon seemed to be showing a degree of separateness from mother that allowed for a moment of hesitation, a space for playing with possibilities. *The nanny took Simon down from the changing-mat and finished dressing him on the floor. He set off towards Sarah and she asked him whether he was going to give her a hug. A mischievous look came into his eyes and he looked in a different direction, vaguely towards me but not directly at me. He then toppled over and fell into Sarah's lap before heading off in the nanny's direction. Tommy promptly dived straight into Sarah's body without a moment of hesitation. Sarah gathered him into her, laughing.*

In my final weekly observation at 52 weeks I was pleased to be able to have more of a sense of contact with Tommy. *Tommy was banging the cupboard door open and shut making a lot of noise as he did so. He then squeezed into the small space behind my seat and sat down on the floor hidden from the view of the others in the room. He looked at me with a complicitous mischievous expression and I returned his smile.* I wondered whether I would have developed a closer relationship with

Tommy had time permitted a continuation of weekly observations into the second year.

When shortly later I reviewed the year's observation with the parents Sarah told me that she and John had been worried that Tommy did not seem to be developing a sense of humour but that recently they had thought that this had started to change. It seemed that they also were picking up a shift in his sense of self.

In a later visit I learned that Simon was generally more confident and outgoing than Tommy, which fits with the hypothesis that at this stage he has been able to internalize a more solid good internal object than Tommy. As Simon has become more of a 'daddy's boy', Tommy has become more demanding of mother both during the day and during the night. Perhaps now that Simon has been able to move more towards father, Tommy has felt that there is more mental and physical space with mother on which he can make demands.

Discussion

I hope that I have conveyed something of the enormity of the demands that rearing twins places on parents. John and Sarah emphasized to me the load they had experienced from the purely physical aspects of the care of twins.

It seems to me that for both parents and twins there are particularly complex emotional demands. Even for these non-identical twins establishing a secure sense of self was beset by difficulties. I recall how angry and exasperated I felt in the seminar group when for months the members of the group were unable to remember which baby was which. To me it seemed almost a life and death matter that each be perceived separately with his own individual history borne in mind. It was only when I was able to acknowledge my own confusion about which was which that the members of the seminar group started to hold them in mind with greater separateness. There had been a period early on in the observations when at the beginning of the visit it would take me a little while to establish which was which and I would not be one hundred percent sure until Sarah helpfully used a name.

One of the dynamics which particularly struck me in this observation was the prevalence of the psychological defence of 'splitting'. As an observer I was continually identifying characteristics of the twins by comparing them with one another and identifying points of difference. Although comparisons are inevitably made between children of differ-

ent ages in families, in the case of twins this is particularly tempting due to the unique phenomenon of their being at the same developmental stage at the same time.

A first child is likely to be a ready recepticle for the parents' projections. Here, where there were two babies it seemed that from time to time the babies were identified with different ends of the poles of the parents projections. As I have come to know the parents better it seems that Sarah is the extravert one and John the more inward looking introvert one. As with most married couples I assume that each is carrying something for the other in this split. The characteristics attributed to the babies, 'goody-goody' or 'charmer' 'self-sufficient' or 'in need of distraction' reflect the introvert/extravert division.

What intrigued me though was not just the way the babies were perceived to shift back and forth, but also the dramatic changes in the babies themselves. The most striking shifts were firstly at 5 weeks when Tommy's feeding improved and Simon's colic started, and then at 31 weeks, which was the point at which Simon's sleeping started to consistently improve and Tommy's to deteriorate. As Sarah said, 'It was almost as though they made a pact between them'.

It seemed that the shift in Simon was prompted by his beginning to work through the 'depressive position'. It was as though a psychological move forward in one child paved the way for the other to be less sparing and thus able to relate at a deeper level to the parents. I am reminded of my work as a social worker with parents of children receiving psychoanalytic help. Particularly in cases where one child has been labelled the ill or troubled one and another child the well-adjusted one, it is not uncommon for the 'well' child to start exhibiting his distress once the child in treatment has started to work through his difficulties.

Another aspect of the development of twins that this observation highlighted was the extent to which, from very early on, even in utero, the twin has the additional task of adapting not just to the mother but also to the other twin. This was evident in the recurring theme of Simon's interference with Tommy's head.

I found the developmental framework of Stern (1985) useful in looking at the changing interactions between the babies. As would be expected on the basis of his work, shifts in the relationship between the babies occurred at around 2 months when the infant usually begins to develop a Core Self and again at around 7 months when the domain of *Intersubjective Relatedness* normally begins. I am thinking here of the indiscriminate touching of each other which occurred in the early

weeks but not later on, and the shift in awareness of each other that occurred around 7 months, of which I gave a few examples.

Davidson (1992) concluded that by as early as 3 months the twins in her study were a problem for each other in relation to the breast, and that this rivalry was 'not so much out of hunger as out of possessiveness'. This, she suggests implies a capacity to differentiate self from other and represent it in some way, a feat which in Stern's model does not become possible until the age of 7 to 9 months.

This observation did fit with Stern's view that at around 7–9 months there is a development of a capacity to form a mental representation of the other. Although there was evidence of competition between the two babies from the first observation this seemed to be of a primitive instinctual nature, which in Jungian terms can be seen as belonging to an archetypal level of experience. It was at around 7 months that there was evidence of emergent ego defences mobilized to cope with feelings of rivalry. Now that the early foundations of personality were established it could be said that the babies were becoming true rivals.

Over 40 years ago, Burlingham (1952 p87) concluded that 'twins have more acute rivalry to cope with than ordinary siblings. The rivalry starts at an earlier age than it does with siblings'. Although it was not until the second year that rivalry between the boys became more blatant, I was interested to explore and think about the origins of these feelings at this early stage. Closely associated with rivalry, but rather more difficult to think about is the quality of ruthlessness that inevitably creeps into the interactions between such young children, interactions in which the full weight of the depressive position, and with it the capacity for genuine concern for the other, has yet to be negotiated. This was particularly evident on the day when there was talk of Simon using Tommy's head like a 'battering-ram'.

I was fortunate to be able to observe twins who were very much wanted by dedicated and sensitive parents. Even in this favourable environment I was taught something of the vicissitudes encountered by twins in the early stages of development. Stresses particular to twins include the task of adapting to each other from very early on, in addition to the task of adaptation to the parents. It seemed that in this observation there was evidence of an ongoing impact of experiences in the womb. Secondly it seems likely that twins are exposed to experiences of rivalry that are perhaps of a different order than those experienced by ordinary siblings. Finally I would suggest that for both twins and parents there are additional stresses around the babies' establishment of a coherent sense of identity. Certainly as an observer

I found that I had to work hard to hold these babies clearly and separately in my mind and to think about the interaction between them.

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BOOK REVIEWS

Narcissism: a new theory

By Neville Symington. Karnac Books 1993 pp 137 Pb £13.95.

Neville Symington explains to us in his preface that this book arose indirectly out of research that he was doing on Psychoanalysis and Religion, when it dawned upon him that the connecting link between these two disciplines was narcissism.

At the same time, recognising that he did not really know what narcissism was, he set himself the task of thinking about it for twenty minutes each day. As a result, by the end of the year his entire understanding of psychoanalysis had radically altered.

The notes he had made were used shortly afterwards as the basis for a series of lectures delivered at the Sidney Institute, and from these lectures evolved the present book, which retains the attractive simplicity of expression and breadth of reading which characterised his previously published lectures, from the Tavistock, in 'The Analytic Experience'.

What Symington has to say contains a serious charge against the psychoanalytic and psychotherapy professions which, reading between the lines, he may have doubts about our willingness to consider.

If, as Abraham said, the aim of psychoanalysis is to put things right at the foundation of the personality and thus to ensure against future mental illness, we are falling far short of it, often contenting ourselves with the attainment of symptomatic relief. When it comes to the underlying problem of narcissism, from which, as Symington believes, all psychopathology ultimately stems, we are failing. Many patients and analysands, including therapists in training, are emerging from extended periods of analysis or therapy still severely narcissistically disordered.

One of the fundamental effects of narcissism is that it renders us unreceptive to criticism. Yet it is of the utmost importance that we recognise narcissistic currents in ourselves and others, because of the damage which they cause to the social structures to which we belong. Indeed, as Symington points out, a way of differentiating a healthy organisation from a pathological one is via its ability to exclude narcissistic characters from key positions in it.

