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WHO NEEDS PSYCHOTHERAPY?

ELPHIS CHRISTOPHER

Introduction

Who needs psychotherapy? The disturbed, the distressed, the disordered, the depressed? Those with psychosomatic illness, sexual and relationship problems? Life problems such as bereavement, loss of job? Life crises such as adolescence, mid-life, ageing? This is a broad canvas of problems. There is perhaps an assumption here about what psychotherapy is that requires definition. The definition I am using is depth psychology involved with the whole of a patient's psyche working with deeper problems over a long period of time.

At one level all of us could do with some psychotherapy at some time or another in our lives. We all go through stresses and life crises affecting our self esteem, our ability to cope and work and sustain our relationships. Whereas in the past people might have turned to religion for comfort (and some still do) it has been argued that psychotherapy has taken the place of religion, the psychotherapist the place of the priest. Indeed, critics of psychotherapy accuse it of being a kind of faith. Another domain of religion, the search for meaning in one's life and wholeness has also now become within the remit of psychotherapy.

The GP, not to mention the public is faced with a bewildering array of therapies: behavioural therapy, cognitive behavioural therapy, cognitive analytic therapy (Ryle 1991), rational emotive therapy, hypnotherapy, neurolinguistic programming, Gestalt therapy, body therapies, bioenergetics, group therapy, psychoanalytic psychotherapy. Which therapy to choose and for what? Proponents for each therapy claim successes for their method.

A recent editorial in the *British Medical Journal* discussed cost benefit analysis and psychotherapies. It said that those psychotherapies that controlled trials have shown to be effective and safe and to offer good value for money will be in a stronger position to argue their case in the health market place. The psychotherapy that has adopted the market approach par excellence is behaviour therapy which has shown itself to be an effective and economical method for treating phobias, obsessive compulsions, sexual and habit disorders. Cognitive behav-

ioural therapy has been shown to be effective for mild or moderate depression and bulaemia nervosa.

There was a spirited response to this editorial from several medical psychotherapists stating that 'purchasers, managers and patients seem to regard dynamic psychotherapy as a valued and wanted component of mental health services'. The patients dealt with were subject to deprivation and abuse in childhood and presented with severe personality disorders; such patients making heavy demands on GP's. Being seen once/week for a year was considered helpful. (There are 100 Whole Time Equivalents medical psychotherapists in the NHS).

Symptoms, physical or mental or both are the calling cards to the doctor legitimising disease, trouble with the body, trouble with the mind, trouble with relationships. Much of a doctor's work is to do with psychological rather than physical illness. No matter what the disease there is always a psychological/emotional component (many training courses for GPs reflect this). The great scourges of the past have been cured by antibiotics, vaccines or good public health measures. However, there are as we know new scourges such as AIDS, and the return of TB. There appears to be a great increase in psychosomatic disease and depression and illnesses connected with or caused by 'lifestyle'/eating disorders, tobacco, drugs, alcohol, not to mention stress and fatigue. A past history of sexual abuse now features prominently in psychological problems manifesting itself in varied ways. Freud (1905), though he never used the term psychosomatic, which was first used by the poet Coleridge in his writings, firmly believed that the health of the body could be affected by mental states. In his opinion depressive affects could bring about bodily disease in predisposed individuals whereas feelings of joy and happiness could have a rejuvenating effect on the body. A recent paper in the *Journal of Psychosomatic Research* (1993) showed that psychological stress really does impair the efficiency of the immune system. L. Jabaaij and colleagues showed that people experiencing stress produce significantly lower titres of antibodies to hepatitis B vaccine than do non-stressed control subjects. Thus there is more truth than commonly acknowledged to the phrase 'being run down' and thereby prone to infections such as coughs and colds. People's expectations of medicine are very high;- a pill for every ill, note the popularity of Prozac. There is greater public awareness of mental health problems and the importance of talking about one's problems due to the exposure in the media, phone-in programmes, radio programmes such as Anthony Clare's 'All in the Mind'. So that counselling is now taking place beside medicine with specialist coun-

selling for bereavement, sexual, marital, fertility, abortion problems, sexual abuse. At what point is more in-depth work needed? It may be when present hurts trigger past hurts and unresolved conflicts, where there is intellectual rather than emotional understanding.

With the emptying of the mental hospitals and the Community Care Act there is increasing pressure on the GP to be involved in mental illness. The term mental illness itself requires further definition and elaboration. There are three broad categories; neurotic, psychotic with borderline overlapping the other two.

When does need imply suitability?

The history of psychosomatic medicine is illuminating in this regard. In the 1930's, and 40's the American psychosomaticists focused their interest on a group of illnesses of uncertain aetiology; ie peptic ulcer, bronchial asthma, essential hypertension, thyrotoxicosis, ulcerative colitis, rheumatoid arthritis and neurodermatitis, known as the 'Chicago 7'. However, these illnesses did not respond to *classical* psychoanalytic treatment. A period of disenchantment followed until interest was renewed in the 1980's with the emphasis on a biopsychosocial model of disease.

At one hospital where I work, I helped to set up a group for doctors and nurses to look at women with pelvic pain for whom laparoscopy had shown no pathology. Attempts to treat such women with a psychodynamic approach had mixed results. The attachment to their pain and its secondary gain was difficult to shift in some women and there was resistance to looking at psychological/emotional causes. The psychic pain though evidently there was somatised and a physical explanation sought. For many of the 'pelvic pain' patients supportive therapy, listening with a sympathetic ear and being seen regularly seemed the best approach. There is something here about the preparedness for analytic work. McDougalls' *Theatres of the Body*' states that:

> 'Analysts would not normally accept people for psychoanalytical therapy solely on the basis of psychosomatic complaints. Although they might well be a reflection of psychological suffering they are not necessarily an indication for analysis. A psychoanalytic *adventure* is undertaken by those interested in charting the unmapped continents of their minds. Individuals engaging in such an expedition do so with the hope that their *discoveries* may enable them to profit from the adventure of living and better weather the storms and disappointments that each lifetime brings.'

For McDougall there are several basic requirements that constitute an acceptable basis for psychological help:

(1) *Awareness of psychic suffering*
That is, not to please someone else, a partner, a spouse, parent or the GP, the patients anxious and depressed, disappointed or puzzled about themselves, have symptoms that do not make sense to them or have discovered endless repetitions of the same unhappy experiences.

(2) *The search for self knowledge*
If the individuals concerned do not seek to know why they continue to experience such unalterable factors in a traumatic way that renders their lives uncreative they implicitly refuse responsibility for the direction of their lives.

The wish for further insight in order to discover the unconscious meaning of unsatisfactory life situations or incomprehensible symptoms implies acceptance of the fact that ultimately the causes of psychological symptoms lie within oneself. This outlook is an indication that the potential analysand implicitly accepts the concept of an unconscious mind.

(3) *Is the psychoanalytic situation bearable?*
That is, saying everything or anything, doing nothing, acceptance that the analyst will not gratify the patient's wishes and needs directly and the work is to understand.
McDougall continues
even when we judge that a potentially complicated patient (described as narcissistic, childlike, impulse-ridden peverse, severely addicted, detached from reality) is able to withstand the painful aspects of the analytic relationship we must ask whether we are willing to engage in the psychoanalytic adventure (and cope with acting out, addictions, eating disorders).

(4) *Can one depend on another without fear?*
'Every demand for freedom from psychological symptoms is a paradoxical one in that these symptoms are childlike attempts at self cure and were created as a solution to unbearable mental pain. There is therefore a strong internal force that fears the loss of symptoms in spite of the suffering they cause.'
MacDougall in talking about the familiar case of 'the devil you know'... ie. wanting change but resisting it.
In connection with psychosomatic illnesses cases of myalgic encephalomyelitis (ME) are interesting here, though of uncertain aetiology, several psychotherapists have reported Cochrane

Hollands (1994) working successfully with such patients. Another way to put this is to talk about 'psychological mindedness'.

Nina Coltart has assessed around 1500 patients for psychotherapy. In her book How to survive as a Psychotherapist. She lists 9 qualities that add up to 'psychological mindedness'. She thinks that a minimum of 3 to 4 of them are necessary for successful therapy:

(1) An acknowledgement, tacit or explicit, by the patient that he has an *unconscious mental life* and that it affects his thoughts and behaviour.
(2) Capacity to give a self aware history not necessarily in chronological order.
(3) Capacity to give this history without prompting from the assessor and with some sense of the patient's emotional relatedness to the events of his own life and their meaning for him.
(4) The capacity to recall memories with their appropriate affects.
(5) Some capacity to take the occasional step back from his own story and to reflect upon it often with the help of a brief discussion with the assessor.
(6) Signs of a willingness to take responsibility for himself and his own personal evolution.
(7) Imagination as expressed in imagery, metaphors, dreams, identifications with other people, empathy and so on.
(8) Some signs of hope and realistic self esteem. This may be faint especially if the patient is depressed but it is nevertheless important.
(9) The overall impression of the development of the relationship with the assessor.

For a patient to settle into psychotherapy a therapeutic alliance needs to be established with that part of the patient that really does want to sort out his problems and is curious about himself. Without this alliance it is difficult to see what can be achieved. The therapist will have to continually 'prove' that psychotherapy is useful or helpful or both.

Josephine Klein, (1990) discussed the conditions *not* propitious for establishing a therapeutic alliance necessary for weathering the storms of analytic work. Her list includes:

(1) A lack of understanding as to what therapists and patients do together, eg free association/interpretations, the relationship.
(2) A lack of trust in the object world. People cannot communicate with a therapist if they believe that given a chance you will do them down. And what you say to them cannot reach them

because they are waiting in a paranoid way to see what you are 'really' after.

(3) Ego weakness: There are two aspects to this: a lack of ego functioning, inability to think, and to make links between the here and now; a lack of ego integration, the therapist has to deal with an inchoate mass of feelings, a heap of terrors, a clump of resentments. When working with such patients there is a sense of immense pain, sense of no one at home, and being skinless. There is no core, no identity, only 'ego nuclei'.

Klein says no alliance can last with a patient lacking identity; all there is to work with is today's bundle of fears, hopes, angers, with little organising principle and little continuity she is probably referring to borderline patients.

It could be argued that providing a safe container, regular times, continuity, can provide a milieu for developing some sense of identity and self reflection, ego strength, with which to face some of the problems. For a time the therapist may have to teach them to think and function herself as an auxiliary ego. This is hard work and it links with Joyce McDougall's point about the willingness of the therapist to take on such patients.

Practical issues

In undertaking psychotherapy commitment and motivation is required. There are also practical issues of time and money and external support. There is the issue of frequency of sessions. While working within the constraints of the NHS I used to long to be able to see my patients weekly, now that I also do analytic work, a week can seem an extraordinarily long time to hold on to a patient's inner world both for him/her and for me. Defences go up, continuity is difficult to maintain, every session can feel very new. There is also the question of fees, the resentment of having to pay for love, interest and concern. A patient might say: 'you only see me because of my money'. Analysts are seen as greedy grasping people.

Freud wrote about the pros and cons of fees, showing that this is not a new issue.

Freud wrote 'Free treatment increases enormously some of the neurotic resistances – in young women for instance, the temptation which is inherent in their transference relation, and in young men their opposition to an obligation to feel grateful, an opposition which arises

from their father complex and which presents one of the most troublesome hindrances to the acceptance of medical help. The absence of the regulating effect offered by the payment of a fee to the doctor makes itself very painfully felt. The whole relationship is deprived of a strong motive for endeavouring to bring the treatment to an end. However, he goes on (1919): 'It is possible to foresee that at some time or other the conscience of society will awake and remind it that the poor man should have just as much right to assistance for his mind as he now has to the life-saving help offered by surgery... when this happens institutions or out patients clinics will be started, to which analytically trained physicians will be appointed so that men who would otherwise give way to drink, women who have nearly succumbed under the burden of privations, children for whom there is no choice between running wild or neuroses, may be capable by analysis, of resistance and of efficient work. Such treatments will be free'.

Several authors have listed why they feel sacrifice in terms of payment is important. De Nobel (1989) reviewed a number of writers who stated that without it:

- the necessary motivation may be lacking.
- it may be impossible to mobilise the psychodynamic element connected with possessing, giving and receiving the treatment, too much material remains unprocessed.
- it deprives the patient of the possibility of feeling more dependent, less protected and more frustrated.
- the transference neurosis ie. what or whom the therapist becomes in the patient's mind cannot develop adequately because the patient cannot freely express negative feelings.
- there may be too much wish fulfillment which would impede the analysis.
- the patient remains too passive, which interferes with his potential for self determination.
- the patient is out of touch with reality.

Personally, having worked in both NHS and private settings I think there is a difference regarding self-value, providing oneself with opportunities, spending one's money on therapy rather than say on an expensive holiday.

Curing or healing or both?

In her latest book *Bridges* (1993), Rosemary Gordon, has a chapter called Curing and Healing. She quotes from Jung, The Transcendent Function (1916).

'there is a widespread prejudice that analysis is something like a cure to which one submits for a time and is then discharged healed'.

Later Jung (1934) made the point more explicitly, 'the object of therapy is *not* the neurosis but the man who has the neurosis'. Jung saw the value of neurosis not as something to be got rid of but to be understood. To quote Jung (*op. cit.*) 'A neurosis is by no means merely a negative thing it is also something positive...hidden in the neurosis is a bit of still undeveloped personality, a precious fragment of the psyche lacking which a man is condemned to resignation, bitterness and everything else that is hostile to life'.

'To cure' could denote taking care of specific symptoms and malfunctions and would refer to a procedure with which one person does something to another.

While 'to heal' would then be specific to that process which is concerned with the evolution of the whole organism towards ever more complex wholeness (Gordon 1993). This should not be idealised for it involves psychological work and pain. The etymological origins of the word to suffer mean to bear. (The latin root the verb *ferre*, to carry in fertility.)

Gordon continues, 'In analytic work hope to do both.... Of course goals of patient and analyst may differ, the patient wishes to get rid of the symptoms, the analyst aware that the symptoms are deeply embedded in his total personality and therefore is concerned with growth and development of the whole psyche of the patient'.

Rosemary Gordon emphasises the point that cures can only rarely be achieved without some measure of healing. She states 'Occasionally some healing has taken place and yet a symptom remains. This may be a signal and potential aid and incentive for further development'.

The role of the referrer

Much depends on who the referrer is: counsellor, GP, psychiatrist or social worker; at what stage they see the patient; whether and for how long they have worked psychologically with the patient; and, the reasons, overt or covert, for the referral. The patient may be thoughtfully handed on. But there may be a suspicion on his part that he is being got rid of, dumped because he is too troublesome, or no one knows what to do next; he is one of these heart sink/black hole patients of general practice.

There is the process of referring, because of feelings of loss, abandonment, or rejection for both the referrer (especially where some psychological work has been done) and the patient. What is the referrer really implying to the patient and how is the referral perceived? There may be fantasies for the patient of being too difficult, too disturbed or mad for the referrer to cope with. The referral may resurrect past feelings of being rejected. There are the patients whom the referrer may be convinced can benefit from in-depth psychotherapy, they may secretly disagree but comply initially as a way out. These may be the 'disavowal' patients written about by Sedlak (1989) who cannot own the seriousness of their condition. The referrer may envy the psychotherapist, who seems to have more of everything: more time, longer training, can charge larger fees, see the patient more frequently, have greater knowledge and understanding.