Moreover, as therapists we have a responsibility to address the narcissistic currents within us. In 'The Analytic Experience' Symington

said that the quality every patient needs in his analyst is self knowledge, and that in areas in which he is deficient in this, the more disturbed patient will find him out.

Symington suggests that the problem may lie in the fact that psychoanalytic theories to date are inadequate to explain the phenomenon of narcissism, and that a model of the mind which renders it comprehensible still requires to be worked out. This is the task which he accordingly sets himself. Firstly, it is essential, he says, when considering how the self is structured, to recognise that it is inherently relational. Without the tendency to seek the breast/mother, the baby would die. This relational nature permeates the self. A relationship implies two separate entities. The core of narcissism is a hatred of the relational, and it will seek to destroy it by destroying separateness itself.

Symington stresses the subject-object nature of the self. The subject is structured by the object and the being of the whole permeates the parts. Thus he refutes the notion that it is possible to find a person's 'inherent being'. There is no such thing: all parts of the self, even dissociated parts, bear the subject-object structure. Each part is itself a source of action.

Our internal objects thus act within the personality, and may even take it over at times. The basic problem then is to get all parts to act in harmony with one another. There is an inherent desire for wholeness, and the struggle to attain it is at the heart of dynamic psychotherapy.

It is also inherent to life itself, to each living organism, that it acts upon the environment, that it has within it an initiatory source of action. A human being should have the capacity to effect change in the emotional responses of those around him. Yet it is impossible to be a source of creative action where the different parts of the self are not integrated. A person dominated by narcissistic currents has smothered his source of creative action. He only appears to relate to others, which he does by becoming adept at sensing the other's emotional tone. Such a person in analysis can deceive the analyst into believing that things are progressing well. This phenomenon has been well documented clinically, and is referred to by Mervyn Glasser as the process of simulation.

How does narcissism arise? To explain this Symington introduces his key theoretical concept, that of the lifegiver. To be born is not the same as to achieve psychological birth. This can only be attained via a choice. What must be chosen is the lifegiver, defined as a psychic object which is neither the breast nor the mother, although associated with these, as later with other primary objects of nurture or fertilis-

ation, such as the penis, the vagina etc. Its existence rests upon a paradox: it exists independently, yet only comes into being through being chosen. It is outside, yet when it is chosen, it is inside.

Grotstein, in his fascinating foreword to this book, suggests that the lifegiver is an internal transitional-like object composed of aspects of the self and of the object. This makes sense, in that it would appear that those aspects of the self with which it must be imbued are closely related to the infant's own innate spontaneity. The notion of trust would also seem to me to be implicit. The narcissistic option however is the repudiation of the lifegiver, and the turning in upon the self. The concepts of choice and of the intentionality of the self are therefore also central to Symington's theory. He argues that the explanations for narcissistic phenomena in terms of early emotional deficit or trauma favoured by Object Relations theorists, principally Fairbairn and Winnicott, are essentially determinist and therefore imply that the narcissistic condition is irreversible.

Whilst supporting the view that narcissism is the response of the individual to trauma in early infancy, and defensive in nature, Symington insists that the decisive determining factor is not the trauma, but the intentional response to it. In attempting to address the question of choice, of whether another option would have been available to the infant, he merely acknowledges that the younger the age at which the trauma occurs, and the greater its degree of severity, the stronger will be the pull towards narcissism. For narcissism is chosen at a deep level within the personality at a point where the spirit is broken by stress or suffering. He draws our attention to Tustin's discovery that the autistic shell covers a black hole of despair. Infantile autism, Symington is convinced, is closely allied to infantile narcissism. Nevertheless there is an intentional element in the infantile response, in the turning away from the lifegiver. By this repudiation he creates a split in the self since he is compelled by the survival instinct into some relation to it.

Only one part of the self now has within it the autonomous source of action and coherence. He is forced therefore to find alternative means of generating action, binding himself into a unity and dealing with the external world. Divided against himself, cut off from the source of creative action from which is derived the ability to creatively fashion one's environment, he is driven to manipulation and pretence.

Below the level of awareness (Symington generally avoids using the term unconscious), he feels guilty and bad, to counteract which he expends energy in seeking strokes and stimulation from outside,

the effects of which are fleeting because of the vacuum within. Everything takes place at the surface, and the impetus for action is generated via what Ferenczi termed the amphimix, the interconnection of erotogenic zones in a unified pleasure centre. The self is eroticised by stimulating or getting others to stimulate the zones. Yet there is no mental object within, only a sensual object. An alternative way of generating psychic energy is via the excitement of killing, or self-killing, cruelty to the self, albeit extremely dissociated. Symington argues that such cruelty invariably accompanies the narcissistic condition, and he disputes the concept of positive narcissism, as used by Bollas, for example, because narcissism can never be divorced from self-hatred.

Symington portrays narcissism above all as a mentality, which is hidden. To flush it out is to weaken its structure. The person is shut off from the other, there is no receptivity, no interest in communicating. It is characterised by denial of feeling and an avoidance of confrontation, which might lead to self-knowledge. One method of concealment is the confusion of inner with outer, the locating of one's disowned feelings in another. The child self is given no voice.

In terms reminiscent of Rosenfeld, Symington portrays the terrible tyranny of the grandiose self over the spontaneous infant self, showing how at the very moment when contact between patient and therapist is made, the tyrant can inflate the regret of the infant self into despair and tempt him to suicide.

Symington is most successful in holding up the mirror to narcissism in all its viciousness, drawing upon myth and literature to illuminate his argument. In particular he turns to Tolstoy, who had, he tells us, a unique understanding of narcissism before the concept was named. Drawing extensively upon 'Anna Karenina', he takes its main protagonists and illustrates how each one's narcissism poses a threat to his or her relationships, demonstrating from the text how in certain instances it is successfully overcome, but how in others, most notably in the case of Anna and her husband Karenin, and Anna and Vronsky, it undermines and eventually destroys the relationship with tragic results.

To my mind the most successful aspect of the book, heightened by his eschewing of psychoanalytic terminology, is Symington's ability to bring home to us the devastation wreaked by narcissism. His everyday language lends reality and force to our recognition of the sheer monstrousness of it, the potential for destruction, in its devaluing and derogatory techniques, of all that is good and loving in the human

heart. Having shown us the beast, he exhorts us, as therapists, to slay it. Not to help our patients is itself vicious.

Since narcissism arises from a choice, it can be reversed. But opting for the lifegiver entails risk, a leap in the dark, and daring is required. Symington gives an example of the reversal of narcissism from Anna Karenina when Levin takes courage, overcomes his wounded pride and for the second time proposes to Kitty. Symington acknowledges that such reversals are rare without therapeutic intervention. The healthy side of the person needs support in giving up the narcissistic way of defending itself. Whilst reluctant to be too explicit in telling other therapists what to say, Symington is impatient with therapeutic passivity and calls upon us to draw upon our own autonomous source of action and overcome timidity in sharing our thoughts with our patients. Like Fairbairn he sees the prime therapeutic task as that of breaking into the closed system of the patient. He quotes Tustin's experience that the autistic child, to emerge from his cocoon, needs the firm intervention of a muscular mother who presents him with otherness. Like Fairbairn too he notes that an upsurge of hatred can presage the patient's movement out of narcissism, before the desperate longing for love is acknowledged.

How useful a concept is the lifegiver? Creative and thought provoking maybe, but I do not think it represents as major a theoretical advance as the author has found it to be. Symington in dealing with the issue of intentionality invokes a concept of an innate force in the personality which stands against the establishing of a personal creation, and this virtually usurps the role of the death instinct. This would seem to provide the additional impetus to sway the infant who has experienced trauma away from the lifegiver.

The problem then is that a shift of focus occurs away from the nature of the real object and onto the invitation proffered by the lifegiver, whereas as Bollas says, 'to come alive a person must be able to use objects in a way that assumes that they can survive hate.' The refusal to use objects in the articulation of one's idiom arises when the infant is brought to the conviction that they will not.

Symington's whole theoretical position reminds one forcefully of Fairbairn's, although he denies Fairbairn the concept of intentionality. Fairbairn however devotes considerable attention to the motivation which underlies the infant's distancing himself from his objects, and motivation implies intentionality although I suspect that he would maintain more distinction between the idea of conscious and unconscious intentionality that Symington wishes to do.

Intentionality is implicit too in Winnicott's concept of a constructed caretaker self and the conservation of a healthy self hidden deeply within, which awaits the necessary conditions for growth. As David Rosenfeld recently pointed out, the encapsulated enclave serves to conserve the most valuable elements of the self in the face of overwhelming terror.

Symington acknowledges the pain and fear that underlies the narcissistic position and tells us that it has to be faced squarely by patient and therapist. He does not, however, as Tustin does, help us to be prepared for the annihilatory rage and terror which we must contain for the patient. I wish that he had retained the emphasis which she places upon the value of understanding, the mutative role of interpretation in the containment process itself.

However, Symington's own clinical extracts are, as always, very individual and instructive. I am sure that many readers will be grateful to him, as I am, for sending them back to Tolstoy. Above all this is a challenging and inspirational book which makes an unusual and welcome addition to the literature on narcissism.

ROSEMARY SOUTHAN

Psychic Retreats

By John Steiner. Routledge 1993 pp 162 Pb £12.99.

Can we actually help the severely narcissistic patient? Can we try to understand their behaviour despite their persistent refusal to stay in contact either with external reality or with us, their therapists? How can we withstand the gruelling tests they put us through? And, how do we keep both ourselves and our patients going in an analysis which feels as though it is going nowhere for long periods of time.

John Steiner attempts to address these questions. His book is a thoughtful and sensitive addition, from an essentially Kleinian perspective, to the fast growing psychoanalytic literature on how to work with disturbed patients, who find it difficult to maintain contact with their analysts. He tries to make sense of the defensive states of mind, the 'psychic retreats', they utilise. These 'retreats' can take any form, such as perversion, addiction, phobia or compulsive fantasy. Although they involve their own quota of frustration and pain, these psychic retreats, by distorting reality, offer a sense of familiarity and protection

to the patient, and seem preferable to the hard-won ambivalence of the depressive position or the intolerable confusion and fragmentation of the paranoid-schizoid position.

Money-Kyrle points out that the three basic *facts of life* for all of us are based on accepting the difficult realities of: (1) recognising the breast as a supremely good object, which means being able to accept one's helplessness and the possibility of dependency on a good, external source for one's survival; (2) recognising the parents' intercourse as a supremely creative act, which means being able to accept the primal scene and the Oedipus complex; and (3) recognising the inevitability of time and ultimately death, which means facing the fact that everything ends including access to the breast, and that the reality of death leads to a need for renewal. Adjusting to these 'primal facts' are monumental tasks for all of us. They involve acknowledging separateness and consequently loss. However, for the narcissistic patient who oscillates between omnipotence and powerlessness and who cannot readily identify with anything, these tasks become impossible goals. The narcissistic patient cannot deal with separation or dependency, or the idea of his own finiteness. He cannot take anything in or imagine anything nourishing coming from outside himself, much less accept the idea of his parents' goodness, power or creativity.

Steiner is familiar with this type of patient. He is at home with their destructiveness. It is somewhat reassuring that he knows them for what they are: their inability to contain anything, their rigidity, their insistent need to control, their lack of symbolisation, their extensive range of attack and protest which prevents any productive engagement, their tyrannical superegos ('a gang or Mafia') which leaves them no room for manoeuvre or to take anything in, and their refusal to acknowledge any positive experience or progress.

Clinically, Steiner follows the well-trodden Kleinian footsteps of Rosenfeld, Segal, O'Shaughnessy, Riesenberg-Malcolm and Joseph who each give precise and careful descriptions of this extreme type of narcissistic patient. We should remember that it was this category of patient which Freud originally warned practitioners against taking into psychoanalytic treatment. Nevertheless, psychoanalysis has moved on since Freud's admonition and Steiner describes the workings of psychic retreats in his consulting room and shows how they are used in an attempt to avoid acute anxiety and pain.

Theoretically, Steiner endorses Joan Riviere's view that narcissistic resistances are part of a highly organised system of defence. He sets these psychic retreats up as a third 'position', usually as a way of

trying to deal with pathological fragmentation. Very little therapeutic work can be done in this position. It does not allow normal splitting which is necessary for growth; instead it involves a defensive misrepresentation which distorts reality and keeps a split going as part of an illusory integration.

Steiner points out that there are two defensive ways to deal with the discomfort afforded by reality: firstly, 'turning a blind eye' as exemplified by the myth of Oedipus; or secondly, retreating to omnipotence. He stresses that there is no growth or development possible for borderlines or psychotics, only relief. The main aim in the treatment of severely disturbed patients is to try to get them, even for moments, to the depressive position. Herein lies the only opportunity for insight and change. This shift can sometimes be achieved by making analyst-centred rather than patient-centred interpretations, although each interpretative focus brings its own problems and risks.

Steiner is well aware just how frustrating and debilitating these patients can be. His book is both perceptive and comforting. He suggests that one needs to discuss these patients constantly with colleagues as they are tantalising and undermining and continuously push the boundaries of technique. Steiner confirms that a narcissistic patient may have very long stretches of time where nothing changes, and one should always remember that when a patient is in the area of paranoid-schizoid anxieties or psychic retreat nothing can grow and the best that we as therapists can hope to do is to provide containment.

JUDY COOPER

Melanie Klein: From Theory to Reality

By Otto Weininger. Karnac Books 1992 pp 210 Pb £16.95.

Given the prominence of Kleinian thought it is perhaps surprising that there are so few texts which provide an introduction to this controversial tradition in psychoanalysis. Weininger's volume is therefore of interest, if only because of the scarcity of such works and the question of how it compares with established contributions, notably those of Hanna Segal (Segal, 1964, 1979) and the recent publications by R.D. Hinshelwood (Hinshelwood, 1989, 1994).

In his foreword, James Grotstein provides a helpful discussion of the location of Kleinian thought within the psychoanalytic landscape.

It is its stress on internal reality and the death instinct, he argues, which brings it into conflict, not only with other psychoanalytic traditions but also with American cultural imperatives, which mean that it is virtually 'un-American' to consider that an infant has a 'death instinct' (p. xvi).

This book was written for a North American audience and, according to Grotstein, Weininger's achievement is not only to have demonstrated the 'theoretical and clinical applicability' (p. ix) of Kleinian thought, but to have repackaged Kleinian theory 'in a way that removes many of the stigmata that have impeded the receptivity to her work' (p. xvii).

Weininger approaches this task, not by directly engaging in theoretical argument with other orientations, but by outlining the Kleinian developmental scheme with copious clinical examples and a novel attempt to describe mental processes from the point of view of the developing infant. As its subtitle suggests, this book is an attempt to move from theoretical argument to the 'reality' of infantile and clinical experience.

In the Introduction he makes use of clinical material to introduce the key concept of unconscious phantasy and stresses the importance of the constant interplay between inner and outer reality. 'Senses and experiences from the very beginning of life become organised into our sense of phantasy – that is, our internal, not spoken or even thought about ways of interpreting the world we live in' (p. xxiv). 'The ego introjects aspects of reality which in turn reshape the original internal phantasy and therefore the perception of reality' (p. xxv). He briefly outlines the concepts of the paranoid schizoid and depressive positions, suggesting that, 'through a process of interaction with the phantasized mother and the real mother ... the infant moves through a series of mental representations that are positions of ego development' (p. xxv).

In working with parents who are seeking help with their infants, Weininger stresses the importance of keeping in mind the child's inner world. 'The infant is not just responding to the parents ... but to an internal phantasy ... we do not simply tell parents what to do and try not to blame them for their babies reactions. Rather we think it is extremely important that parents receive some help in understanding what their infants' phantasies might be and how they may adjust aspects of their own behaviour to help diminish whatever is terrorising their infants' (p. xxvi). The book is replete with examples of the author's creative and sensitive application of a Kleinian perspective to clinical problems.

The main body of the book consists of three chapters devoted in turn to the Paranoid-Schizoid Position, the Depressive Position and the Oedipal Phase.