There follow some general points for the referrer who has not worked psychologically with the patient:

(1) Resist the temptation to rush to refer.
(2) Give space for the patient to talk about/explore some of their difficulties, observe and listen.
(3) See whether they are curious, interested in themselves and what is going on inside them as well as external events.
(4) Explore family/personal relationships. Often what a partner/family member is blamed for may be some aspect of the patient that he/she does not like/cannot cope with/needing help with (the blame game: innocent victim 'if only', 'nothing but' from the doctor, shadow elements).
(5) Can they reflect and make links.
(6) Be alert to a present crisis (why now), loss of job, bereavement especially of a parent, divorce, abortion, or fear of loss, physical illness, triggering awareness of past painful experiences of being neglected, abused or abondoned.
(7) See them a few times to see what sense they have made of the sessions.
(8) What are their hopes and expectations of what therapy is about and can offer.

For the counsellor there may be feelings of getting out of one's depth, knowing more needs to be done or could be done with more frequent sessions over a long period of time.

While preparing this paper I looked in detail at 26 patients who had been successfully placed with trainees, half were men, half women. They were mostly in their 20's–30's. The majority had been to their

GP, seen a counsellor, psychologist or psychiatrist. Half of them had experienced the loss of a parent through divorce or death, alcohol problems in one or both parents, mental illness in a parent or sibling. The reasons they gave for seeking therapy were clustered around feelings of low self esteem, depression, self-hatred, panic/anxiety attacks. Many felt lost, failures without direction or purpose in their lives, failed or unsatisfactory relationships. There was no joy, spontaneity or pleasure in living. Three had drink or drug problems. Three of the women had been sexually abused by a close family relative. Three had physical illness, asthma, irritable bowel, eating disorder. All of them wanted to know more about themselves and why there were the way they were and why they were stuck or repeating the same self-destructive patterns of behaviour.

Some case examples

Mrs A. A woman in her late 20's was referred to the psychosexual problems clinic due to painful intercourse. During the physical vaginal examination she revealed that she had had an abortion. She cried about this, she had not told her husband (he was not the father) nor her family. She felt ashamed with this secret. After this she found sex less painful but began to lose interest in sex (previously masked by the thought of pain). She was unable to understand this; her husband was kind, thoughtful and attentive. She felt safe with him. She said almost as an aside, that the father of the abortion was no good but sexy. She puzzled about this. Could sex only be good with a no good man? She was in personnel management and as part of her job she had to do some counselling skills courses. On one of these courses she found herself talking about her much respected father whom she had tried hard always to please in an angry negative way. She began to wonder about her relationship with her mother whom she had patronised. We explored some of these feelings for a few sessions but we both felt that she needed more than I could give in that setting, so she was referred to a psychotherapist. She had become frightened of being trapped in an old pattern of behaviour; she had begun to see an older, very attractive Don Juan at work and feared this would break up her marriage.

Mrs B was referred to the psychosexual clinic, a woman in her late 50's, childless. Her mother of whom she was very fond, had recently died and she was finding it hard to cope. She had seen a bereavement

counsellor and had managed to tell her that she had been sexually abused by her father and wanted to see a psychosexual counsellor. The sexual abuse had begun when she was around 10. At first it was masturbation, later full intercourse until her late teens. Father was never rough and always used a condom. When she protested he said it was her duty as his daughter. Mother did not want sex and suffered from depression and was in and out of mental hospitals. Mrs B had left home as soon as she could. She worked as a secretary, got married and, indeed, enjoyed sex with her husband and described her marriage as a good one. The death of her mother released many feelings, guilt and shame. She felt she had wronged her. She was confused about her father, now an old frail man who wanted to see her. She still hated him. We met for several sessions, she grieved with me and was able to visit her mother's grave and 'talk' to her. She managed to phone her father and told him she could not forgive him but would keep in touch by phone. Something had shifted in our short term work together and she is back at work and making plans for the future with her husband.

I present these two patients as a contrast. With Mrs A. I had anticipated short term work, but there turned out to be much deeper seated problems. Mrs B I had initially thought would require longer term work, the sexual abuse, the death of her mother triggering very painful memories. She was able to benefit from cathartic exploration and confirmation from an authority figure that she was not to blame for what had happened. She had shared the abuse with her husband and had determined that it would not spoil her life. It was decided to leave well alone and respect her remaining defences.

Summary

In this paper I have attempted to describe which patients would be suitable for and benefit from in-depth psychotherapy: this being defined as the exploration of the whole psyche. The need for psychological mindedness, the acceptance of the concept of an unconscious mental life and the development of a therapeutic alliance is emphasised as crucial. Whether curing or healing, or both, are aimed for as possible outcomes is also examined. Two case examples are given to illustrate who might or might not benefit from in-depth psychotherapy.

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COUNTERTRANSFERENCE: SIGN, SIGNAL OR SNARE*

ROSEMARY GORDON

'The unexamined life is not worth living', so wrote Montaigne echoing Socrates, and thus defined his own system of values, which accords, of course, with the Delphic oracle's injunction 'Know Thyself'. I believe that the very choice of our profession expresses implicitly, our agreement with Montaigne.

But as analysts and psychotherapists we take this idea one, or even several, steps further. For not only is it encumbent on us to examine and explore ourselves, our feeling, thinking, acting, again and again, but our self-examination is and can be used to help, guide and inspire others, primarily and particularly our patients, to join us and also become engaged in such self-examination.

Clearly the most effective tool to advance the examination both of ourselves and of our patients is the countertransference. Because of the very central role it can play, I want to discuss at some length some of the observations and theories about it before I come back to the main theme of this talk: 'Countertransference: sign, signal or snare.'

For a long time countertransference was regarded by most psychoanalysts as indicative of a pathological reaction of the analyst to his patient. It was only in the 1950's that analysts like Paula Heimann, Margaret Little and Marion Milner re-opened the discussion of countertransference, which then led to a new evaluation of it as a valuable tool for the understanding and diagnosis of the psychic processes in the patient and of the patient-therapist intercommunications.

And yet Freud himself in his lecture to the physicians in 1912, recognised that the analytic process involves – and must involve – a strange interaction between two persons, for the doctor 'must bend his own unconscious like a receptive organ towards the emerging unconscious of the patient.' Unfortunately this early awareness of the inter-communication of the unconscious of patient and therapist was not pursued, followed up or elaborated till four decades later. And

*Paper given at BAP Conference October 1, 1994.

yet, as John Kerr reports, in 1911, in a letter to Jung, Freud suggested that an article on 'countertransference is sorely needed.'

Jung also believed quite early on that affective unconscious forces are in fact released by the analytic process and that this can expose the doctor to danger or to pain and so he too may be changed. He thought of the analytic process as being so intense and forceful, that it could be compared to what happens if two chemical substances meet and combine, for then both substances are changed and transformed.

Thus while both pioneers, Freud and Jung, recognised early on this powerful and special quality of the patient-doctor relationship. Jung made it one of the major subjects of his observations, interests, explorations and reflections, reminded himself and others that by not taking refuge in the cool and neutral stance of an objective, uninvolved pseudo-scientist, the analyst does expose himself to many different dangers, aloofness being one of them or seduction of the patient – and not only sexual seduction – or collusion with the patient's unconscious demands, illusions, phantasies, or acting them out being another.

Thus while he must be able to sense, to experience and to decode the unconscious communications of his patient, he must also retain consciousness. For if he lets go of his consciousness, then he, and I quote

> 'falls into the same dark hole of unconsciousness as the patient, and then instead of the transference-countertransference situation, you get "participation", which is a characteristic of primitive psychology, when there is no longer discrimination between subject and object' (Tavi lectures p. 140).

This double 'game' inevitably imposes a very heavy burden on the analyst-therapist. It is therefore not surprising that different protective and defensive techniques have been sought and elaborated. I am thinking here of, for instance, the 'ritual' to sit always behind the patient; or to deny and avoid all emotional involvement with the patient; or to limit oneself to a restricted register of possible interpretations; or to concentrate on the collective, the non-personal, material of the patient.

I believe that the patient-therapist relationship is shaped and affected by the three principal unconscious processes, which are:

1) *Projection* – and here we must remember that Jung believed that all unconscious archetypal contents must take the route of projec-

tion on their way to consciousness, the physical equivalent of projection being excretion.

2) *Introjection*, that is the assimilation of contents and processes that belong to somebody or something else; Its physical equivalent is, I think, eating and ingestion.

3) The third major process is *projective identification*, a process that is more primitive than either projection or introjection. For projection and introjection can only happen when a certain amount of ego differentiation has already been achieved, which means that an experience of 'otherness' is now available. But one of the purposes of projective identification is to dismantle once more whatever boundaries have come to exist and to return instead to experiences of fusion.

Jung's continuous interest in the experience and effect of the analytic process on the analyst, has of course stimulated some of his friends, colleagues and successors to explore and develop further the understanding and also the clinical use of the countertransference.

One of the most creative and valuable contributions has undoubtedly been made by Michael Fordham. He has introduced a most important distinction between what he has named 'countertransference illusion' from what he has come to call 'countertransference syntony'. Obviously consciousness and self-awareness of the analyst are absolutely crucial and determine to what extent the countertransference can help or hinder the development of both therapist and patient. Fordham uses the term 'countertransference illusion' if the analyst's understanding, interpretations and reactions are based on and have resulted from his own personal complexes, hang-ups or theoretical dogmatism. 'Countertransference syntony' on the other hand denotes the fact that whatever the analyst feels or experiences does belong to the inner world of the patient! Clearly it requires considerable ability to introspect and a ruthless willingness to examine oneself if one is to be able to differentiate countertransference syntony from countertransference illusion and able to assess how much and where one of them predominates over the other.

In as much as countertransference is moulded by introjections, projections and projective identifications a further questions suggests itself: is the person, or the quality projected, drawn from his or her personal experiences in the far – or not so far – past, as remembered or imagined, or is it an inner figure that had been emotionally important, in which case the analyst may be cast into the role of this 'other' in order to enact or rather re-enact with the patient some particular

drama. Following Professor Wisdom's suggested vocabulary, I find it convenient to speak of an ex-nuclear projection when it is the patient's self that is projected or an ex-orbital projection when it is an inner 'other' that is projected. Of course what is self and what is other is not necessarily fixed and permanent. They can easily change place, as was shown so clearly by Masud Khan in his paper 'Silence as Communication'.

Andrew Samuels in his book '*The Plural Psyche*' deals with the same kind of distinction, but he speaks of '*reflective countertransference*' when the analyst has received the projection of the patient's ego-self, and he calls 'embodied countertransference' when the patient has projected an internalised figure.

I have recently been preoccupied by another quality that may leave its mark on the countertransference; this is the quality which has to do with the nature of the love that the analyst experiences towards his patient, a love that may be dominated either by *Agape* or by *Eros*. Agapaic love is essentially altruistic and concerned above all with the needs and advantages of the Other, the loved person; while love under the aegis of Eros is passionate, all-consuming and ecstatic. Although I have already written on this theme – it is part of a chapter on countertransference in my book '*Bridges*' – I would like to repeat here some of my arguments and discussion as they are particularly relevant to the over-all theme of this conference.

I am indebted to Kenneth Lambert who has suggested that the incorporation of the two Greek concepts of '*Agape*' and '*Eros*' into our analystic vocabulary may increase our understanding of the patient-analyst relationship.

Lambert found that in classical Greek '*Agape*' referred to qualities like:

1. not seeking one's own advantage
2. not being inflated with pride
3. not being envious
4. not being vengeful
5. caring for the advancement of truth
6. being hopeful for all things

This term '*Agape*' might indeed remind us of and draw our attention to those attitudes we need to cultivate in relation to our patients. But, there is a danger that a list of such desirable qualities could encourage an idealisation of the analyst and of his or her role and function. It could encourage the illusion that he or she is invulnerable and free from all defects and all temptations.

It is important that, rather than simply relying on repression, denial or identification with an analyst's persona, we analysts remain sufficiently confident that we will be able to control and more or less master our own reactions to patients. This can then help us avoid acting out in a hasty, untimely or self-gratifying way. When we feel threatened or tempted to act out, a re-powering of agapaic love could then encourage and re-strengthen our capacity to listen and to trust that the patients and we, the analysts, remain capable of further development and growth by sacrificing various self-gratifications.

Now the concept of *Eros* was used and discussed by the Greeks more often, more freely and with more enthusiasm than *Agape. Eros* meant to them power, magic, ecstasy, desire and attraction to physical beauty. Although it could degenerate into frenzy, in its higher form it was capable of transporting man or woman beyond himself or herself. Euripides described the God Eros as 'the tyrant over gods and men.'

Now, however desirable may be the presence of *Agape* in the countertransference there is also, I believe, a real need for *Eros*.; for his dynamic force can complement and counterbalance *Agape*. If there is but little *Eros* available for investment in the patient-analyst relationship, and if there is a dominance of agape at the expense of *Eros*, the analytic work is likely to be dull, flat, colourless and without vitality, passion and deep mutual involvement.

Admittedly without *Eros*, and the temptations evoked by *Eros*, the analyst and/or patient may come to feel very virtuous, pure and correct. They may think and feel that they are good and are doing their duty. But the cost is high and the possible achievement of an actual transformation of the psyche is extremely limited.

After all, analysis involves a long term commitment and the passage through many moments of anguish and pain, of love and hate, of resentment and gratitude. All this could probably not be sustained by either patient or analyst if agape alone were present without Eros. Neither patient nor therapist could or would be willing to accept the risks and upheavals of their internal and often deeply unconscious feelings and phantasies and the exposure revealed by the analysis of projections, introjections and projective identifications. All of this demands an enormous amount of effort, work and pain. Where not just normality, but actual transformation is sought, the transporting power of *Eros* must be available. Thus, so I believe, both *Agape* and *Eros* are essential concommitants of an analyst's experience of and love for the patient. The balance between these two forms of love is, of course, bound to vary and shift from person to person and from

time to time. It must therefore be assessed and re-assessed continually. We must explore again and again when, how and in what way an imbalance between them might have produced some particular negative therapeutic situation.

The fact that both kinds of love are valuable and even necessary in analytic work has made me speak and write about the 'twinning of *Eros* and *Agape*'.

Having described briefly some of the exploring, thinking and theorising about countertransference, it must be obvious that it is a very complex process indeed. If it is to serve the exploration of oneself and of the other, the analyst must always remain vigilant, curious, receptive, open-minded and constantly questioning: What do I feel? What do I experience? And how much is what I experience my own experience, coming out of the workings of my own psyche; or does what I feel and experience belong to my patient which has been put into me by this mysterious process, the process of projective identification. Or is it my conscious or not so conscious reaction to my patient's conscious or not so conscious experience or communication: of course, the examination of oneself and of the other is the avowed purpose of analysis; but the more the study of the workings of the psyche advances, the more we come to recognise what an intricate, subtle and potentially confusing or even disorientating an adventure we have undertaken and constantly have to renew.

I want to explore further what might be the purpose of a communication and how we might understand it or be misguided and fooled by it. I would like to give a few examples as they might explain better what I have in mind.

A patient, let me call her Joan, a woman in her late thirties, married but no children. She had been in analysis with me for three and a half years. She had come to analysis because she suffered from bouts of panic and anxiety, which had intensified and become more frequent since the death of her father. She was also prone to attacks of asthma; some of them were so severe that she had to be hospitalised on two occasions. She rarely brought dreams to her analysis, and her capacity to play, to imagine or to think and experience in term of symbols was limited. Instead she was often tempted to act out many of her feelings and phantasies. Her feelings towards me tended to waver between strong love and strong hate; they were very split, so that when she felt one of them, say hate, she was completely cut off and could not even remember or be in any way in touch with her loving feelings. When

she hated me she experienced me as cold, dominating, intrusive and persecuting.

But as the analysis progressed, the asthma attacks became very much less frequent and less disabling. Her feelings became less violent and much less fragmented or fractured. I felt that the bridges between her various internal processes had been strengthened and more of them were being made. But just as were beginning to think that perhaps we were nearing a possible end of our work together, she began to look less well. It felt that she seemed uneasy, as if she laboured and battled with some apprehension. Yet nothing clear or specific appeared in her analytic sessions, except that she became more often almost silent, and the form of her associations moved more slowly.

But one day she, as it were, settled down into the couch, instead of just lying on top of it, as she seemed to have done. And then, half way through the session she said rather softly, as if she was not sure that she wanted me to really hear it, 'I have had three attacks of asthma during the last two weeks. It is as if the old trouble has come back.' I too was a bit taken aback, I waited. 'What do you think is going on? I wonder?' I asked myself. We both stayed silent. But early in her next session she told me that she seemed to have fallen in love; a colleague, quite a bit older than herself; he also was married and had two children, a boy and a girl; both were now grown up and had left home. But she was also very fond of her own husband. Nothing had as yet been said about her feelings either to her husband or to the colleague. She did not know what the colleague felt about her; but he seemed to like it when they talked together, mainly about their work. She feared that her feelings were irrational and probably not reciprocated; but still they did not go away. Clearly, so it seemed, her inner turbulence had again found expression in and through her body; it had re-evoked the somatic reaction, the very somatic reaction which was familiar to her.

Furthermore the asthma was not only familiar to her; it was the very psychosomatic illness that she alone had shared with her father. Neither her mother nor her other sisters had suffered from this illness; nor were any of them particularly close to or even particularly fond or caring of her father. She certainly was closest to him; she would at times spend an evening sitting with him, which she nowadays remembered with much nostalgia. It had been difficult to bear his loss when he died, and there had been moments when she had hoped that she might join him in his death.

The re-appearance of the asthma was, I believe, a sign with more than one meaning:

(1) It acted as a sort of alarm sign that all was not well; the inner world was not calm, rather there was upheaval.

(2) The fact that the psychic upheaval expressed itself in the very symptom that she had shared with the loved father suggested to me that the feelings that belonged to the Oedipus complex had not yet been totally left behind and overcome – although it had been one of the important themes in her analysis. Also these asthma attacks might have been a way of dealing with her longings for her father by identifying with him, a solution she had already found while he was alive. Nor was the fact that she had become infatuated with an older man irrelevant to her oedipal problem. Rather I wondered whether that very fact was also an expression of her oedipal longings, and was, I suspect, both at the root of the infatuation, but also re-evoked memories of longings for her father.

(3) The fact that I, her analyst, am a woman made it easy for her to project on to me once more the mother; the rival who would disapprove of her daughter's fond feelings for the father, her mother's husband. This is, I think, the reason why she found it so difficult to tell me about her feelings for her colleague.

(4) But the asthma also, I suspect, was her expression of a death wish, which she had already told me about.

In other words the re-appearance of the asthma attacks was a sign that there was still much power and vitality left in her oedipal experiences.

The distinction of sign from signal is not easy to make. And yet I believe there is a difference. As I see it, for me the sign is like an adjective; its purpose is to apprise, to indicate, to show and lead to, to connect; like a road sign it shows that there is or can be a connection between a 'here' and a 'there'.

The signal on the other hand calls for action; it provokes attention so that something may be done or not done. Traffic signs are signals and so of course are the sirens of ambulances or fire brigades.

As an example of a patient giving out signals I remember a patient who had come into psychotherapy because she was anxious, perplexed and also depressed which, she felt, made her rather inefficient. She was a quiet, a somewhat inhibited, conforming and submissive woman. She had been a well qualified secretary; she was married to a business man and had three children, two daughters and a son. Two of them

had already gone to University. But the marriage had become somewhat fraught. Her husband was a practical, ambitious but cold person, who did not tolerate fools or foolishness gladly. He demanded and valued efficiency and he reckoned that efficiency in the way his wife ran their home was a token of her love for him. Aware of her husband's linkage between love and efficiency added a further pressure on his wife, my patient.

She brought to her sessions memories of her childhood, adolescence, her early training career, and her marriage. Her husband's work had taken them to Africa for a number of years. They had had a relatively comfortable, conventional life; no great passions, but no great dramas or conflicts either.

Our therapy work went on, also rather calmly. But nothing changed very much in the patient or in her life. I began to feel uneasy. There was so little going on either in the patient or even in me. What had we not dealt with? What had we by-passed? Was there really so much anger or hate or frustration in my patient in relation to her husband or to me? Or was the depression so deep that it, as it were, paralysed her, and obstructed access to the deeper levels of her unconscious. Yet she also told me, but with some anxiety and fear and apprehension, that her husband was getting more and more annoyed with her when she forgot various things, when she had not remembered some item on her shopping list or some items were missing when she laid the table.

Then what began to really alarm me was when she mused one day without much affect, panic, anxiety or regret that perhaps she may get to a point when she might no longer be able to drive herself into London for her sessions with me. Somehow this did not feel like a hostile resistance to me or to analysis. I began to feel despair and a sort of hopelessness, but also some concern bordering on a tender pity. I suggested that she might consult her doctor who might like her to see a neurologist. Her first consultation did not produce any clear or significant diagnosis. In a way we both felt relieved and so we worked on together with her therapy. But still nothing changed very much. Her general functioning did not really improve and her family did not seem to become any less irritable or critical of her. A few months later I asked her to ask her G.P. if he could arrange for another consultation with the neurologist. He now sent her to Queen's Square where, after a battery of tests she was diagnosed as suffering from pre-senile dementia, what nowadays would be described as an Alzheimer syndrome. She came to see me once more to tell me about the result of the neurological investigations. She thanked me for having

helped to clarify what was happening to her and that she would go to live with a sister who lived in East Anglia and who could help her to get into a hospital when this became necessary. Her quiet resignation was heart-breaking. How much was this part her illness? How much did she herself experience some of the pain that I felt – *for* her or *with* her or instead of her? Yes, I had finally come to recognise her request for therapy as a signal and had responded.

Recognising the element of snare in the transference-countertransference is perhaps a more familiar theme in our analytic thinking and discussions, and yet we are still often caught by it or in it.

I am thinking of my very first training patient, a man in his late twenties who had been referred for analysis because having stopped the drug habit, he had become anxious, depressed and mildly paranoid.

Very soon after starting analysis with me the patient produced an erotic dream in which he was trying to seduce a woman, somewhat older than himself. She had dark-brown hair and was rather elegant. Also in the sessions at the time of the dream he began to talk about his sexual attraction to me, his need of me, the difficulty he experienced during the week-ends, the longing to be close to me and his almost hallucinatory images of being in bed with me. I began to suspect that he was enacting the, at the time, popular notions about analysis and how patients tended to fall in love with their analyst. Was he trying to convince me that his feelings for me had an adult, a genital quality? Yet he evoked in me feelings and images of an infant, about 15 months old, who needed much care and protection, though he tried to adopt the posturing of an older, more masculine, more independent, more self-relying boy.

As we had already discussed his very close relationship to his mother, it was not too difficult for me to recognise that his transference feelings were really far from a truly phallic-genital level, but belonged to a pre-oedipal stage. They were centered on the two-body relationship to the mother. The father or a father figure was still almost absent; the three-body relationship with its passions and conflicts had not yet been reached. Thus the apparently erotic sensations were 'snares' to keep me from discovering where he really was.

However, occasionally one gets some evidence that snares may be laid not only by patients but also by analysts. Here the snare could for instance serve a male analyst who fears that he may become uncomfortable in relation to a woman patient because she has come to experience erotic feelings and desires for him. This could make the analyst feel put on the spot by his patient; so he protects or better

defends himself by believing and interpreting the patient's desires as being not yet really genital but primarily as still oral in nature and origin. In other words here the analyst ensnares the patient and so tries to hold him or her back, like a possessive mother, in an earlier, a less tempting and seductive infantile state.

I have as a second example a case that I had worked with in a trainee's supervision. My trainee's patient was a woman in her early thirties. There was a congenital malformation; her head sat straight on her body; there was no neck linking head to body, which of course limited her movements, quite apart from the fact that it set her apart and gave her a somewhat abnormal, almost grotesque appearance. After a rather promiscious phase in late adolescence, she had married a quiet, reliable but somewhat gormless electrician and had five children with him. They lived, the seven of them, in a two-roomed flat; the children were noisy, restless, quarrelsome and one of them had already been referred to a child guidance clinic; a second one was waiting for a vacancy in the same clinic.

The patient, let me call her Dorothy, seemed to use her analytic sessions as a sort of dumping ground for her anger, self-pity and despair about her situation; She did talk about her own childhood and the trouble and pain she had experienced from her back, her spine, and the many treatments, corrections, exercises and surgery she had had to endure; quite apart from the teasing and cruelty she had suffered from some of the children at school and even from some of those in her neighbourhood. Her parents, as she described them, were efficient and practical, but emotionally cool and undemonstrative. In fact they seemed to feel embarrassed, almost ashamed at having produced this handicapped child, their only child. Her childhood appeared to have been as gloomy, joyless and unsatisfactory as her present adult life. The trainee began to feel somewhat less than enthusiastic at the thought of her sessions with this patient. For each session seemed to produce only another litany of anger, despair, rows with the children or rows between them, and sighs and groans at the general turbulence and dissatisfaction of her life. The trainee felt also much pity for her patient whose situation seemed really unbearably difficult; but she, the trainee, also felt deskilled and hopeless about herself and about the possibility of ever being able to do anything for Dorothy. After a time, I tried to make the trainee more aware of the destructive, envious and paralysing attacks on her analyst which were expressed in and through Dorothy's complaints. I suggested to her, the trainee, that her experience of pity and compassion, very understandable given her

patient's troubles, was actually collusive with her patient's self pity and rendered her, the analyst, also impotent and hopeless; and so the analysis ground to a halt. But it seemed that my remarks were well-timed for the trainee understood what I said, felt relieved and, as it were, confirmed and justified in terms of her own negative feelings for and reactions to her patient.

She now became more sensitive to the hostile and aggressive forces in her patient and her patient's transference and was able to use it in her work with Dorothy and in her interpretations to her.

The consequences, perhaps one might even claim the effects of this change of understanding and approach were quite astounding. A few weeks later the patient decided to apply for training as a marriage counsellor; and to our surprise she was actually accepted. And then she began to look for and indeed she found and bought a small house in a town about 80 miles away from London. She respected the time needed to bring a relatively satisfactory end to her own therapy, as well as the therapy of two of her children, but she also explored the possibility and the provision available of further therapy for the children as well as for herself in her new location.

We could only make sense of these changes by remembering the intensity and violence the patient had deployed in a destructive and self-destructive manner. So when her analyst conveyed to her and acknowledged the presence and reality of her violence, she was then able to harness this violence towards a constructive goal, and the self-pity was then seen as a snare for both patient and analyst.

As another example of being caught in a snare was my work with a young psychiatrist coming from a different culture. He was married and had two children. He seemed to me a very good analysand. Most of our work was in relation to me and to the transference. He could get extremely angry and hostile, particularly if he felt that I had failed to provide exactly what he needed. At one point road works were going on at the top of my road; of course they were noisy and this intruded into the general silence of 'our' room. After about 35 minutes of this noisiness the patient exploded with rage and rushed out of the room well before the end of his session. He made me feel that he believed that I should have been able to protect him from this disturbance, very much like a young baby who sees his mother as omnipotent and therefore responsible for all that is good and pleasurable and satisfying and for all that is bad and painful.

The main themes of his analysis were about work with his patients in the hospital, recounting and re-experiencing some of his own child-

hood experiences and above all whatever he felt for me or imagined about me and the different personages he projected upon me. He also spoke with warmth and care and pride about his two children.

It was therefore with shocked surprise when he mentioned one day that his wife had decided to leave him and return to their country. Yes, he had done all the 'right' things – he gave all his attention to exploration of his history and to the transference; but he had hardly ever mentioned his wife and whatever was going on in the marriage.

So here I had fallen into a trap, a snare; surely, I believed, transference is the main and principal work of analysis. I now hope that I have learned an important lesson from this analysis: don't forget what is absent!

There is one other snare that I feel I ought to mention. For it is a snare which sometimes traps both patient and therapist; it is a snare which I suspect, had been a little responsible for the snare I fell into in the case of the patient I have described last; the snare that if we concentrate on the transference the analysis is going well. This is the snare when the analyst, and also the patient who wants to please his analyst, is so concerned with and is so wedded to a theory that it can and might interfere with or blunt the sensitive, open and receptive perception and observation of the patient and of what is really happening in the patient-analyst relationship.

I suspect that all of us are at times in danger of resisting 'the sacrifice of beautiful theories to ugly facts'.

I have tried to summerise in this paper some of the ideas, observations and theories about the nature, quality and function of countertransference. As our understanding of countertransference increases and becomes more differentiated and sophisticated, so our use of it in our work with our patients becomes ever more subtle and efficient. For the more we can analyse our own feelings and phantasies and thoughts as they emerge and break through in our analytic work with patients, the better and the more perceptive will become our insights into the inner psychic processes of our patients and our own.

However the main purpose of this paper is to draw attention to yet another, a further facet of the patient-therapist communication, namely to the possible purpose or function of a communication, which may not be so clearly and immediately obvious. For this purpose or function may not be apparent in and through the content, all be it symbolic, of what is said, dreamed, reported or imaged. It seems to me possible that such extension of our understanding, the recognition of sign, signal or snare, may be useful, as it may make us aware of

some further demands by the patient on the analyst-therapist. For instance in the case of the signal and the snare there is an intrinsic demand on the analyst to do; to change or adjust his understanding of what the patient needs or wants, or wants to avoid. In the case of the sign we may be dealing more with a further clarification, a further elaboration or confirmation of what is already partly known.

Thus by drawing attention to another aspect or facet of the patient-analyst communication I may have helped to extend and to deepen some more understanding of the persons involved.

But lest we grow too self-satisfied and thus obstruct or arrest further development I want to end this paper as I began it with Montaigne:

> 'And so it is with this knowing about oneself: the fact that each man sees himself as satisfactorily analysed and as sufficiently expert on the subject are signs that nobody understands anything whatever about it – as Socrates demonstrates too ... 'I who make no other profession but getting to know myself, finds in me such boundless depths and variety that my apprenticeship bears no other fruit than to make me know how much there remains to learn'. (Book III: 13.)