In contrast to the generally well argued Introduction, these chapters are frequently written in a confusing style and the reviewer often had the greatest difficulty in finding any clear thread of argument or exposition. There are many well written and sometimes beautifully illustrated individual paragraphs but somehow these do not coalesce into a coherent and digestible account. The overall effect of reading these chapters is to be rather carried along by the author's proselytising zeal into wave after wave of dense expositions and clinical examples until one feels in danger of drowning.

Weininger's numerous attempts to put complex mental processes into the infant's own words deserve particular mention. In discussing the transition from the Paranoid-Schizoid to the Depressive Position for example, the infant is held to think, 'I don't have to split, I don't have to projectively identify. I can now see – because I have had good enough experiences to have been able to integrate good and bad ... – that mother is not just a breast, a hand, an arm but is a whole person who mediates both good and bad experiences' (p. 38).

Attempting to convey via words something of the remote pre-verbal experience of an infant is of course extremely difficult. Nevertheless, at the risk of sounding churlish, the reviewer found Weininger's attempt rather awkward and as perhaps giving the impression of considerably greater mental sophistication than could properly be attributed to an infant at this stage of development.

The author's enthusiastic exposition sometimes leads to a rather sloppy presentation of complex concepts. In discussing envy, for example, Weininger states, '[w]e all contain a degree of envy. It becomes a problem for us because we have been raised to believe that all envy is "bad" ... and this produces the varying degrees of anxiety in each of us as we integrate the envy in ourselves while trying to cope with what we have been taught' (p. 77).

This comes after some five pages of discussion of 'Some Defences Against Envy' in which it is clear that the author sees the problem of envy as far more complex than this exclusive emphasis on the external world and the superego would imply. I don't think Weininger is confused but I think he might well confuse his readers with such carelessly drafted statements.

In one respect however the difficulties with this book are not with presentation but with substance. Presumably, in an attempt to deal

with the critics of Klein who object to her emphasis on the internal world, the death instinct and aggression, Weininger is constantly at pains to emphasise the importance of the infant's external environment. He even borrows the Winnicottian phrase 'good enough mother' and from p. 14 onwards seems to use it at every conceivable opportunity. Now few contemporary Kleinians would dispute the importance of the infant's external environment. What they would, however, emphasise is the interaction between this and the infant's unconscious phantasies which are not only the result of environmental factors but are infused with (for Weininger) inconvenient factors such as the death instinct and aggression. Although the author makes reference to these, this is at best cursory and nowhere are these concepts fully integrated into his account.

Weininger's rewriting of Klein to give her work an environmental emphasis may serve an ideological purpose but comes dangerously close to editing out that which is essentially Kleinian, at least in the British sense.

A fourth chapter applies a Kleinian framework to the problem of 'Elective Mutism in Children'. Here the author adapts an entirely different approach. A careful review of relevant literature is followed by two case studies in which Weininger demonstrates his sensitivity and skill as a psychotherapist and the potential of Kleinian concepts to illuminate the understanding of clinical problems.

The book concludes with a useful chapter devoted to a diagrammatic summary of the developmental scheme outlined in the first three chapters.

I think this book provokes two questions. Firstly, how well does it succeed in its own terms, in its stated aim of elucidating the Kleinian view by moving from 'theory to reality', by attempting to convey complex concepts via the copious use of clinical and observational material. Unfortunately, I suspect that many will find Weininger's exposition rather dense and confusing, although greater clarity and therefore conviction may have been achieved by the Introduction and the chapter concerned with Elective Mutism.

Secondly, what of the larger project? Is such a treatment of Kleinian ideas, assuming they are conveyed cogently, likely to convince a sceptical audience? The key assumption of this book seems to be that the problem is one of presentation, that there is no need to directly address the objections of the sceptics. Outline the Kleinian view with a liberal dose of clinical examples, stress the role of the environment by adopt-

ing the concept of 'good enough mothering', put unconscious phantasies into words and the objections will melt away.

Unfortunately I do not think it is that simple. There are differences of substance between Kleinians and their critics who are unlikely to be persuaded unless these are directly addressed.

Had Weininger drawn on the developing Kleinian tradition rather than relying almost exclusively on Klein herself, he might have been better able to engage in a necessary debate. As it is, I think that if he has succeeded in persuading sceptics, this might be the result of his careful editing out of the more controversial (but crucial) parts of Kleinian thought.

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PHILIP ROYS

Counter-transference: Theory, Technique, Teaching

Edited by Athina Alexandris & Grigoris Vaslamatzis. Karnac Books 1993 pp 269 Pb £18.95.

At the Eighth Congress of Psychiatry (1989), the editors presented a paper 'Some Thoughts on Insight and its Relation to Counter-transference', which was greeted with positive comments by psychoanalysts and a request by the authors' colleagues and students for further expansion of the ideas. The authors contacted numerous highly respected psychoanalysts requesting articles, and it was thus that the book was born. Although many of the contributions have been published elsewhere, it is indeed valuable to have them together in one small book.

Athina Alexandris offers a review of the riches to follow. She states that the authors of the articles selected their vignettes of cases where the patients had been 'objects of massive parental projections and so the patients' powerful projections induced diverse feelings in the analysts which acted on their minds.' This theme is illustrated in all the articles, each author highlighting different facets.

Hanna Segal (1981) reminds us of Bion's model (1967) of a mother containing her infant's projections but 'whereas parents react instinctively, analysts have to observe their own reactions but never be swayed by them ... When our countertransference is in a good functional state, we have a dual relation to the patient – one is receptive ... the other active ... it might be analogous to the breast as containing and the nipple as feeding.'

In an erudite but difficult article, Leon Grinberg (1990) unravels two co-existing processes in the complex interaction between analysand and analyst. The second of these he terms 'projective counter-identification' when the analyst reacts to the analysand's projections by becoming a passive receptacle and seeming to have assimilated *really* and *concretely* the aspects that were being projected and turns into 'what the patient unconsciously wants him to be.'

The reason why one person should have been traumatized for life after an event which another individual seems to have weathered is explained by Joyce McDougall (1975). The acquisition of verbal communication is the key factor, traumata stemming from events before this acquisition resulting in the difficulties encountered in therapy as described in her article. McDougall's article is by far the longest in the book. Her patient Annabelle had had three previous analyses. Ultimately McDougall understood Annabelle's difficulty 'through the unconscious pressure exerted on the analysand's *way* of being and speaking.' She warns that the attitude of 'expectant silence' that 'opens a psychic space' for the neurotic patient ... offers little but desolation and death to patients who have been traumatized very early in their lives.

Throughout the book the way patients may communicate will strike chords for readers, e.g. 'pressured talk that sounds like free association but has the effect of forcibly crowding the therapist out; stream of accusations: words as weapons, as camouflage, as a desperate cry for help, a cry of rage, stubborn silence.' The same is true of the therapist's feelings, e.g. 'for some moments my mind went blank; my capacity to function was disrupted; I felt irritated, anxious, guilty, helpless' etc. The danger when the therapist does not understand these reactions or cannot surface is well spelt out, e.g. seeing the patient as unable to use psycho-analytic psychotherapy and referring him/her for supportive psycho-therapy or terminating therapy, or suggesting medication, or retaliating perhaps by withdrawal.

There are articles on Counter-transference and Hospital Treatment (Otto Kernberg); Transference-countertransference interactions in the

Supervisory Situation (Theodore J. Jacobs and Grigoris Vaslamatzis); on Projective Identification (Thomas H. Ogden 1982), and more.

This book has, I think, implications beyond the settings illustrated, e.g. for marital therapy and for an understanding of many breakdowns in relationships where one partner cannot contain the projections of the other and retaliates or flees. Also light shines on how problems are handed down from one generation to the next by parental projections. However, Hanna Segal's warning that 'countertransference is the best of servants but the worst of masters' must be remembered. I think that it is probable that many of the recent articles in the press denigrating psychotherapy are due to mishandling of the transference/countertransference, often but not always by untrained 'therapists'.

I recommend this book to you wholeheartedly.

ZELDA RAVID

Psychotherapy with Couples: Theory and Practice at the Tavistock Institute of Marital Studies

Edited by Stanley Ruszczynski. Karnac Books 1993 pp 236 Pb £16.95.