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BOY CRAZY ADOLESCENCE. FREUDIAN, FEMINIST, AND LITERARY PERSPECTIVES

JANET SAYERS

Male-centred teenage sexual experience often features prominently in the stories adults recount of their lives. Certainly this is true of the longest ever autobiography – Proust's *Remembrance of Things Past,* begun when Proust was fourteen (Shattuck, 1974). His several thousand page novel starts with the narrator remembering his first glimpses, in his early teens, of the erotic preoccupations of the men who are to become the models of his life – Charles Swann's jealous obsession with Odette, repeated in the narrator's desire for Swann's daughter Gilberte, passing strangers, the Duchess of Guermantes, and Albertine, and in M. de Charlus's abject longing for Charles Morel.

Male-centred desire likewise figures largely in women's teenage reminiscence. Such desire includes the wish to be a man, as in South African feminist Olive Schreiner's novel, begun when she was eighteen, in which the heroine dreams:

> How nice it would be to be a man. She fancied she was one till she felt her very body grow strong and hard and shaped like a man's. She felt the great freedom opened to her, no place shut off from her, the long chain broken, all work possible for her, no law to say this and this is for woman, you are a woman (Schreiner 1925: 226)

Schreiner and Proust grew up at the end of last century. Treating adult patients at this time, Freud found they too recounted their lives in terms of male figures of their teenage years: Katharina, who consulted him when he was staying in the Austrian Alps, dated her breathlessness to being sexually abused by her father when she was fourteen (Freud, 1895); his patient Elisabeth von R attributed her pains in her legs to nursing her dying father in her late teens (Freud, 1895); while another patient, Dora, traced her symptoms to her father's friend trying to seduce her when she was fourteen (Freud, 1905a). Freud (1896) early concluded that teenage sexual experience is the trigger awakening infantile memory which, in so far as it remains repressed, can only gain expression pathologically in non-verbal, symbolic, hysterical, or somatic form.

Today's psychiatrists, at least in England, tend to explain such illness

– both neurotic and psychotic – as the effect of genetic, organic, or immediately precipitating social causes. Nevertheless their patients, like those of Freud a century ago, often trace their symptoms to male-centred teenage events. Surveying all available initial assessments made by one consultant psychiatrist through 1993, I found a significant minority (eleven out of fifty-nine) referred to such experience in explaining their ills: several referred to adolescent paternal conflict, while others mentioned rape, or loss of a brother, boyfriend or father in their teens. Similar upsets also often characterise the life stories told by those seeking social work support. Tales of teenage sexual abuse, being ousted from home by a father or stepfather, or discovering that the man they had taken to be their father was not related to them (that they were adopted) are rampant. (For further details see Sayers, 1995.)

Arguably fathers, and men generally, acquire particular significance in adolescence because of the pressure on teenagers to define themselves in male-dominated society in terms of acquiring or becoming a man. Our definition of ourselves in terms of our sexed identity and orientation may, as Foucault (1976) observed, be a distinctly modern phenomenon. Certainly the pressure on teenagers to secure an identity in terms of the educational and work options – supposedly available irrespective of sex, race, and class – is a product of the development, out of feudalism, of the capitalist 'free market'. And it is clear that both boys and girls as teenagers orient themselves toward masculinity in self-report studies (see e.g. Flaming & Morse, 1991), questionnaires (Galambos *et al.,* 1991), in adopting male celebrities as heroes (see e.g. Greene & Adams-Price, 1990), in the male figures of their dreams (see e.g. Westerlundh & Johnson, 1989), and in the fact that girls' (unlike boys') sexual arousal often depends on the presence of an external male stimulus (Knoth *et al.,* 1988).

Pressure on teenagers to measure themselves against our culture's male ideals and standards doubtless also contributes to the heightening of bodily and emotional self-consciousness in adolescence (see e.g. Hauser & Smith, 1991), and to its verbal expression not least in the diaries girls particularly begin keeping in their teens (see e.g. Rekers et al., 1989; Berzoff, 1989; Evert, 1991). Many address their diary to an *alter ego,* in the case of New Zealand poet Janet Frame to a man she imagined 'with a long, gray beard and 'smiling' eyes, who ruled over the Land of Ardenue' (Frame, 1982: 144).

Frame recalls herself as a teenager 'looking outward and myself looking within from without' (Frame, 1982: 143), acutely ashamed of

her woman's body outgrowing her gym slip, seeped through with blood from her home-made sanitary towels. Israeli novelist David Grossman (1994) likewise depicts a teenage boy driven inward by adolescence – in his case to put into words his anguish at not being more of a man.

The inwardness of teenagers might explain why doctors are more prone to diagnose adolescent as opposed to childhood complaints in inward psychological rather than outward behavioural terms (see e.g. Place, 1988). Why, though, are teenage girls more likely than teenage boys to be diagnosed as depressed (see e.g. Angold & Rutter, 1992; Barron & Campbell, 1993; Cohen *et al.*, 1993; Petersen *et al.*, 1991, 1993; Compas *et al.*, 1993; Goodyer *et al.*, 1993), to have an eating disorder (see e.g. McCarthy, 1990), or to be dissatisfied with their bodies (see e.g. Adams *et al.*, 1993)? Why, like the heroine of Wedekind's classic 1890 play *Spring Awakening*, do teenage girls so often become dejected at the prospect of becoming women (see e.g. Perlick & Silverstein, 1994), worry about being too big, while boys (like David Grossman's hero) worry about being too small (see e.g. Diamond & Diamond, 1986; Kilbourne, 1994) and welcome signs of manhood (growing penis, breaking voice, sprouting beard – see e.g. Duncan *et al.*, 1985)? Is this too an effect of sexual maturation alerting teenagers to the value accorded men and masculinity by male-dominated, patriarchal society?

Freudian perspectives

One might have expected an answer to this question from psychoanalysis given Freud's attention to the importance accorded men and masculinity by children in their fantasies of castration. But as Freud shifted attention from his patients' consciously recollected teenage memories to their repressed and therefore unconscious infantile precursors, he lost sight of adolescence. He simply summed it up as giving 'infantile sexual life its final, normal shape' (Freud, 1905b: 207), as deciding our final sexual 'organization' (Freud, 1940: 155).

His analysand and disciple, Helene Deutsch (1944), paid more attention to the adolescent determinants of adult psychology. Indeed she began her two volume book about women with adolescence – with girls' frequent indulgence of inward-turning romantic fantasy compared to boys' more outward-turning activity. (For recent evidence on this point see Robbins & Tanck, 1988; Nolen-Hoeksema, 1991;

Armitage, 1992.) Meanwhile Deutsch's contemporary Karen Horney (1935) wrote of the obsession of many teenage girls with triumphing over their mothers by securing a man – sacrificing all other interests, including work, in the process.

But the formative effect of such lop-sided obsessions with men and masculinity – of what Stanley Hall (1904) long ago referred to as the 'aggressive phallicism' of early adolescence – is scarcely mentioned in today's psychoanalysis. Instead it assimilates adolescence to a gender-neutral account of infancy following Anna Freud's (1958) description of puberty reviving in girls equally with boys their infantile Oedipal wishes to have sex with their parents: Peter Blos's (1967) characterisation of adolescence as involving girls and boys similarly reworking the separation-individuation crisis of early childhood; and Erik Erikson's (1968) emphasis on the identity crisis posed teenagers, whatever their sex, by pressure on them to forge a social self beyond the private self developed in their immediate family of origin.

Erikson drew attention to the negative impact on teenage identity development of class and race discrimination. Blos (e.g. 1984, 1989) has described teenage boys' idealising pre-Oedipal merger with the father as escape from childish fusion with the mother. Neither Erikson, Blos, nor their followers and critics (see e.g. Atkins, 1989), however, mention the gendered asymmetry involved whereby girls as well as boys often define themselves as adolescents in terms of men and masculinity. Nor do they mention men's social dominance as a contributory factor to this process.

This factor is likewise ignored in psychoanalytically-minded feminist theory. Instead it focuses on mothering to the neglect of men and fatherhood. Adopting US ego psychology's characterisation of boys as negating connection with the mother in forging a separate male identity (see e.g. Greenson, 1968; Stoller, 1975), as advanced by feminist sociologist and psychoanalyst Nancy Chodorow (e.g. 1978), many feminist theorists characterise female adolescence as likewise centring on individuation from the mother (see e.g. Dalsimer, 1986; Apter, 1990; Gilligan, 1990).

Gilligan (e.g. 1994) suggests this process peaks for boys on first going to school, and for girls in their teens as indicated by the higher rate of child guidance referral of boys in middle childhood, and of girls from early adolescence onwards; and by the greater vulnerability of teenage girls to parental separation and divorce. Examples from my survey of 1993 adult and child psychiatric referrals included forty-one-year-old Dawn[1] who attributed her recurrent anxiety and panic

attacks to her father, for whom she had always been a daddy's girl, leaving her mother for another woman when Dawn as twelve, after which, although her father lived nearby, Dawn never saw him again. Another instance was thirteen-year-old Sharon, whose parents separated when she was twelve, leaving Sharon bitterly resenting seeing her father drive his new partner's children to school when she had to walk several miles to get there. Otherwise she never saw him, and was so depressed and withdrawn she could scarcely say a word to her referring doctor about what was bothering her.

On the basis of interviews with more forthcoming girls attending a private single-sex school in America, Gilligan (e.g. 1988) concludes that conflicts between attachment and separation exact a considerable toll on teenage girls. Whereas ten- and eleven-year-olds are highly articulate about feeling interconnected with others despite pressure to treat everyone as separate and equal irrespective of variations in their personal circumstances, older girls are more inhibited about voicing this conflict. They 'disavow' themselves (Stern, 1991) and, perhaps because of anxiety for peer group approval (see e.g. Claes, 1992; Frydenberg & Lewis, 1993), they tailor what they say to society's dominant individualistic ethic.

Gilligan (1990) likens teenage girls' betrayal of their previous commitment to interpersonal connexion to Miranda's declaration in *The Tempest* that had she Prospero's power, she would stop the storm he had started given the harm it was doing its shipwrecked victims. Later, by contrast, Miranda announces that 'for a score of kingdoms' she would be prepared to call false play fair. In appropriating Shakespeare's play as emblematic of the moral conflicts facing today's teenagers, however, Gilligan overlooks the patriarchal factors involved. It is arguably the fact that Prospero reacts to Miranda's dawning womanhood by telling her he is not only father of their island family but rightful ruler of all Milan that alerts her to men's power and hence to subordinating her concern for others to its dictates.

British psychoanalysis likewise neglects the place of patriarchy in shaping our psychology. Overlooking the macho resistance by teenagers to its law, Winnicott (e.g. 1984), Bowlby (e.g. 1988), and their followers (e.g. Parkes et al. 1991) attribute the delinquency in which such rebellion is often expressed solely to disrupted early maternal attachment. Meanwhile Kleinian analysts, in keeping with their long-standing disregard for developmental psychology in attending instead to moment-to-moment changes in our paranoid-schizoid and depressive states of mind, treat adolescence as though it were just another

defensive constellation, occurring in adults just as in teenagers (see e.g. Meltzer, 1973; Astor, 1988).

By contrast Moses Laufer and his colleagues (see e.g. Laufer, 1989a, 1989b; Laufer & Laufer, 1991) draw attention to the emergence, eroticisation, and acting out of previously latent object relation scenarios in teenagers' masturbation fantasies (but see Sullivan, 1992), and in their relations with others, including their transference relations with those who seek to treat or counsel them. They also draw attention to their teenage patients' resulting hatred of, and alienation from their sexually maturing bodies.

Laufer (1989b) argues that puberty confronts the teenager with the task of finally differentiating 'oneself as male or female'. He says nothing, however, of the asymmetry of this process. He overlooks the fact that whereas it is often regarded as perfectly normal for girls, at least at first, to regard their dawning womanhood as alien, or to adopt tomboy or other 'masculine' defences against it, boys' hatred of their masculinity is often regarded as *ipso facto* crazy: one young man I saw in therapy was so ashamed of having wanted to be a girl when he was thirteen he could only tell me about it in a letter in which he also told me of his disappointment that the police, who had caught him stealing women's underwear, had not punished him more severely.

Neither the Laufers nor other British psychoanalysts comment on the fact that the acting out of cross-dressing and sado-masochistic or fetishistic fantasy resolutions of earlier conflicts (see e.g. Glasser, 1986) often begins and becomes fixated in adolescence, and more often occurs in boys than girls. Nor do they comment on the fact that boys still masturbate more often than girls (Leitenberg et al., 1993). They also overlook the patriarchal gendering of the fantasies involved – of teenagers' dreams and daydreams (see e.g. Kirkendall & McBride, 1990) – even though evidence on this point has been available to psychoanalysis ever since Anna Freud (1922) reported the sexual excitement she herself derived as a teenager from imagining her father as overlord of a castle torturing her as a noble youth till, just as she was about to die, he nursed her back to health (see also Freud, 1919).

The ramifications of the sexual excitement teenagers derive from casting their parents as rulers and aristocrats (see Freud, 1909) are also forgotten by US and British psychoanalysis's Lacanian critics, even though they adopt Lacan's (e.g. 1955) emphasis on the asymmetrical structuring of what Freud termed the infantile 'castration complex' by 'the law-of-the-father'. Yet its effects, through adolescent restructuring of the priority this complex accords men, are abundantly

evident in the preoccupation of teenage romance with becoming or getting a man.

Male-based teenage romance

Reconstructing infancy, often on the basis of their patients' adolescent reminiscences, psychoanalysts (e.g. Klein, 1956; Chassequet-Smirgel, 1964) describe the child's early experience of the mother as a persecuting, engulfing force against which they defend through flight to the father. Feminist psychologist Dorothy Dinnerstein (1977) argues that dread of the fantasy-ridden mother of infancy drives both sexes to flee her for men's more reality-bound, circumscribed-seeming rule. In common with her psychoanalytic mentors, Dinnerstein overlooks the way this bifuracting process is an effect not only of infancy but also of subsequent developments in which the mother is often yet further defensively repudiated to get away from her sexuality (see e.g. Temperley, 1993) to which arguably girls become particularly alerted by their own teenage sexual maturation.

Yet it is arguably precisely because they speak to this defence that particular novels from the past remain popular today. Examples include *The Brothers Karamozov* in which, unlike Dostoevsky's previous less well-known 1875 novel *The Adolescent,* the young hero's mother is killed off leaving him to single-minded crazed obsession with sexually bettering his father. Another instance is Alain-Fournier's *Le Grand Meaulnes* which depicts sickly fifteen-year-old Francois escaping confinement with his impoverished- childlike-seeming mother Millie through infatuation with the frenzied desire of seventeen year old Augustin for a princess – Yvonne de Galais.

Like their male counterparts, the heroines of classic and popular teenage romance also find themselves sexually through becoming smitten with men and boys, having disposed of the mother as either absent or dead. Examples include Carson McCuller's *Member of the Wedding,* Colette's *Ripening Seed,* and Francoise Sagan's *Bonjour Tristesse.* In other stories, perhaps because the mother is the same sex as the heroine, her repudiation is done more savagely. Classic instances include Charlotte Bronte's *Jane Eyre* from which Mrs Reed is dismissed as cruel, bed-ridden, and forlornly abandoned by her children, leaving Jane to find herself through marriage to Mr Rochester; and *Story of an African Farm* (started, like *From Man to Man* with which I began this article, when Schreiner was in her teens) in which the

heroine quits her ridiculed sex-starved Boer foster mother for a passionate affair with a handsome stranger.

Similar themes also doubtless contribute to the popularity of girls' boarding school stories (see also Auchmuty 1992) on which Virago capitalised in starting its reprint series with Antonia White's *Frost in May*. The mother of White's heroine, Nanda, never appears, having been written off as an invalid, leaving Nanda to be taken by her father to board at a convent school where the nuns are described as either mortally ill, telling stories of brides dying on their wedding day, vetoing all intimacy between the girls (including Nanda's crush on the boy-like Rosario), and as being generally so anti-sex they eventually expel Nanda for writing a novel in which the main female protagonist is kissed by a reckless, exotic foreigner.

Nineteenth century folktales recount similar yarns: of Cinderella saved from her wicked stepmother by Prince Charming; and of the heroines of still successful operas, such as *Eugene Onegin* and *Katya Kabanova,* getting away from a sex-deprived widowed mother or mother-in-law through infatuation with a passing stranger. Pre-teen comics likewise depict maternal figures tyrannising over their daughters who reply with selfless devotion to others, thereby preparing the way for them to be rescued by the heroes of teenage magazines (Walkerdine 1985, 1987). The delights of such male-centred romance, however, can become ossified and sour, as I shall now explain with examples of depression and mania.

Depressive and manic fixation: Clinical cases

Freud (1917) argued that adult depression is an effect of defending against loss of, disillusion in, and hatred of those we love through clinging onto, internalising, and identifying with them as ideal figures such that we then berate ourselves, not them, for disappointing us.

Arguably the sexual maturation of adolescence exacerbates this process. A case in point was Ann whom I first met when she was in her mid-forties. (For further details see Sayers, 1995). Her house was piled high with romantic fiction into which she first fled her mother in her early teens. Ann remembered her mother, when she was a child, as cuddly and warm, as someone Ann used to snuggle up to, and who used to gently lull Ann to sleep with her crooning. With puberty, however, Ann experienced her mother as a monster, as someone who beat her, kept her off school for failing the eleven plus, imprisoned

her, starved her of food, and never bought any fuel, leaving Ann to comfort herself by staying in bed all day, huddling under the blankets, reading endless girl-meets-boy stories, always wary lest her mother come upstairs and kill her, driven crazy, as Ann now realised, by the voices she heard talking to her inside her head.

Ann felt she was as bad as her mother, that that was why the police took them both off in a Black Maria to the police station after her mother wrote to the School Board threatening to murder Ann. Remembering her older sisters talking about 'Our father who works in the War Office in London', and putting this together with the first words of the Lord's Prayer she said every day at primary school, Ann felt she could only escape being entirely engulfed by her mother's craziness by finding her father who had left when Ann was two.

As though she were some latter-day Dick Whittington in search of her fortune, Ann trudged to London. Discovering her father, however, proved a bitter disappointment: he turned out to be ordinary, no different from anyone else. Or Ann *would* have been disappointed had she not instead idealised his new wife, baby son, and most of all his home to which she was soon sent to live. By comparison she felt she was no good, that she was the same 'wicked murderess' her father depicted her mother as being.

It was all her fault, Ann reasoned, that she was raped when she was thirteen by a park attendant who invited her into his hut to shelter from a storm in which she berated herself for neglectfully taking out her baby brother. It was because she was so bad that she wanted to have sex with her rapist, or some other man, again. She was therefore not at all surprised when her father soon ousted her from his home lest she shame him in front of his new mother-in-law to whom he had never acknowledged her existence or the fact of his previous marriage. Deprived of her father, Ann idealised the foster father to whom she was now sent. Then, on being returned to her father's home, she tried to staunch her feeling of 'unbelonging' with binge eating and a succession of boyfriends, berating herself the while for not having the willpower to resist, nor the wherewithal to cure the patients she now nursed. Eventually she broke down.

Nobody, however, either then or subsequently, ever addressed the fixation of her teenage infatuation with men contributing to her breakdown, to her depressed self-loathing for being so overweight, inert, and having none of the energy and life with which she credited the men of her dreams. She continued to suffer bouts of depression and, after her second husband battered one of her daughters, she became

dumb with grief – so weighed down with herself it seemed she could not surface to make room for words. She became suicidal. Her children, she believed, would be better off without her. It was she, she felt, not her husband, who was the no good parent. Eventually she recovered. She began talking out her despair. Briefly she thought of going to college. But she never did. Another man showed up. She became besotted with him, just as in her teens she first flirted with the idea of her father as haven from self-loathing identification with her mother.

The converse of such depression is mania. It too, arguably, often involves male-centred teenage romance. But, whereas depression, at least in cases like Ann, involve self-dividing celebration and repudiation of the men and women respectively with whom one identifies, mania involves identifying wholly with an idealised superego version of the self (see Abraham, 1924), as defence against anxiety regarding the destruction wrought by hatred of those we love (see Klein, 1940). More recently Kleinian analyst, Henri Rey (1977) claims mania involves defending against knowing anything of the bits-and-pieces of love and hate through imagining we have magically cohered them together, symbolised by the male phallus, expressed by one patient in a dream of himself balancing a long pole on his nose.

Arguably this same defence also contributes to the fixation of teenage male romance – in girls as well as boys. An example was Kate who I first saw as a psychotherapy patient when she was in her late thirties. Like many others she traced her symptoms to adolescence. She came to therapy burdened by tension and irritability with her husband and children which she linked to her experience of responding with anorexia to her mother leaving her, when she was sixteen, an only child alone with her father.

It subsequently transpired in therapy, particularly acutely at times of anticipated holiday breaks, that Kate felt her mother had never wanted her, that she had never held Kate close, and that she particularly hated Kate when Kate began to become sexually mature. Kate described her mother, as though she were the wicked stepmother in *Snow White,* looking in the mirror and then enviously turning on Kate as a teenager with 'laser beam' loathing. It made Kate conscious of, and allergic to her mother's sexuality, to her bodily 'thereness'. Kate hated her. She dreamt of stabbing her.

In keeping with the male power symbolised by the phallic imagery of her dream, Kate looked to her father to rescue her just as he had when her mother put soap up her rectum to make her shit as a toddler.

But now she was becoming sexually mature her father kept his distance. He neither sided with Kate nor let her in on his side in his rows with her mother. Kate now experienced their togetherness sexually – whether fighting, or going off together to the hospital where her mother was treated for depression. Kate felt painfully excluded by her parents leaving her to stay with her grandmother whom she was sure hated her.

For fear of becoming depressed like her mother, however, she negated any misery such exclusion might have awoken in her by instead cultivating an image of herself, modelled on her father, as superbly detached and self-sufficient. She went off on long country walks alone with her dog. At school she energetically strove to be top of the class: 'I knew to excel as a child was a way of surviving'. In keeping with our culture's gendered Cartesian divide of mind and body (see Bordo, 1993), she declared her intellectual 'cut and thrust' competitiveness 'the male thing'.

Unlike the depressed Ann she was full of determination – and of words. She became a master of them. She used them, she said, to hurt others – to take revenge on children who used to chant 'Fatty' at her in the playground. She complained however that her teenage dedication to being the cleverest of the clever and 'the thinnest of the thin' also made her 'stick out like a sore thumb'.

Nevertheless, her exhibitionistic triumph of the will persisted. Omnipotently she denied she needed anything, least of all the food with which her mother fobbed her off as a child as substitute for the emotional and physical closeness she felt unable to provide. She sought to become the straight-up-and-down figure of her 1960s Twiggy teenage years, an ideal man, better than her father, someone who, unlike him, might succeed in seducing her mother back home.

Meanwhile she made the men in her life the repositories of her manically denied, split off feminine-seeming neediness. Unlike Anna Freud who as a teenager, as we have seen, imagined herself being tortured and then rescued by an overlord, Kate imagined herself as patriarchy – as the one in control. She remembered exciting herself as a teenager with the idea of watching a man being beaten and then saving him, thereby arousing every ounce of his desire.

She chose 'lame ducks' for her boyfriends. None, she said, ever swept her off her feet: she was always in charge. It was she, not them, who called the tune. She bedded her first man, just after her mother left home, when she was sixteen. He was ten years older:

> He was very serious about me, much more serious than I was about him. I left him for a light-hearted affair. He tried to commit suicide. He asked

me to see him again. I didn't feel I couldn't. So I saw him. And then we had the crash: he died. I didn't. I felt so guilty afterwards. I wanted out of the relationship. I felt I was destined to live, him to die. I felt so guilty – my egocentrism.

She felt she had willed his death in the car accident that killed him, just as Gwendolen Harleth in George Eliot's *Daniel Deronda* feels she wills the drowning of the man she marries to get away from the poverty of her mother's home. It was fixation to this self-same grandiose identification with the power socially accorded men that Kate had deployed since she was a teenager to get away from her mother's sexuality and depression that brought her into therapy in her thirties: namely the stress of sustaining her romantic teenage image of herself, now equated with her oldest son, as superman.

Conclusion: Therapy and politics

'Hysterics' Freud once famously remarked, 'suffer mainly from reminiscences' (Freud & Breuer, 1893). Or, more accurately, we suffer from the defences which, for all their adaptive promise, rigidify us in the past. Freud himself focussed on the damage done by repression of infantile memory into the unconscious such that it can then only be expressed in backward-looking, imagined, neurotic, and symbolic – including patriarchal – form. In this article, by contrast, I have focussed not on repressive regression to infantile unconscious fantasy but on depressive and manic fixation of consciously remembered teenage male romance.

I began with the example of Proust's narrator in *Remembrance of Things Past.* Faced with dread of the mental and physical debility of old age, and the oblivion of habit and death, he devotes himself to defeating the transience of the present by driving pillars into the past – 'stilts ... giants plunged into the years' (Proust 1927: 1107). Delving into the pile of memories, he returns to his teenage strategy of awakening and maintaining his desire by dwelling on the elusiveness of women and women-like men whose physical presence his mysogyny portrays as always disappointing – as variously fickle, besmirched by lesbianism, feckless upstarts, or fatuous wits (in the case of Odette, Albertine, Charles Morel, and the Duchess of Guermantes respectively). He feels he can only sustain his desire by never possessing those he desires except through master-minding their recovery as creation of his idealising memory.

The resulting mix of male-centred sexual excitement and disillusion, which Edmund Wilson (1931) termed Proust's masochism, is not confined to fiction. It is also the effect, as I have sought to demonstrate, of everyday depressive and manic fixation to teenage romance.

Psychoanalysis can only ameliorate the ill-effects of such adolescent stagnation by exposing and confronting the defences involved as they manifest themselves in the here-and-now transference and counter-transference relation of patient and therapist. In Ann's case this would include confronting her depressive assumption that, just like the men she romanticised since her teens, I too criticised her. In Kate's case it involved attending to Kate's teenage male idealisation of herself as played out in her always being late for our appointments thereby putting me in the feminine-seeming position of being dependent on, and waiting for her to come.

Psychic change depends on attending to the present operation of the psychological defences involved so as to mitigate and temper the extreme figures – male and female, loved and hated, idealised and reviled – with which they populate our inner and outer world. Beyond this, however, psychic change also depends on recognizing and challenging the continuing inequalities between the sexes reinforcing such splitting. And this, of course, is a matter not so much of therapy but politics. Hence feminism's struggle to bring about a society in which women and men can realise the ideals of youth (theorised in gender-blind terms by non-psychoanalytic psychologists Piaget 1932, and Kohlberg 1981) no longer so prey to being crazed by depressive or manic fixation to teenage male romance.

Endnote

1. In the interests of confidentiality I have, of course, changed all identifying details, including names, of the clinical cases mentioned in this article.

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THE CONTRIBUTION OF ANALYTIC PSYCHOTHERAPEUTIC UNDERSTANDING TO THE DEVELOPMENT OF COLLABORATION IN THE HELPING SERVICES

SALLY HORNBY

Introduction

Much has been written about the need for collaboration in the helping services and the lack of it. Structures and procedures have been designed to foster it. Practitioners of all professions believe in it. Yet it is still difficult to achieve. In this paper I hope to show how the understanding of unconscious processes deriving from analytic psychology throws light on why this should be. My focus is on human relationships; individual, group and institutional. I shall draw on material from my book, *Collaborative Care: Interprofessional, Interagency and Interpersonal*, which is written for all who work at ground level in the helping services and which assumes no previous analytic knowledge. This paper is written for those who whilst practising as analytic psychotherapists are concerned for, whether or not involved in, the application of psychotherapeutic understanding to wider fields of helping.

My interest in collaboration

Having spent much of my time in settings where I worked both as a social worker and a psychotherapist, with individuals, groups and families, I have always been interested in the combination of skills from different disciplines. It was at the Paddington (now Parkside) Centre for Psychotherapy that I realised the importance of psychotherapeutic understanding applied to the problems of collaboration in the helping services. Between 1973 and 1976 the staff at the Centre ran a series of courses, each consisting of 30 halfday-a-week sessions, on the integration of psychotherapeutic skills into the practice of those with a helping role. This was the theme of the large group session, whilst the small groups, which took up the other half of the afternoon, had more specific themes. The course was open to a wide range of helpers

as well as health and social services practitioners, and included voluntary agency and community workers, teachers, clergymen and police, but was limited to those who worked in the area round the Centre. It was this feature which provided an unexpected dimension to the course. After sufficient trust had been established between the participants, discussions sometimes turned from the subject of working with the user to the difficulties encountered in working with each other. This alerted me to the fact that goodwill alone did not bring about good enough collaboration. There were underlying problems with psychological roots.

The term 'user' is becoming commonplace and I adopt it because, in the process of writing about the area of work which is common to all in the helping services, that of relating to the person who needs help and working with others who are also providing it, I have found the need for a common language, not to replace professional terminology but for use when discussing collaborative work. Language can be divisive and, although here addressing psychotherapists with whom I share a professional vocabulary, because I am talking about working in the helping services overall I am still using the language of collaboration. I explain this at the beginning, in an attempt to forestall negative reactions. It requires some considerable adjustment to adopt terms which do not belong to one's own professional vocabulary, but in order to cross boundaries, which is what collaboration is all about, I have found it essential.