This book, 'Psychotherapy with Couples' is about just that, but it is not only about couples. This issue of relationship and collaboration, fundamental to an understanding of the couple, is a more general theme. We read about it in the account of the setting up of the Tavistock Institute of Marital Studies (TIMS), the organisation in which the work with couples has been developed. It is there in the relationship between individual and couple therapy, between the internal and external world, between therapists and their clients, between co-therapists, between therapists of different orientations working together at TIMS, and finally, a relationship between different aspects of the work, therapy, research and consultation. While there are many differences at all these levels, what is unifying is the belief in the important role of unconscious factors, in object relations, in the value of psychoanalytic understanding and its application in therapy. The sense of relationship and collaborative effort is there from the moment you begin to read the book, in a sensitivity to what might interest the reader, a sense throughout of a guiding hand, providing

the reader with the kind of safety and structure that is consistent with all aspects of the work.

The book is divided into four sections. The first section gives the background to the establishment of TIMS and the different aspects of the work. Then there are papers on the idea of the unconscious contract in the couple relationship. The third section is about the couple and the individual, that is the importance of 'difference' in the relationship. Finally, there are two papers about the therapeutic approach to the couple relationship. Each section is preceded by an introduction, headlining what is to come.

TIMS was founded in 1948 by Enid Balint and was an application of psychoanalysis beyond the individual. The focus of clinical work and research was to be, and is, the couple relationship. Freud is seen by some as having been opposed to such a step and David Scharff in his introduction says that 'while he (Freud) understood that children benefitted vastly from supportive and loving parents and were lucky indeed if they had parents who loved each other emotionally and sexually, his clinical writing is pervaded with the assumption that family members constitute a frequent source of harassment to the psychoanalyst getting on with the job of freeing the neurotic individual from the shackles of his past and of those family members who, in his view so often offered formidable resistance to change' (p. xi). Enid Balint, however, saw it differently. She understood that by wanting to understand early history, Freud 'right from the beginning recognised that the atmosphere of the family was of paramount importance for the future development of the individual' (p. 30). Some shifts in thinking had to accompany this step. The 'patient' was not the individual or the individuals, but the *relationship* between the couple and secondly, there was the recognition that while transference was a feature of the relationship between therapist and patient, it also needed to be understood as part of the relationship between partners.

There is an account of how the work is done. The model of working depends on an assessment of the nature of the defenses employed by a particular couple. This assessment would determine whether there are two person meetings, each partner with an individual therapist, three person meetings, the couple with one therapist, or four person meetings which consist of the couple with two therapists.

The main theme in Part Two is the Unconscious Contract in the Couple Relationship which is central to much of the work. This contract may be used developmentally, that is so that more can be known about repudiated aspects of the self, located in the other and

in so doing become more integrated. Or this unconscious contract may be used defensively, there being an unconscious collusion to retain splits and projections in a shared defence against shared anxieties. This is an intriguing idea and there are different views put forward as to how and why this unconscious contract occurs. Enid Balint with a touching warmth and generosity about human nature says 'people never give up trying to put things right for themselves and for the people they love' (p. 41). She sees marriage as an attempt to get back to something good or to put right something unsatisfactory. Alison Lyons calls her chapter 'The Mysterious Choice' and, following Jung, emphasises the unconscious drive toward individuation. People, according to her, choose partners who will activate undeveloped aspects of themselves. Both Cleavely and Colman emphasise the notion of the couple relationship as a container. Implicit in this is the idea that a couple relationship is potentially therapeutic. For example, Cleavely suggests that marriage is partly about man's need to regulate his need for intimacy and autonomy and that the container must be safe enough for couples to externalise and, hopefully resolve, internal conflicts in the interactive processes. Colman using the ideas of Bion, Winnicott and Jung points out that while marriage may be therapeutic it is not therapy and makes some important distinctions between the two. There is, however, one important similarity which is that neither therapy nor marriage can fulfil the longing for wholeness.

The third section follows in some respects from the idea that marriage cannot fulfil this longing. Each contribution in its own way and with its own particular orientation stresses the importance of individuation and difference within the couple relationship. Fisher puts forward the view that to be an individual 'separate and hence capable of a relationship with another rests on mastering the Oedipal triangle' (p. 145). Mattinson and Lyons emphasise the infantile needs which had not been met earlier in both partners' lives. Colman suggests that the couple relationship is modelled not on the mother child relationship but on the copulating couple. The importance of managing difference is stressed by all of them, as is the ongoing nature of the struggle. In the paper entitled 'Betrayal of Troth' we are reminded of the importance of small failures in relationships, neither too soon nor too severe. With this comes the possibility of forgiveness and learning to trust again, knowing there is the possibility of a further betrayal.

One of the striking features of this book is the clinical examples. They are clear, vivid and closely linked to theory, with graphic examples of projective identification and the creative use of counter-

transference. This is very evident in the final chapter where the therapy at TIMS is described in detail. Throughout, there is emphasis on unconscious communication and particularly clearly in this final chapter. The author talks about the nature of the transferences not only to the individual therapist but to the therapists as a couple. It is important for the therapists to be open about their work, since the feelings around may reflect interaction in their own relationship. If they can contain and reflect on this process either by verbal interpretation or, as shown the example given, by non-interpretive intervention, the couple is then able to do the same.

The papers in this book have been written and edited with care and sensitivity. It was very interesting to read and I would have liked more. What would they have to say about homosexual couples, about issues of race and gender? David Scharff said at the end of his preface that all practitioners of couple therapy will find pleasure in this book. I quite agree but would go further and recommend it to practitioners of individual therapy as well, who might benefit from a broader understanding of the transferences between partners.

RUTH BERKOWITZ

View from the Cradle. Children's emotions in everyday life

By Otto Weininger. Karnac Books 1993 pp 240 Pb £17.95.

View from the cradle is an eloquent title, giving the idea of container and contained from first sight. Dr Weininger is a professor in the Department of Applied Psychology at the Ontario Institute for Studies in Education and in this book he gives an overview of long and short term individual and group psychotherapy in different settings, informed by and permeated with the theoretical thinking of Melanie Klein. His approach can be experienced as unique, just as a virtuoso instrumentalist would interpret Mozart bringing his own insights and emphasis.

Each chapter addresses theory by illustrating it in practice, object relations theory being implicit. Thus in chapter one, Klein's 'good internal object' is 'the mental representation of repeated experiences of a satisfying interactive relationship' which enables the child to 'anticipate consequences and risk experiences ... and keep the object in both pleasurable and discomforting experiences. When ... experienc-

ing joy and happiness, he is able to try to integrate the physical aspects of the pleasure ... with the emotional if not cognitive elements of the feeling.' (Masculine pronouns are used throughout the book in Klein's tradition.) The child needs a good internal container to survive separation from his mother and to learn to trust new environments. Throughout the book Dr Weininger emphasises that when the original relationship has not provided this secure internal representation, things go wrong. The child has nothing to keep him going and falls back on aggressive behaviour or avoids anything new which is perceived as a threat.

Discussing early experiences and consequent eating problems, which can lead to bulimia and anorexia nervosa, Dr Weininger says that is the actual feeding experience is satisfying, all the other aspects of being handled can be accepted as comforting and pain relieving rather than experienced as persecutory attacks. The resolution of early eating problems depends upon the working through of the child's destructive and hostile impulses in his inner world towards both the loved objects and the combined parents as a loved and loving couple, within the paranoid and depressive positions. Dr Weininger describes how in the external world it is important to address these developmental issues with the child's parents, involving them in amending the environment at home based on his interpretation of the child's expressed anxiety. Chapters take us through eating problems, loneliness, sleeping problems, toilet training, envy, greed, jealousy and gratitude, and rivalry and its origins in pre-oedipal relations. Phantasy, projection, introjection, splitting, reparation and the movement towards the depressive position are all discussed and defined with vivid clinical vignettes.

In Chapter six we move from more 'normal' development to what Weininger calls rigid parenting and perfectionist children, that is more pathological interactions between parent and child. Dr Weininger says that he felt stricken watching parents and children participating in the 'dance of denial and resentment'. Again he points to the importance of early parenting being sensitive to the needs of the baby. Weininger states that parents who are not able to manage their own ambivalence find it personally threatening when their child is frightened. They have to impose their version of reality on the child – because they feel so unsafe when their child is frightened or needs their reliable, thoughtful containment. He quotes Bowlby who put the child's position so succinctly as 'knowing what you are supposed not to know and feeling what you are supposed not to feel'. Weininger describes how children in this position use denial in their play and block their curiosity and

ability to take in knowledge. These children are not able to introject ideal and persecutory aspects of their first object but have to maintain a rigid split between extremely good and extremely bad; thus their development of a capacity to think and feel is blocked. These children become watchful, trying to perceive how their parent expects them to be thus denying who they really are and how they really feel. Weininger explains this phenomenon, which is so familiar in clinical work, by using the ideas of Bion and Klein: 'conforming to and placating the demands of an idealised part-object'. (Winnicottians would think in terms of false self.) These are the children who are unable to take advantage of the education system because they cannot learn.

Dr Weininger, in amplifying his thoughts about what constitutes an adequate internal container, cites Bion's definition of reverie as the mother's willingness and ability to think about and learn to know her baby and its impulses, needs and feelings, this being a prerequisite for the baby to become aware of, acknowledge, know, and accept its feelings. He sees this inability in parents as being the reason for learning difficulties and in chapter ten he summarises his ideas, by giving examples in a graph form, comparing how a paranoid-schizoid child, a depressive child and a normal child would deal with different appropriate developmental challenges. Dr Weininger's thesis has confirmation in contemporary research in Britain. Peter Fonagy in his paper (1992) on the development of the self, stresses where his research has shown how the ability of parents to think about and empathise with their baby is significant for the baby's emotional development or sense of self. Trevarthen and Murray and of course Daniel Stern have all shown in their observations and research the importance of the quality of interaction between mother and baby and the emotional availability of a mother, for the baby's future mental health. That Dr Weininger uses his Kleinian theoretical structure to state the case so strongly shows how well Mrs Klein understood children and their parents, and how her ideas have contemporary relevance and importance.

This book is important for the clinician because Dr Weininger demonstrates repeatedly how to listen to children and to use a therapeutic understanding in working with them in classroom settings with teachers, at home with their parents, or in individual therapy. It is also important for policy makers and local government and health authority commissioners. Dr Weininger's approach has practice implications in this country, in that there should be more importance given to early problems between parents and their infants as intervention is not only vital for parent and child, but would preclude the need for

later more expensive provision. There should be wider access to parent-infant psychotherapy.

The second important implication for clinical practice and educational policy highlighted by this book is in the provision of special educational environments, currently being cut as a result of education and health service reorganisation. Schools for emotionally and behaviourally disturbed children had formerly a psychiatric team and a psychiatric social worker who worked with the families of the children in the school. The implication throughout this book is that it is important to intervene with needy parents as well as listening to their children.

As a BAP trained child psychotherapist, I am grateful to Dr Weininger for reminding me of the range, depth and richness of Melanie Klein's contribution to my work. I did find myself saying, at times out loud, 'but what about identification with the aggressor?', Anna Freud's vital contribution, particularly in work with abused and traumatised children and adolescents and especially relevant to Weininger's description of a desperate little four year old, Carla. I was longing for him to take her into therapy because she, having had appalling early experiences, was clearly attacking her little sister because of her own persecuting and murderous inner world. He seems to have left her with a lonely and distrustful future, having observed her in therapeutic and foster environments that seemed to fail.

In contrast, most interesting and exciting was the group play psychotherapy research described in the last chapter. In this a group of initially unreachable, emotionally disturbed four year old boys were able to play cooperatively, pay attention, concentrate, perform group tasks and ask for help from their teacher, after only six months of four times weekly play psychotherapy. The control group, without psychotherapy but in a special educational setting, had not changed in that time. This would seem to be a fruitful way of working, an exciting way of extending clinical practice with joint working.

NIKI PARKER

Speak of Me as I am: The Life and Work of Masud Khan

By Judy Cooper. Karnac Books 1993 pp 140 Pb £14.95.

At the time of his birth in Pakistan (1924), Masud Khan's father was 78 and his mother was 19 years old; his mother had been a singing

and dancing girl who, prior to marrying his father, had given birth to a son. This marriage stigmatised the family and, possibly to avoid family hostility, they moved from Montgomery to Lyallpur in 1937. From 1942 to 1945 Khan studied at the University of the Punjab, gaining his BA/MA in English literature. In 1942, his younger sister died, followed by his father's death in 1943. Unable to cope with this double bereavement, Khan entered therapy with a Dr Latif from 1943 to 1946.

He arrived in England in 1946, was accepted as a student at the Institute of Psycho-Analysis, and started analysis with Ella Freeman Sharpe, who died after one year. Then he had analysis with John Rickman from 1947 to 1951, when Rickman died, and from 1951 to 1966 he was analysed by Winnicott. He qualified as an adult analyst in 1950, aged 26, and as a child analyst later. He became a Full Member of the British Psycho-Analytical Society in 1955 and a Training Analyst in 1959.

He worked tirelessly for the Institute of Psycho-Analysis for many years. He was Editor of the International Psycho-Analytical Library, Associate Editor of the *International Journal of Psycho-Analysis* and the *International Review of Psycho-Analysis*; he was Honorary Librarian and co-director of Sigmund Freud Copyrights. He edited all Winnicott's papers.

He had particularly strong relationships with French analysts, especially Victor Smirnoff, André Green, and J.-B. Pontalis. He became Foreign Co-Editor of the *Nouvelle Revue de Psychanalyse*, and his first three books were translated into French.

Khan's life in the seventies reads like a great human tragedy, and Cooper's telling of it evokes sympathy and admiration for his stoicism and bravery. In 1971 Khan's mother and Winnicott both died, replicating the double loss of his sister and father. His second marriage, to Beriosova the ballerina, finished in divorce. (He had been married previously to another dancer.) He had a cancerous lung removed, followed by eye operations, the removal of his larynx and trachea, leaving him defenceless and speechless. He continued to read and write, and never complained, winning him the admiration of his friends and the scorn of his enemies. In 1975, his right to train and supervise patients was withdrawn and his busy practice disappeared.

By being 'unreliable, extremely outspoken, and by disregarding professional confidentiality and ethics' he had made many enemies over the years. He became more grandiose and isolated and hit back against his healthy colleagues by writing his last book, *When Spring*

Comes. This book casts psychoanalysis into 'disrepute' and contains 'anti-Semitic venom'. The author enables the reader to understand Khan's desperate state of mind at this time. Cooper (and Eric Rayner, in the forward to the book) also enable one to feel sympathy for the British Psycho-Analytical Society who felt 'they had no choice but to expel' Khan in 1988. Khan grew up feeling an 'outsider' and Cooper suggests that Khan recreated this all his life. By writing *When Spring Comes* he made himself an 'outsider' from the British Psycho-Analytical Society, which was, according to Rycroft, 'Khan's substitute family'. 'It was Masud Khan's (unconscious) ultimate way of provoking the whole establishment' (Smirnoff).

Cooper tries to understand Khan's anti-Semitism. He had many Jewish friends, e.g. Anna Freud and Robert Stoller; he supported the State of Israel, and found 'nothing more impressive than a cultured Jew'. Cooper sees his last book as being aimed at his healthy Jewish colleagues whom he envied and by whom he felt rejected. She also sees his anti-Semitism as revealing another deep split in Khan, who 'had a chip on his shoulder about everything and this became focused on Jews because he knew so many.'

Masud Khan died on Wednesday 7 June 1989, having never integrated his Eastern background and his Western influences; neither having recovered from the early humiliation he suffered due to his parents' marriage, nor having resolved his relationship with women (mother). Cooper tellingly states that his whole life was 'an acting out in search of the mother even though his sense of father predominated.' He requested that he be buried on the right side of his father in Pakistan.

When one considers Masud Khan's contribution to British psychoanalysis, Cooper's words at the time of his death make poignant and sad reading: '... in London there was no ceremony to mark Khan's life or achievements. Despite his previous long years of service, he died *persona non grata* at the Institute of Psycho-Analysis.'