On one of the courses just described, in a large group meeting, the following exchange took place. It is written up from notes which I kept after the meetings:

> Discussion had focussed on the difficulties of helping disorganised families with multiple problems.
> Teacher: As I've said before, when the parents of my pupils are being helped by other people, I find it odd that so often they never make contact with me. Why don't they?
> Health Visitor: When you speak about 'my pupils and their parents', I keep on thinking 'these are *my* families'.
> Social Worker: But they are *my* clients.
> GP: (half joking, but with feeling) Not to be outdone, I must establish that they are *my* patients'.
> Area social worker: I get angry with hospital social workers who speak about 'my patients' when they are talking with doctors. Why don't they say 'my clients'? After all they are social workers.
> Hospital Social Worker: Sometimes I feel I'm more in tune with doctors than I am with are social workers.
> Teacher: We were discussing disorganised families not disorganised social

workers! What I wanted to know was who should take responsibility for contacting other workers.
The discussion came back to the families with problems and the responsibilities of practitioners. Some criticism was directed at social workers in the local area office.
Area Social Worker (defensively): We don't always get the support we could wish, particularly from GPs.
Health Visitor: You can't get out of it by blaming someone else.
Social Worker: (angrily) Well health visitors can visit and be seen as kind and helpful, and the social workers get turned into the 'baddies' because they have the power to take children away. You hide behind us.
Another Social Worker: Often in this group you have been hinting that we were not doing our job properly. You seem to think you know it all.
It was true that this health visitor had taken a didactic attitude.
Health Visitor: (after a short pause, and in an unexpectedly distressed voice) I don't know it all. I wish I did. Sometimes I feel I am no help at all to the families I work with.
(silence)
Social Worker: I feel just the same.
A wave of fellow-feeling swept the group. The tone changed completely. Suddenly people were free to express doubts about their work. They spoke of cases which had gone from bad to worse or certainly had shown no signs of improvement.
Someone: Often I go home at the end of the day, wondering why I do this job. It all seems so hopeless.
Another: There are so many problems that are beyond us to put right.
(long silence)
The Health Visitor who had sparked off the exchange: I feel better having said what I did, because I realise that I'm not the only one, and I do know that sometimes I can make a difference to a family.
Social Worker: I know you can, from some of the cases of yours that have come my way.
Someone: Then perhaps we should look at what it is possible for us to do - given that we work in an inner city area and we're none of us superhuman.
Another: And perhaps we should see what we can learn from them here.
One of the Centre Workers: I wonder if you had the idea that we at the Centre were setting ourselves up and thought we 'knew it all'.
(laughter)

Because of the large group setting, the above exchange shows psychodynamic processes manifesting in the raw; usually their expression is covert, politely phrased in professional language or acted out in accepted professional behaviour.

You will have noticed processes going on in this discussion that are similar to those found in both group and individual psychotherapy. However here, defence mechanisms are operating at the professional,

agency and role boundaries which coincide with the personal boundary of the individual.

In addition to psychodynamic theories I have found systems theory essential to understanding collaboration, and I have therefore made use of work coming out of the Tavistock Institute of Human Relations, in particular that of Eric Miller, Gordon Lawrence and Isabel Menzies Lyth, especially the latter's classic paper on 'The functioning of social systems as a defence against anxiety' (1959).

An open system is an entity with an internal organisation designed to sustain itself and carry out its functions, with an external boundary which separates it from its environment and other systems, across which intake, output and relationships can take place. All living systems have potential for growth, stimulated by internal activity, external influences and feedback, the latter aiding self-evaluation and planning for change. A system may contain sub-systems and it may form a sub-system of a supra-system. The combination of this theory with psychodynamic theories offers the possibility of applying what has been learnt in individual psychotherapy about the individual human system to other human systems, such as groups and institutions. However, the way in which this understanding is used is different, and further knowledge of group dynamics and organisational systems, is necessary.

As a result of these courses, when I retired from the Paddington Centre I decided to study the psychodynamics of collaboration by setting up as a freelance consultant, limiting my work to a specific locality so that I could continue to study the transboundary relationships of workers in agencies covering the same area. As well as becoming involved in, and in some instances promoting, various interdisciplinary and interagency groups, I also acted as consultant to several local voluntary agencies. This led me to a much greater appreciation of the amount and quality of work in the helping field done by people without a professional training. I realised what a restricted view I had previously held and I was impelled to re-evaluate the place of practitioners in general and psychotherapists in particular, within the whole spectrum of helping.

So much for the background to the work I did over ten years in the field of collaboration.

An analytic approach to collaborative problems

To go back to the material given, participants in the group felt threatened by isolation and had a need to establish some shared identity.

Sub-groups are seen to emerge; at first based on professional identification then, in the exchange between the area and hospital social workers, on agency identification. The need to establish a shared identity, was followed by the need to give it a satisfactory image, and it was perhaps this that contributed to the hospital social workers aligning themselves with doctors in their agency. In a group of practitioners and other helpers facing inner city problems the potential sense of inadequacy is likely to be great, and the wish to find a way to defend against experiencing its defeating and depressing effect correspondingly strong. Discussion of the needs of disorganised families touched off considerable uncertainty-in-role and, to deal with feelings of inadequacy, defences were brought into action. The maladaptive function of these defences is clearly seen, in that it rendered collaborative relationships impossible.

Like most defences, although they bring some sense of security, they work against the development of a satisfying reality based self-image, which here would include ability to collaborate. To be effective in one's job and to help others are two strong personal needs which seek satisfaction through belonging to a helping profession. Identification with the image of an effective helper can be crucial to maintaining a good-enough self-image. Thus, at all costs, the professional image must be protected. It was only in that long and heavy silence in which I felt that the depressive position had been reached, that the feared calamity, that of being identified with total uselessness, was faced, thus rendering defences redundant. Then the shared aim could manifest in a shared identity: that of the inner-city faceworker up against incredible odds. 'Faceworker' is the comprehensive term I use for all those who are working at the interface with the user, whether professionals or others; they are the human face of the helping services. Only when defences were discarded could there be a realistic appraisal of the problems these faceworkers were up against, of the helping skills they needed and the value to them of the course.

The analytic concepts which have contributed most to my work in the field of collaboration are: primary narcissism, projective identification, anxiety, coping and defence mechanisms, the depressive position, the shadow and the archetypal image. I use these not to look at the problems of the individual but of the individual-in-role when he or she is working across professional, agency and role boundaries. I have found this distinction essential in all consultancy concerned with collaboration.

Identity

Fundamental to my understanding of the problems of collaboration is the concept of identity. Widely used, in reference to race, religion and nationality, it is equally relevant in the field of collaborative care to all the faceworkers involved in helping. It is an interesting word having two meanings which, at first sight, seem incompatible: that of sameness, sharing common qualities, being identical; and that of differentiation, uniqueness, possessing individuality. The identity of a group is based on a shared factor which binds its members together, and here the quality of sameness is apparent; however the common denominator distinguishes it from all other groups, and provides it with a unique identity. Individual identity is the uniqueness of the person. A sense-of-identity is built up not only from the person's individual identity but also from his or her identification with groups; for instance, the family, work-place, ethnic or religious group, professional body, and with roles such as that of parent, socialite, sportsman, helper, practitioner, psychotherapist.

The root of a sense-of-identity, the foundation of the existential entity to which we ascribe the pronoun 'I' is, as I see it, primary narcissism. This self-image is very early evaluated in terms of 'good' and 'bad'. Throughout the rest of life, we seem to be striving to maintain a 'good-enough' self-image.

Individual identity is made up of a core identity deriving from physical consitution and inborn tendencies and abilities, and from a core personality which is developed from emotional and relational patterns and ego structure, laid down very early in life. This is hard to modify except through deep analytic work. Overlaying this foundation, there is an extended identity which is more modifiable, developed as a result of maturation, later developments in personality, meaningful relationships, cultural influences, education and external events, together with the acquisition of personal, social and working skills, new roles and membership of new groups. The weaker the core identity the more a person relies, for maintaining individual identity, on role and group identifications. Every one relies on them to some extent. They enhance our identity. In fact, except in the most personalised relationships, we are always functioning in some kind of a role, for which we have developed appropriate skills, whether those of ordinary life or of specialised activities.

We all have a number of part-person identities based on roles and, because we are often so identified with the role we are functioning in

at any one time, it may feel like the whole of oneself. Who am I when stripped of my roles and group identifications? It is a deep philosophical question, as well as a psychological one. When people suffer an identity crisis it is often as a result of the loss of an important role, such as that of raising a family or holding a job, or loss of an important group identification, say, with their family, professional colleagues, cultural background or neighbourhood environment. The primary narcissism of the inner world can be severely affected by blows to a person's identity in the outer world. Conversely, it can be positively influenced through the development of satisfying roles and group identifications.

Role

Before continuing with this line of thought, I find it necessary to look more closely at the different kinds of role. What I term the *modal role* is a class of relational role, which embodies complementary patterns of role-relationship such as active/passive, dominant/submissive, responsible/dependent, giving/taking. They may be operating between strangers as, for instance, between two people trying to board a bus at rush hour; they are invariably present in personal relationships. Modal roles are archetypal patterns of relationship which become personalised when manifested by individuals. Archetypal images can be polarised to their extremes, for instance the good and the bad mother image, or they can be brought together and integrated in a more mature way. The good and bad aspects of the archetypal mother are usually modified by her personalisation in the human mother, and the extremes brought closer together and combined in the experience of the actual mother figure. Similarly archetypal modal role-relationships can take an extreme or a convergent form, whether in political systems, in marriages, parent-child relationships, in the relationship between faceworker and user or between one faceworker and another. In whatever sphere we look, it seems to be a task for humankind, in the process of its maturation, to make these modal role-relationships convergent.

Although manifest, modal roles are only ever known subjectively. The way in which they are experienced internally, or by the other person in the relationship, or how they are perceived by an uninvolved observer, may be very different. For example a man in the character

role of a father may be perceived by a friend as dominant, experienced by his son as a tyrant, whilst he feels himself to be weak.

The second type of role important to collaboration is the *character role*. It confers a descriptive title on the person who carries it, for instance that of father and son, user and faceworker, carer, practitioner, psychotherapist etc. These are composite roles, incorporating both functional and relational roles: that is to say, what the person in role does and how he or she relates. The *archetypal role* is the third type relevant to helping. It is based on an archetypal image; for instance that of the healer, sometimes carried by the doctor, the ministering Florence Nightingale image by the nurse, the image of authority or of the parent, whether in a positive or negative aspect, carried at times by most practitioners.

Modal, character and archetypal roles are interwoven and are all crucial in the role-relationships of faceworkers with the user and with each other. The three main forms of collaboration, in which these role-relationships take place, I define as: primary, that between user and faceworker; secondary, that between faceworkers in the absence of the user; and participatory, that between user and faceworkers together.

Role definition

How are role-relationships determined? The archetypal role may be identified with unconsciously, when it is likely to lead to inflation: the state of a blown up self-image resulting from the ego identifying itself with the archetypal image. It can also be projected on to one person by another. In the helping services, users frequently project the archetype of the healer on to doctors, investing them with exceptional wisdom and authority. If consciously made use of by the practitioner, this projection can sometimes be of help to the user. Character and modal roles may be designated consciously, but are often assumed unconsciously because they have been built into systems of which they have become an unquestioned feature. Since modal role-relationships are complementary, change in one party will inevitably require change in the other. The most obvious example of this at the moment is the change in the role-relationships of women and men. When working in individual psychotherapy, I used to find it difficult at times to distinguish between society's problems of role-definition and the woman's own personal problems, and often they were inextricably

mixed. In the field of collaborative care, relationships between users and practitioners and between the professions themselves are also currently in a state of flux.

Who it is who determines modal roles depends very much on who is in the power-position. Persons or groups who hold this position, almost inevitably define the roles of others in relation to themselves in such a way as to build up and maintain their own sense-of-identity. In the helping services, modal roles are incorporated in the character roles of the patient, client, resident, inmate, etc. The names show how the roles have been defined in terms of the profession or the institution providing help, rather than the person needing help. Current movements for user-participation and the rights of carers, are evidence of a shift in the power of role-definition. These groups, as a result of their efforts to organise themselves and of changes in societal values, are taking a greater part in defining their own roles within the helping scene as a whole. It is in some respects comparable to the change in power positions within a family, when adolescents are seeking to define their own identity for themselves.

Aims of helping

The way in which roles are determined depends partly on the attitudes and values of those holding power positions, partly on social, political and moral values. There is probably general agreement that the overall aim of the helping services is the well-being of the user, but this comprehensive aim must be interpreted. I interpret it as: maximum self-responsibility, optimum quality of life, personal and social integration. I call this 'the triple aim of helping'. In the help we offer to achieve these aims, role definitions and group identifications are of considerable importance. To give an example:

> In a centre run by a local association of MIND, which provided a shop of new and secondhand things, a coffee bar and a number of leisure groups and classes, referrals were sometimes taken from the psychiatric services. On crossing the threshold of the Centre those referred ceased to be users and became a member of a group or class, or a volunteer who might serve in the shop or coffee bar, sort clothes or make new things for sale. Filling this new role, they were no longer a receiver but a giver, no longer a poor thing but a worker, someone who did something useful; they belonged to a group with a meaningful purpose. Through identification with the group, they could share in its satisfactions, for instance, the excitement when the weekly takings were the highest ever. Their sense-

of-identity was radically changed through the new role they were given and the group with which they had become identified. Their mental health improved. Some also needed psychotherapy or counselling, but not all.

I used to think that some form of psychotherapy based on analytic methods was the treatment of choice for most people with psychological problems. Since acting as consultant to various voluntary and community agencies I have shifted my position. This is in no way to devalue analytic psychotherapy in all its forms, but to place it in the context of helping overall. I see its methods of working directly with the core personality as one important method of helping, particularly for those who wish for insight; but it takes its place along with other methods designed to influence primary narcissism by improving the user's sense-of-identity through the development of effective roles and meaningful group identifications.

If this is seen as an objective in helping, then the growth of self-help groups with the user in the role of a mutual-helper becomes of great importance. Potentially almost all users are self-helpers and many of them are now taking steps to define themselves in this role. However the power of role-definition is still largely in the hands of practitioners. Analytic psychotherapy is based on involvement of the user in a participatory role. The value of this has often been ignored by other helping professions, partly for historical and social reasons but also, I suspect, because the role-defining power of professionals has sometimes been used to serve their own narcissistic needs: to enhance the practitioner's self-image rather than that of the user. I see this as an institutionalised form of projective defence.

A health visitor provided me with an example of this, when she said: 'I used to think that if I went into a home and found the baby crying and I picked it up and quietened it, I had done a good job. Now I realise that quite likely I did a bad job, making the mother feel deskilled while I felt wonderfully competent.' The modal role-relationship of competence/incompetence had been carried to its extremes rather than being brought into balance. To do the latter the practitioner must have skill in developing a working alliance and encouraging the user into a participatory role.

Practitioners coping and defence mechanisms

The need for a secure and satisfying identity in the practitioner is a motivating force which can work out in both creative and destructive

ways. We saw in the group discussion I described earlier, how the need for security in the role of faceworker led to the adoption of defence mechanisms. I shall now describe some of those which are most commonly used by practitioners in the helping services.

Sometimes defence mechanisms have developed out of coping mechanisms that are necessary to good practice. For example, the suppression of feeling responses may be essential when a practitioner's emotional reactions are strong and their expression would be inappropriate, or when the practical action needed in an emergency demands total attention. It is only later that the suppressed emotions can safely be experienced. Practitioners have their own personal coping mechanisms but also make use of those belonging to their profession or agency. Because groups are systems made up of people, they are able to incorporate in their structure the coping mechanisms used by individuals. These may become institutionalised in a standard form, and are then available to individuals to adopt as their own. Coping mechanisms are necessary for the support of practitioners, their purpose being to foster efficiency in the fulfilment of tasks. However, they are only really necessary in moments of stress.