As a theoretician, Khan integrated Freud, Fairbairn, and Winnicott. He believed that the experience of the 'self' required the presence of an 'other' to achieve it. He contributed brilliant insights into the schizoid personality and the understanding of the perversions. He stressed environmental factors in development, seeing the mother as both environment and object, and as a 'protective shield' against stimuli. When many breaches occur in the shield, a schizoid personality may emerge. He ascribed all schizoids' 'disturbed primary affective integration' to 'the failure of their primary maternal environment'.

Khan was recognised as an original theoretician in 1963, with his concept of 'cumulative trauma', 'which involves the continuation of small traumata ... often imperceptible ... Singly, each breach can be experienced as merely a strain, but cumulatively and in retrospect they have the effect of a trauma.'
Cooper divides Khan's 'specific syndromes' of schizoid pathology into four categories:

1) Symbiotic omnipotence, which 'is a way of merged relating ... based on *mutual* idealization' by mother and child, 'without any real understanding of the other's needs.' It is a 'combination of relating through compelling and clinging demands which ... constitutes the hallmark of "symbiotic omnipotence".' It comes about due to 'failures in the mother's role as protective shield resulting in cumulative trauma'.

2) The phobic stance, which comes about as 'both a consequence and a continuation of symbiotic omnipotence.' There has often been an un-mourned '*sudden* separation from the intense symbiotic relationship with the mother' which has quickly been replaced by another object related to it in the same way as mother was.

3) The hysteric, who has suffered from its 'mother's failure to cater to the ego-needs of the child'; the infant's body is used for the mother's own gratification 'which produces sexual symptomatology.' The hysteric deals with the failure of environmental needs by precocious sexual development. Khan's elegant use of language is illustrated in Cooper's quotations: 'hysterics live in a perpetual psychic state of grudge' and 'the inner world of the hysteric is a cemetery of refusals'.

4) The perversions, in which environmental influences are again stressed. The mother *idolises* her child as a 'narcissistic extension of herself'. These children ... 'learn to augment the mother's efforts and gestures towards them as the special created-thing.' Perversion is seen by Khan as another way of dealing with schizoid splits, like the hysteric, through sexualisation. Khan introduces a new concept in describing the internal world of perverts: the collated internal object which is made up of 'the idealised bits and pieces of body-care they did receive from the mother.'

Khan's clinical practice evolved from his belief that the schizoid patient needed to become aware of his object. Khan stressed the need for '... the analyst to provide a setting in which a patient can safely regress in the company of an other whose presence they can register.' He allowed both fantasy and reality elements of himself to intermingle in the clinical situation. He saw acting out as a signal of distress to

the environment and a frenzied search for the mother and 'self'. He distinguished between benign and malignant regression. He used interpretations sparingly and saw analysts who over-interpreted as replicating the patient's experience of an 'intrusive mother'.

He believed it was the capacity to dream, and not the interpretation, that signified potential for growth. Countertransference for him meant meeting his patient's needs as a person in order to hold the regression. He became their 'auxiliary ego' and 'protective shield'.

Khan allowed ego boundaries to merge, and was often phallic and controlling. At best, he provided 'paternal authority' and maternal nurturing, but he was a maverick, a law unto himself, with all the danger and freedom that that implies. At times he ran into trouble. He was careless about maintaining boundaries, and sometimes took an over-active role of parental provision: 'I have never known what is *comme il faut* in psychoanalysis unless it be a synonym for a rigidity that refuses the reality of others' (Khan).

In Cooper's words he had 'a touch of genius along with the power to destroy his extraordinary talents.' The author acknowledges her debt to Khan. From her analysis with him she learned to be 'less frightened to be human with patients', to have an active holding attitude to regression, to see in her patients the possibilities between conventional and radical solutions, and that at times the risky choice may be the better one for them.

The book combines biography, psychoanalytic theory, and ideas about clinical practice. It is written in a clear and concise manner. The author's use of comments by well-known analysts, and her own personal revelations about Khan, bring the text alive. Cooper manages to offer some explanation for a man who could be so brilliant and tragically awful, by tracing the childhood roots of the adult Masud Khan. It is a book that should be read by everyone dealing with schizoid patients, and will, I am sure, stimulate many to read Khan's original works and restore an interest in his great contributions to psychoanalysis.

DANIEL TWOMEY

LETTER TO THE EDITOR

Homosexuality, Biology and the Work of Richard Isay

ANNE HURRY

Richard Isay's book *Being Homosexual: Gay Men and their Development* (1989) received a thoughtful, scholarly and very positive review in the last issue of this journal. (Twomey, 1994) I do not propose to re-review the book, but I think it important to set Isay's work in context, for in my view it is based on a misunderstanding of development and makes potentially harmful technical recommendations.

Recent studies on the biological substrate of homosexuality have greatly influenced both scientific and lay thinking, although many are so far uncorroborated, methodologically questionable, dubiously applicable to humans, and/or oversimplistic in approach. Critical reviews may be found in Burr (1993) and Byne and Parsons (1993). Findings have been widely disseminated via the media, often only partially quoted, misquoted and misunderstood as proving biological factors to be the primary cause of homosexuality. The 'gay movement' interprets them as evidence that homosexuality is 'normal', innate and immutable. The far right argues that homosexuality could/should be abolished through genetic engineering. Indeed, since fear and condemnation of homosexuality are not restricted to the far right, such views may be found in surprising quarters: in July 1993 a former Chief Rabbi, Lord Jacobovitz, suggested that genetic engineering be used to prevent the birth of homosexual children.

This debate has its effect on individual lives. In such a climate of thought the sexually conflicted young person is subjected to new pressures. Societal condemnation of homosexuality has long resulted in fear, shame and guilt. But today, in some social groups, there is considerable pressure to be homosexual. The conflicted adolescent can experience a very real demand to opt for homosexuality and blot out other aspects, at great psychic cost. This is evident in some universities in this country, but is particularly the case in higher education in the United States, where it would be hard to overestimate the power of the 'gay' movement. Students are subjected to a barrage of propaganda from their first day; dissent, outer and inner, becomes increasingly difficult. (Jeanette Howard received death threats and abuse in

response to the book describing her move from lesbianism to heterosexuality, *Out of Egypt* (1991))

Further, the belief that sexual orientation is inborn and immutable reinforces any denial of conflict; the adolescent can feel 'doomed' to being 'a homosexual', losing touch with the pain and hope of conflict and choice. Where there is a known genetic or hormonal abnormality, this feeling of being 'doomed' can be the more intense. (Indeed, studies of the effects of biological factors on sexual orientation may be contaminated both by the subjects' psychic response to medical interventions, and by their knowledge, accurate or inaccurate, of research findings.)

Where does psychoanalysis stand? Freud said many things about homosexuality. At one point he described it as an arrest rather than an illness: 'Homosexuality is assuredly no advantage, but it is nothing to be ashamed of, no vice, no degradation, it cannot be classified as an illness; we consider it to be a variation of sexual function produced by a certain arrest of sexual development.' (1935). He often discussed the possible role of both constitutional and environmental factors in the aetiology of homosexuality.

Later analysts, focussing mainly on psychological features, have added much to our understanding. In this country writers such as Limentani and Glasser have been well aware of the pain which may lie behind the homosexual solution. Far from attempting to 'change' it, Limentani (1977) specifically counselled against attempts even to analyse it in some cases. Many English analysts and psychotherapists have been particularly aware of the impact of hostile social pressures. Among these, Berenice Krikler (1988) in an article in *this journal* which should be more widely known, wrote movingly and illuminatingly of the intrapsychic effects of the AIDS epidemic.

But there is no doubt that some analysts have been condemnatory of homosexuality, and have aimed to make their homosexual patients heterosexual. Ex-analysands have described their experiences of attempting to conform to their analysts' standards; Isay gives poignant accounts of their pain, their depleted post-analytic lives, and their subsequent relief when treated by a 'gay' and accepting analyst.

Isay takes what is fundamentally a biologic determinist stance. While he does not entirely discount environmental factors, genetic factors are, for him, pre-eminent. 'My clinical work with gay men over many years has led me to consider the importance of a genetic predisposition for homosexuality. *Without such an hereditary influence, environmental*

factors do not appear to be able to influence the development of sexual orientation' (1987, p. 292, my italics).

Isay has the courage of his convictions. He is a leader in the US 'gay rights' movement, speaks at and leads protest demonstrations. His work has had a considerable impact, perhaps partly because of the current ethos, and partly because psychoanalytic clinicians, immersed in clinical work, have not been natural scrutinisers of scientific evidence from related fields.

Recently however, Friedman and Downey (1993b) have reviewed the implications of the biological findings for clinicians. They conclude that 'enough evidence has accumulated from various sources to support the strong likelihood of primary biological factors shaping and influencing the emergence of homosexuality *in some individuals*' (1993b, p. 1104, my italics). They point out that no biological test reliably distinguishes between groups on the basis of sexual orientation, and find no evidence that biological influences are universal. In some cases they appear to play no part in the genesis of homosexuality; here psychic needs and pressures may be seen to be sufficient causes. *Thus current findings do not support Isay's biological determinism.*

But atypical genetic and/or hormonal factors do in some cases influence the development of homosexuality. I see such influence as indirect, one of a complexly interacting series of factors impinging on the individual during the course of development, as described by Byne and Parsons: 'temperamental and personality traits interact with the familial and social milieu as the individual's sexuality emerges ... such traits may be heritable or developmentally influenced by hormones' (1993, p. 228).

How might such influences impinge on psychic development? We have much still to learn, and we lack detailed clinical accounts of patients where there is a known biological abnormality. But we can begin to consider possibilities. In 1993 Hamer reported that some *but not all* of his homosexual male subjects carried a particular genetic marker on the Xq28 region of the X chromosome, (as reported in *The Independent*, July 1993.) In the media this finding was headlined as, 'A gene for homosexuality.' Hamer himself later insisted that the genetic marker involved was found in only some subjects, and did not 'cause' homosexuality. He thought it probable that it affected temperament, for instance that it might lead to an unusual degree of timidity (*The Independent*, February 1994).)

Now we have always known that babies are born with different temperaments: some, for instance, are lively, active, eager feeders;

others anxious, apparently vulnerable to almost any stimulus. It seems to me possible that an anxious baby and child might find it harder to deal with early conflicts around ambivalence towards the mother, might resort to a defensive female identification more readily than would an active confident infant. If such a child projected his aggression onto the mother, her felt dangerousness could increase the likelihood of the child's turning to the father as an alternative love object. Or, similarly, such a child might well find the oedipal situation more dangerous, might need to defend against the terrors of castration by avoiding competition with the father through a negative oedipal solution.

Such thoughts are, for the present, purely speculative. But we do know more about the effects of prenatal hormonal exposure. The effects of prenatal androgens on childhood play and sexual orientation have been studied through females suffering from congenital adrenal hyperplasia (CAH) or whose mothers were prescribed androgens during pregnancy. For some time it was thought that prenatal androgens influenced the development of sexual orientation, e.g., Money and Ehrhardt (1972), and that where there had been excessive foetal exposure to androgens, girls were more likely to become homo- or bisexual. It is now clear that this is by no means certain. In a follow-up of the prenatally androgenised subjects from an earlier Money and Ehrhardt study, none of the six women who could be found reported homosexual fantasy or activity in adulthood (Money and Mathews, 1982). Friedman and Downey (1993a) think that evidence for a link between sexual orientation and neuroendocrine factors is sparse: the various studies showing such a link cover only 76 subjects of whom the majority were heterosexual. Other studies have given negative results (*ibid*, p. 146).

The primary influence of prenatal androgens is on *non-sexual* behaviour. Most authors, including Friedman and Downey (1993a), see the evidence for a link between prenatal androgenisation and childhood play as convincing. Prenatally androgenised girls are more likely to be tomboys, to be energetic, to choose boys' toys, to play with boys and to take part in fighting and rough and tumble play. This effect of prenatal androgenisation may then become a cause, for it will inevitably influence ongoing psychic developments.

Similarly, some hormones (medroxprogesterone acetate and some combinations of progestogenes and estrogens) are thought to interfere with androgenisation: current research, as reported in Friedman and Downey (1993b) suggests that such hormones may affect masculine

play, but *not* gender role behaviour. In line with this view, Coates *et al* (1991), who carried out a very large study of boys with gender identity disturbances, point to the effects of prenatal hormones on aspects of temperament, stressing that if they influence sexual orientation they do so only indirectly.

Conflict exists in the mind. While input from the body of course influences the mind, it is what the mind makes of that input which determines the outcome. Some analysts have followed Isay in questioning whether homosexual object choice may in some cases develop without conflict (Panel 1993). I do not believe this could be so, any more than I believe heterosexual object choice could develop in a conflict-free setting. If that were so, our job might indeed be less to analyse, more to relieve socially-inspired guilt and inhibition, as Isay recommends.

Isay takes the view that homosexuality follows a normal developmental path to consolidation in late adolescence or early adulthood. But any normal developmental path is routed through conflict. Homosexuality represents the best available adaptation to current needs and pressures at the time of its establishment, but may become maladaptive at a later time. (Questions of social pressures aside, homosexuality in adulthood inevitably brings conflicts not present for the heterosexual, since it does not permit parenthood within the relationship of choice. In this sense, homosexuality is in conflict with biological reality, and productive of pain.)

This view has implications in regard to the possibility of change. It is important that we not close doors for our patients by assumptions about 'normal' development and unchangeability. For while gender identity appears to be established as early as 18 months, sexual orientation is often amenable to change through late adolescence and early adulthood. (The often expressed view that sexual orientation rarely changes in treatment appears to have been based on work with adults, and I would agree that it is less amenable to change following psychic structuralisation and the establishment of a fixed social setting.)

Isay warns against any attempt to change a patient's sexual orientation. He recommends an attitude of 'positive regard' as helpful in relieving guilt and lessening inhibition, and suggests that the homosexual analyst reveal his own sexual orientation to his patient, as he himself does, so as to provide 'a model of personal integrity.' (Isay, 1985; 1986; 1987; 1991).

I believe this stance to be fundamentally anti-analytic. Of course I agree that it is wrong to try to change a patient's sexual orientation,

just as it is wrong to try to mould a patient in any way. But it is also wrong to take a patient's conscious 'realisation' of homosexuality, and/or memories of childhood sexual fantasies, as indications of a fundamental, inborn given. This denies a patient access to hidden areas of his/her psychic life; only ordinary analytic listening can allow these to emerge.

Further, Isay's suggestion that the analyst reveal his own homosexuality, although far from coercive in intent, might well prove to be so in practice, even if through love or loyalty. It blocks understanding via the transference. It avoids underlying fears and wishes, just as would be the case if a heterosexual analyst stated his orientation, blocking the understanding of homosexual fears and wishes.

We might question how a courageous and thoughtful analyst came to such conclusions. It is my impression that they are based on work where analysis stops at Oedipus. Again and again, as Twomey (1994) points out, Isay refers back to the age of four, and no further. The pre-oedipal conflicts and identifications which shape the Oedipal conflict, and influence its outcome, do not appear to be worked through: often they do not appear even to be acknowledged. (I am indebted to Elizabeth Daunton of the Cleveland Centre for Research in Child Development, who first pointed this out to me.)

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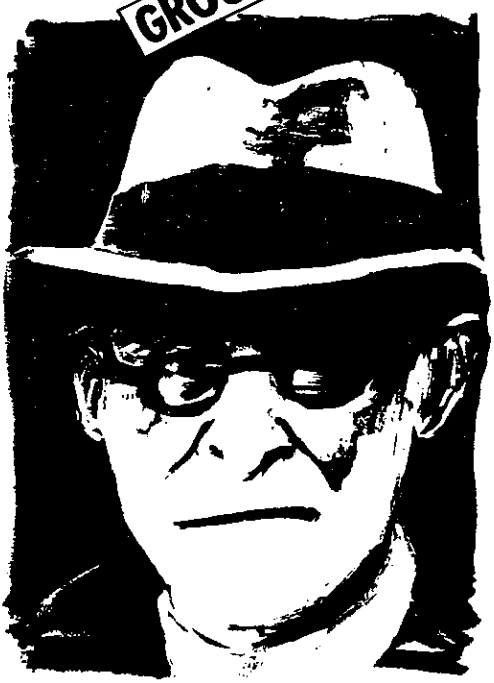

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Printed by The Charlesworth Group, Huddersfield, UK. 0484 517077

ISSN 0954-0350