Coping mechanisms work against good practice when they become converted into defence mechanisms for use at other times, operating automatically and largely unconsciously. Then the suppression of a feeling response is used for the purpose of avoiding the anxiety which arises from inability to cope with emotions adequately, whether the user's or the practitioner's own. A *fragmenting defence* is illustrated in the restriction by a GP of his or her viewing-point to include only the physical aspects of a presenting trouble when, in order to make a proper diagnosis, they need to be open to their patient's emotional state. A user's situation can easily touch off in the faceworker reactions of distress, inadequacy or hostility which may lead to role-insecurity. This frightening experience can be warded off by the defence mechanism described above, which I term *perceptual fragmentation*, because it inevitably fragments the user by focussing on only one aspect of the whole person. A similar defence is what I term *procedural fragmentation*. In this, tasks are so organised that the practitioner has only fragmentary contact with any particular user for the purpose of carrying out a specific function, and therefore need never relate to them as a whole person. Both these defences militate against one of the three aims of helping, that of personal integration.

Projective defences are common in collaborative situations. In individual relationships they make use of the personal boundary, but here

they operate at the personal boundary where it is co-terminous with one or more group boundaries, usually those of profession and agency, but also others, such as hierarchic position, ideology or school of thought. There are three main types of projective defence, displacement and what I have termed 'downing' and 'drowning'. I give descriptive names to the various defence mechanisms because I think it facilitates their recognition by practitioners. *Displacement* uses a group boundary for removing hostility from inside the group where it belongs, by projecting it on to an object beyond the boundary. To give an example:

> In a small meeting of mental health practitioners coming from the same area, a social worker said she thought that the local drop-in centre, which was run by one practitioner and a number of volunteers, was more helpful than professional psychiatric help for certain types of disturbed people. A psychiatrist agreed and went on to describe how, in trying to engage the help of the local community, he sometimes had contact with employers. It emerged that he did not always first obtain the consent of his patient, and he was criticised for this, the suggestion being made that he was over-involved. Immediately another psychiatrist from the same hospital turned the discussion back to volunteers, saying that he supervised a group of them in another mental health project and, although he admired their enthusiasm, he questioned their motivation and thought many of them were over-involved.

The displacement is obvious – the negative emotions of the second psychiatrist being displaced on to other workers who were not present. What I have termed a *downing defence* was also in operation. The informal agency was 'downed' in order that, on the principle of a see-saw, the psychiatric department was 'upped'. The adoption of these defences prevented the development of a useful discussion on confidentiality and the need to obtain the user's consent, an exploration which might have caused anxiety but could have clarified attitudes and furthered the development of good practice for all members of the group. Although the psychiatrist's comments did not directly damage the volunteers referred to, his comments may have damaged the project's image.

The *drowning defence* differs from the downing defence, in that it involves the process of projective identification and has a directly damaging effect on individual workers. I have named it this because the picture conjured up in my mind the first time I observed this defence was of a person keeping his head above water by pushing another person under.

> On one occasion, a team leader from an overstretched area social work office and the head worker of a counselling agency were trying to sort

out why referrals did not flow easily from the former to the latter agency which had more time available. The team leader complained that she and her workers as well as having to provide a long report for the counselling agency were often subjected to further questioning over the phone. Frequently this left them not only frustrated, but feeling deeply inferior, useless and hopeless. In the course of discussion, it became clear that this intensive questioning resulted from the counselling agency workers having doubts about their own ability to cope adequately with the referred case. They had not admitted this to themselves and, through a process of projective identification, had got rid of this feeling of inadequacy on to the area social workers. The latter, who were also not very confident in their ability to help, seemed to have introjected this unwanted quality and accepted it as their own.

Withdrawal defences are common and include denial of reality, omipotence and withdrawal behind professional or agency boundaries.

A teacher who specialised in reading difficulties said in a group discussion: 'Many of the parents of my pupils need help but I have not the time to see them, so they have to go without'. When it was suggested that there were other people attached to the school and also other agencies which might help the parents, she changed the subject.

On another occasion, a consultant psychiatrist said: 'I have trained as both an individual and group analyst so, when it comes to looking at family therapy, I have to choose between one of three positions: either, because of the qualifications I already have, I can do it; or, I have not got the skills but they are not worth having any way, because family therapy is useless, the "sour grapes syndrome"; or, I have not got the skills, so I must either acquire them or be able to assess when family therapy would be useful and be ready to refer on'.

The conscious thought processes described here, frequently manifest at the unconscious level as a *sour grapes defence*, with envy at its root. Lack of time, given as an excuse in the previous example, is a fact but the phrase is often used as a euphemism for lack of skill, a cover for unrecognised envy and rivalry, inevitably present on occasion in every practitioner. The non-event of non-referral is an extensive and damaging hidden aspect of poor collaboration.

Role-care

Rivalry is inevitable. In psychotherapy we see it as a potential source of both creative and destructive activity. In the field of collaborative help, rivalry problems can arise between individuals as such, but more often they are between individuals in-role, when the role itself is the focus because of its identity-enhancing power. Concern for the role,

what I term 'role-care', whether that of a practitioner, profession or agency, can take various forms, each with a positive and negative aspect. Role-maintenance in its positive aspect ensures that the role is properly defined and that skills and resources are available to fulfil it, but it can be debased into status-maintenance. Role-promotion, publicising an accurate image, can be inflated into oversell. Role-development, increasing skills and fields of operation, can expand into empire-building. Role-protection, ensuring that the role is not devalued, eroded or encroached upon, can shrink into protectionism.

The positive aspects of role-care result in a defined *sectional position*. In this, practitioners are clear about their own role and that of their profession and agency; what is specific solely to them and what may also be within the province of others. The proper activities of a practitioner, profession or agency take on a negative quality as soon as the primary beneficiary ceases to be the user and becomes the member of the profession or staff of the agency. These defensive processes lead to *separatism*, the establishment of rigidly fixed boundaries which often lead to disputes over territory. The language appropriate to their description is reminiscent of international politics. On one occasion, some practitioners were speaking about a project recently set up by their agency. They described it as 'providing a much needed service'; they went on to discuss a project proposed by another agency, and referred to it as 'empire-building'. I do not know, but I suspect that practitioners in the other agency would have reversed the appellations.

The institutional input

In the last part of my paper I want to look at the ways in which professions and agencies can foster good collaborative relationships and the contribution which psychotherapeutic understanding can make to this.

The reduction of the need for defensive processes is the first essential. In agencies this means reducing stress in faceworkers by providing structures in which they can share and work on their anxieties. Also the provision of structures through which internal difficulties can be contained and worked on within the agency, so that hostility need not be displaced outside the agency boundary.

Hierarchic boundaries within an agency are also available for such displacement. A social services deputy director once said to me, and

only half-jokingly, that he thought one of his functions was to be the object of bad feeling for the teams working at ground level, because this enabled them to be on better terms with workers in other agencies. The implication was that bad feeling had to go somewhere. This was clearly a false solution, trust in management being an essential factor in producing good work at ground level. The alternative is to develop an agency ethos in which open communication is encouraged and feelings relevant to the job can be expressed in the right quarters.

The professions have an obligation to look at their institutionalised defences, their ethos and models of role-relationship, all of which are imparted, largely unconsciously, along with their training. They need to consider what changes should be made in their training for the sake of good collaboration between their members and users, carers, volunteers, non-professional and professional workers. Also between practitioners in the helping professions and those qualified in management.

Both professions and agencies can make a contribution to collaboration in providing a secure working base for their practitioners, thus reducing role insecurity and the need for defensiveness. This means defining the profession's or agency's identity in respect of its functions, relationships and priorities and clarifying the roles of its practitioners.

Whatever the system, the structure of identity seems to be based on a similar pattern. There is a *core identity* which, in a group system, is carried by every member. In addition there is an *extended identity* belonging to the group as a whole, but with different parts of it belonging to certain members only. Although professional identity includes many other things such as accepted patterns of behaviour and ways of relating, it is rooted in a *core province*, which is the sphere of skilled practice in which all its members are qualified. Besides this core each profession has an *extended province*, based on specialisations either in particular methods of help, or in different fields of help, or in practice specific to particular settings.

The profile of each individual practitioner in a profession is defined according to two parameters based on competence: one, the sphere of competence, which may be enlarged through development in the profession's extended section; the other, the level of competence attained in each area of their practice. Some practitioners may have a large sphere of competence at an average level, others may focus on attaining a high level of competence in the area of their profession's core skills. The practitioner profile is specific to each member.

Whether in the individual, group or institutional system, identity is partly defined by the system itself, partly by other systems the bound-

aries of which impinge on it. I realised, when involved in the preparation of directories of mental health services for two particular localities, how hard it was for agencies which were unclear about their identity to prepare their entry for publication. The effort to do so brought out subtle differences between practitioners, in their helping philosophy, methods and priorities. These could be muzzed over until it was necessary to go into print. The strong feelings then aroused demonstrated the close link between group identity and each individual's sense-of-identity. In addition, there was often concern about the entries of other agencies, because of the overlap of boundaries.

Boundary overlaps In the helping services boundary overlaps, whether of professions, agencies or roles, are inevitable and have positive value in providing choice and flexibility; they can also have negative effects by providing fertile ground for rivalry and cross-projections. To take '*relational work*', a comprehensive term I use to cover befriending, counselling, psychotherapy and analysis, this can be within the province of all helping professions, thus creating large overlaps between nurses, doctors, social workers, psychologists and others. There are also overlaps between, on the one hand, certain members of these professions who have developed relational skills to a high level, and on the other, professionally trained psychotherapists and analysts.

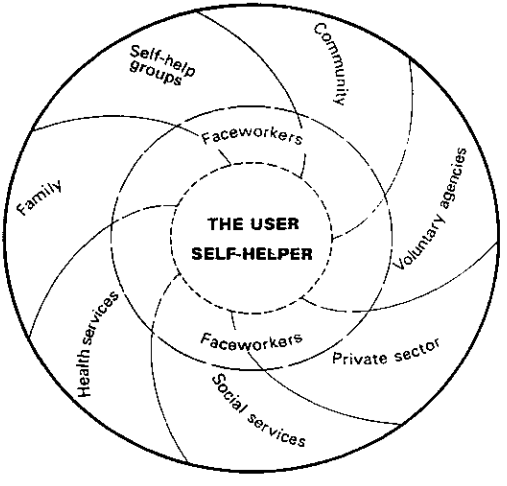
Boundary problems are inevitable, whether at organisational or practitioner level. To describe them words spring to mind such as territory, no-man's land, frontiers, protectionism, separatism, empire-building. These overlay archetypal images of greed: in one discussion, reference was made to 'that agency with its spreading tentacles'. Food is essential for psychic as well as physical life. I think that, unless the self-image is exceptionally strong, a person's psyche always needs to be nourished through group and role identifications. If these become fused with the individual's sense-of-identity, unconscious forces may produce intense and primitive emotions which then infiltrate the rational approach to boundary problems.

> In one discussion in a group of mental health workers serving a particular locality, a presentation of their agency was given by practitioners from a recently opened day hospital. The response by the group was negative, although these same workers and their agencies had all campaigned strongly for the establishment of this new day hospital. Finally a practitioner from one of the social services day centres voiced the fear that an important source of referral would dry up, and another added: 'Our centre might disappear'. Death through starvation. Once this fantasy was verbalised, it freed the group for a more realistic discussion which estab-

lished beyond doubt that local need would continue to outstrip local provision of psychiatric day care, and that variety in setting was of value. However, the other great fear, that of abuse of power, was not totally dissipated. The anxiety was based on a more realistic fear that the hospital psychiatrists might, in the selection of cases, give preference to their own day hospital and the social services day centres would be marginalised. I think it is a fact that those in a power-position may easily, and often unintentionally, subtly abuse it for their own personal, role, professional or agency ends.

The user-centred model

I learnt from such discussions how easy it is for practitioners to become role, agency or profession centred. I found that in addition to uncovering fantasies and fears which underlie defence mechanisms, it was also necessary for practitioners to be reminded of the purpose for which their agencies had been set up, and for which they had been trained. The common denominator which defined the identity of the group described above needed to be reaffirmed: quite simply, it was a service to those with mental health problems. This is the basis for a model which puts the user in the centre of his or her helping network.



In this diagram, around the user, who is almost always a self-helper and who may be an individual, a partnership, family or other group,

are the faceworkers who need to collaborate with them, and with each other. They are the human face of the organisations or groups, shown in the outer circle, which provide resources. The following example demonstrates how things can easily go wrong in the absence of adherence to the user-centred model.

> A young man had been referred to a residential therapeutic community by his probation officer. There had been some contact between the latter and the community and a report had been given by the GP. When the three met fortuitously in an interagency meeting and began discussing the case, they each assumed that they were the key worker: the community worker, because she was in a close therapeutic relationship; the probation officer, because he had authority from the court and had also had a close relationship with the young man before he went into the community; the GP, because he had known him since a boy and had carried a father figure role after the boy's father had disappeared. The GP was particularly annoyed because he felt he had been ignored. The young man had visited him occasionally and complained about the community, in particular this worker. The GP, knowing little about the community's methods, had picked up the young man's attitudes and was highly critical of the centre and its workers. He had not contacted them and now said that he thought it was for them to contact him. The community worker attacked in return saying that the GP was encouraging the boy to split his helpers into good and bad figures in a most unhelpful way. The hostility aired, the common cause of trying to help the young man began to manifest itself and led them to work out the role of each faceworker both at this particular time, and over time. This led to appreciation of each other's input and recognition of the GP's continuing relationship which would probably go on long after that of the other two. They were developing into an 'ad hoc' confederate group of practitioners to meet a particular situation.

In such a group, each practitioner needs to have their own viewing-point, based on their professional practice and their agency function. They can then put forward a valid sectional viewpoint concerning the situation under discussion. The combination of the various sectional viewpoints can then produce an integrated plan of action and a clear distribution of tasks.

Confederate groups of this kind should, if possible, include the self-helper and carers. Such groups, whatever their constitution, have no built-in authority structure; they are held together by a common objective and rely on mutual trust for the development of collaborative relationships. In the situation described above it can be seen how, as the workers got to know each other better, they could drop some of their defensiveness and trust began to develop. They could also contribute a useful sectional viewpoint in place of practitioner-centred separatism. Without face-to-face contact, it is extremely difficult to develop

sufficient trust for complex collaborative work, and this is one of the reasons why it is so time consuming. Worse still, time in meetings is often consumed without any increase in mutual understanding or trust. This is why development in the helping professions of an ethos which encourages open communication is so important. It is also why the defence mechanisms and separatism that I have described need to be understood by all practitioners in order that the latter become sensitised to their presence. This is the first step towards dealing with them.

The functioning of a confederate system with its unifying factor based, not on a power structure, but on a common objective shared by semi-autonomous elements, has, I think, a parallel in the individual system of the patient or client in psychotherapy: only with some strong central unifying purpose, such as a wish to function better, a search for insight or for individuation, can the separate interests of parts of the individual's internal world be brought into collaborative relationship with each other and form an integrated whole, greater than its parts.

Conclusion

I hope that I have shown the important contribution that understanding derived from analytic psychotherapy can make to meeting the difficulties of collaboration in the helping services. One further point I wish to make. I am struck very forcibly at the moment by the manifestation of the same root problem in so many different places at the same time. Viewed with the insights of analytic psychotherapy, there seems such a close parallel between the collaborative problems of those working in the helping services and, say, former Yugoslavia, the European Union, the pluralist society in Britain, the whole spectrum of psychotherapy. The common root seems to be the issue of how to maintain identity at the level of the individual and smaller group, whilst also being part of, and identifying with, the larger systems which are essential for the well-being if not the actual survival of the individual.

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THE AFTERMATH OF ADOPTION. TWO CLINICAL CASES

CLAUDIA KRAMER KLICH

The aim of this paper is to explore the experiences particular to those who have been adopted as children by looking at their inner world as adults. This was done by consistent examination of analytic material from adult adoptees who were seen in psychoanalytic psychotherapy for a number of years.

Although varied aspects of their experience were revealed, I will focus here only on the trauma occasioned by a lost mother, on their thoughts and phantasies about the effect of adoption in their own life and the impingement of adoption on their sense of belonging as perceived by the adoptees; and on the interference by adoption in the establishment of object relations as perceived by myself, their therapist. The nub of my work was to explore in the transference their experience or perception of me as an object (Brenman Pick, 1992).

'When we use such phrases as "adopted at birth" or "adopted at a young age" we by-pass the horror of being torn away from one's natural mother, of waiting as a case number until a couple arrive and takes the baby or child away. Experience in the consulting room tells us that such events leave an emotional scar, although the individual may be unaware of its origin. In Klein's view early relations with the individual's primary object are shaped by projection and introjection which in turn form a major part of the individual's inner world, and these relations emerge in all relationships with other people (Symington, 1990).

In writing this paper I worked retrospectively; I started with the consequences: adoptees believe that they are second best for their adopted families and are anyway bad, which is why they were originally rejected. Although it is clear that many variables play a part in determining how a child responds to such an event, I feel confident that the most significant factor is the loss of a constant figure (the adoptees discussed in this paper all remained for a minimum of six weeks to one year in the care of the biological mother). It may be that adoptees do not form a homogeneous group. Those discussed in this paper may differ from other adoptees, for example those given for

adoption at birth or those whose mothers wanted to keep them, but could not.

Adoption has a silent impact on the individual; it is not always possible to see the depth of the emotional scars. This 'disaster' is a private matter and can be repressed by adoptees and those who surround them. Most of the time its impact appears dormant, although a traumatic situation later in life can trigger an avalanche, breaking down a defensive system not strong enough to cope with any acute, subsequent trauma. Such defensive collapse is mostly connected with life changes (Garland, 1993).

Traumatic situation, object relations and loss

Personal trauma and social catastrophes, impair the capacity for thinking in those individuals who are victims of disasters. Under pressure from these catastrophes there is a tendency to re-enact the traumatic situation (Garland, 1993).

Trauma is experienced as a consequence to hostile events, mainly seen as generated in the external world. The prevailing emotions are overwhelming despair, helplessness, shocking disorganization of the self and feelings of dislocation. The victim of the traumatic situation is usually unable to put into words what has happened to her/him. The basic traumatic situation is that of 'helplessness', and all traumatic situations refer to the original. From the point of view of psychoanalytic theory the trauma is always an infantile one, which not only involves the subject and a breaking through of his barriers against stimuli but also a life situation-helplessness (Baranger, Baranger, & Mom, 1988).

Let us suppose that the intention to give the baby up for adoption is already clear in the biological mother's mind during the course of the pregnancy; this mindset may well cause the mother to distance herself psychologically from the baby. Let us suppose, too, that the baby accurately perceived the hostility coming from the biological mother. The adoptee introjects and identifies with a mother who does not enjoy giving or receiving from the baby and an internal basis for denigration starts to develop (Spillius, 1993).

Two main issues in connection with the object become clear: (a) the adoptees feel that they were given for adoption because they had destroyed the object and cannot repair it; and (b) they feel that they are so strong and powerful that they can actually destroy the object,

whom they consider to be useless anyway. In their eyes the object had failed them.

Several authors focus their investigation of object relations not on the situation of internal anxiety but on the external nature of them. Balint (1969) was the first to develop the idea that the trauma is situational and, consequently, appears as one of the vicissitudes of the object relation. According to Balint, trauma requires at least two persons, both in the internal and in the external worlds. This, he says begins with the mother. He postulates that a mismatch between mother and baby leads to a misunderstanding between them, hence to an undoubtedly traumatic situation.

Psychoanalytic experience invariably shows that there 'exists a close and intimate relationship between the child and the person who inflicted the trauma upon him' (Balint 1968 and 1969). According to Etchegoyen 'The child feels every experience as the result of the action of objects'. These adoptees encountered a rejecting mother. When they turned to the mother to find a container for their anxieties, they found instead a giver who did not want to be associated with their anxieties.

Khan (1963) shed significant light on the issue of cummulative trauma; he believes that it is the mother who protects and consoles the child in face of inevitable trauma. For the adoptee the breakdown or the deficiency of the mother's function of administering and regulating external and internal stimuli, produces a situation of impingement which has a disruptive effect on the ego's organization and integration (Baranger, Baranger and Mom 1988). It is significant to note, however, that these patients did not give the adoption any importance at the time of first interview, nor do they view any of their subsequent traumatic life events as the consequence of the adoption. In fact they spoke about their adoption in matter-of-fact tones.

As the means of combating the effects of their trauma the first thing that was observable in these adoptees was their establishment of a terminology aimed at containing, regulating and localizing an unspeakable danger: 'I am afraid that I will never fit in', 'I fear people', 'I have recurrent dreams about failing at exams', 'I spend my life rehearsing how to talk to people', etc (Baranger, Baranger & Mom, 1988).

One of the first tasks was to dismantle this terminology, coined in desperation to defend the adoptees against the occurrence of the trauma, and to question the histories which justified them. These patients came to therapy to demand some explanation, to understand what up to now had been for them a succession of different ways to name their trauma. The event of the adoption cannot have meaning

if it remains incidental and foreign to the adoptee, even if it is recognized as a traumatic event by the therapist. These patients come to treatment hoping to regain the projected part of themselves, thus to regain an identity of their own. On the defensive side they cling to their old defensive system to ward off the unknown, unbearable aspects of themselves and the separateness of the analytic experience. These patients constantly try to convince the therapist that what is most unbearable need not to be faced (Mariotti, 1993).

Psychoanalytic theories of human response to loss have suggested that an individual's adjustment to that loss is dependent on their early object relations and experiences with separation and change. Moreover, individuals appear to experience loss in ways which suggest that fundamental aspects of their personality have been reached. The adoptees in this paper have shown an individual and unique sensitivity to separation. This was expressed in how much difficulty or ease they felt in confronting a crisis such as how they were able to change jobs, move to a new home, deal with disappointment, or surrender an old way of understanding (Brinich, 1980, Bowlby, 1969, 1973 and 1980).

In summary, the basic tenets of psychoanalytic thinking, as well as the significant contributions of Bowlby, support the notion that an individual's adaptation to loss is dependent on how well or how poorly they have been able to negotiate changes and deal with loss in the past. Experiencing a significant loss is normally followed by grief analogous to that of bereavement. These reactions have long been of interest to professionals with Freud making one of the first important contributions to the formal literature in his classic paper 'Mourning and Melancholia'. Adaptation to loss is a subjective experience. The self is left unprotected, resulting in a disturbed communication with reality (Brodzinsky & Schechter 1990).

The interference of adoption in the establishment of object relations:

Although it is clear that the individual does go through intense instinctual developments and vicissitudes from birth that are essential for growth, there is equally a basic relationship with the mother from birth and certainly before birth, which rapidly extends to father and others. These basic relationships and the personal qualities and attributes of the mother and other objects play a crucial part in the development and growth of the individual and of his internal psychic

world throughout his life as well as in all subsequent relationships (Stewart, 1987).

The establishment of a shared meaning is vital for a reciprocal relationship and it is essential as part of an adequate development. The achievement of a shared meaning is problematic as failure will be encountered on both sides. At the time that baby and mother are struggling to understand and meet each other, the adoption disturbs the achievement of this reciprocity (Brinich, 1980).

The adopted baby who has gone through a different set of 'mothers' before adoption has been completed thus must negotiate a different mode of communication with each attachment. In every transaction it must learn a new language.

Adoption spoils the close intimacy which is needed at this very early age. In fact, it hampers the formation of the reciprocal relationship. This carries other implications, such as the adopted parents' mental representations of their relationship with the baby, and how the feeling of infertility, if that is the case, intrudes in the relationship with the adopted baby. The biological mother knows that the baby has come 'out of her'; for the adopting mother the child 'belongs' to somebody else (Brinich, 1980).

In many cases where the adoption has been the result of infertility, the adopted baby is a constant reminder to the adoptive parents of their failure to conceive. Mixed and ambivalent feelings are constantly present, interfering in such a relationship. When the child reminds them of their infertility, s/he brings to the fore awareness of a bad, dysfunctional part of them. This needs reparation, which has to be undertaken by the baby, and is moreover expected during all their life time. When the adoptee fails to repair, s/he is experienced as a bad, unfulfilling and difficult object. Thus, the internal representation of the adoptee as good or bad shifts according to how skillful s/he is in reading what is expected of her/him. When the adopted individual fails in this endeavour s/he is experienced as bad and disappointing and not 'belonging' to the parents. The message is that 's/he is not one of us'. In the same way adoptees may find that their adopted families do not belong to them. This is especially so when the families do not appreciate skills or wishes that adoptees may have, for example their liking for classical music or sport which does not correspond to the family traditions (Hodges, Bolleti, Salo & Oldeschulte 1985).

It is crucial to understand the struggle that a normal baby goes through to appreciate the many things that go 'wrong' with the adopted child. For the adoptee, the object fails to acknowledge their

desire for recognition. The unwanted child is rejected for its very existence; her/his creativity and personal growth are being attacked by what is experienced as a rejecting object. For the child the attack has a retaliatory function as a result of her/his own destructive impulses. The adoptee has been exposed to a nonidealized object, as well as to bitterness, disappointment and denigration. The realization that the source of life and goodness lies in the external world has had a traumatic effect for the adoptee as s/he believes that the object rejects her/him for having been too demanding. Undeniably, the child's actual experience with external objects and the function of those who enhance the child's development have been damaged. In the case of the adoptees, the external object halts the internalization of the good object. For the adoptees their perception of the experience of the adoption is that the object – the biological mother – has been unable to cope with their 'demands'. The fact that a child has been adopted does not by itself produce irreversible trauma, nonetheless there are issues which appear to be particularly important in understanding those who have been adopted.

Case presentation: Ms. A

Ms. A came to therapy at the age of thirty-two, after three serious attempts to take her life. Such attempts were characterized by confusion, panic and fear of total disintegration. She told me that previous treatment, i.e. medication and hospital admission had 'failed' her. Ms. A had her first depressive breakdown after the death of her adoptive father. She knew nothing of her real parents and claimed to have no interest in them whatsoever. Her main complaint was that she felt herself to be a social misfit and, therefore, was failing the expectations of the adopting family. It was unclear whether she was intelligent as her difficulties had made it impossible to master skills. She was unable to stay in a job for long or to maintain close relationships with men or women. Her presenting problem was panic at any change, i.e. in her office the upgrading of the switchboard with which she, as a receptionist, had to work, impelled her to leave the job.

Ms. A was adopted at the age of three; she was the first adopted child of an infertile couple, and was closely followed by the adoption of a boy. A year and a half after her adoption, the mother gave birth to a boy. According to Ms. A both brothers were successful in life. She recounted her adoptive mother's recollection of Ms. A as a silent

child, one who refused to talk. The latter experience was also encountered during her therapy. Ms. A let me know that she actually knew a great deal about her adoption as she had been given details by her adoptive parents, but told me she preferred to forget them.

She gave conflicting versions of her adoption and of her first years of life. She told me that she was the daughter of royalty, that she was the child of a servant of the house, and so on. Sometimes she would idealize her biological mother and accuse the system of failing to help the mother to keep the baby. At other times the biological mother was described as a prostitute who was probably dead by now, was or had married a rich man and was looking desperately for Ms. A. All this material in its different disguises gave a clear picture of her phantasies about her own representation of her biological mother and of her adoption. Sadly, Ms. A did not have any factual information about her mother, but she had some information about her time at different institutions. For her, the most striking detail in her adoption papers was that she was described as a good girl, as one who would only play on her own; an 'easy child'. In anger Ms. A used to tell me that the 'easy child' in her was what appealed to her adoptive parents, somebody who would not disturb them.

Ms. A had felt a failure since childhood especially when her inability to perform had led to her removal from private education. A busy mother had failed to recognize her anxieties. Performing well at school was but one link in the chain of family expectations. Likewise, she was afraid of being unable to perform according to the therapist's expectations in her therapy. From the first day, Ms. A always sat on the edge of her chair, never allowing herself to relax. She looked constantly at the floor. I understood her determination not to relax in the chair as her way of keeping our contact to a minimum. This behaviour persisted during her entire time in psychotherapy.

In the course of therapy, Ms. A revealed that she still wet her bed, but did not see this as a problem inasmuch as it affected no one. When asked whether the wetting might affect her, she took such a question as a sign of dislike and became terrified. With hindsight, my question was premature; it led her to feel not only disliked but potentially robbed of her babyhood. Her refusal to discuss the issue suggested a frightening relationship with an early object, one that would not accept her messy, smelly baby self. While on the surface the disclosure of the bed-wetting appeared as the patient offering material, the question seemed to Ms. A as critical of her mess and as an attempt to make

her fit in. She clung to her own discharge of urine, to avoid ordinary communication.

I will now refer to a period which I think exemplified Ms. A's connection with what she thought was a resourceless biological mother/therapist. During this period Ms. A was convinced that I was a poor person, that I did not have sufficient food, and as a consequence I could not offer her any help. With sarcasm, she would offer to do shopping for me. This material was followed by distressing feelings connected in her mind with her fear that she had depleted me of all internal food and that because of this I was not sufficiently strong to cope with her demands. She used to say 'I am too much for you'. This period was followed by some confusional state which did not allow her to think or talk. Much of her subsequent sessions were marked by a profound and deadly silence. This material was interpreted as her fear of having spoilt my inside by being there, and her wish to do my shopping was seen as connected with her desire to put something back into me. She felt that she had damaged me and had left me impoverished. Usually, this type of interpretation made her more communicative.

However, Ms. A and I were not seen as nurturing the baby within herself, but as robbing her of babyhood by forcing her to grow up prematurely. Most of the time, she feared that her own internal source of food would be taken away by me. In fact, when despair took over she would complain that I was not as good as she was at satisfying her own needs. She felt trapped and claustrophobic and wanted to finish therapy and her life.

Just before one summer break, which had been announced several weeks in advance, the patient became considerably disturbed. Consciously, she seemed unconcerned about my going away. However, two weeks before the break she became anxious and confused, fearing a breakdown. For my part, I became so anxious that I actually thought it would be necessary to request her admission.

The disturbance started with the patient's complaint that in the restaurant where she was then working the food was excellent but the customers were rude and not appreciative of the food. Because of that she had decided to leave this job. She went into all sorts of details about the customers' table manners, how they were treating the wonderful food, and how intolerant they became if the food was not ready in minutes. The above material exemplified partly the many and diverse dimensions of her psychic interaction. The patient tried to turn away from good food, meaning a reasonable job, as she felt that she

did not belong where good food was served. Can one say that this was a duplication of her adoption? She was turning away from what was a good and nourishing experience. She has thus identified with the original 'hostile' giver and now re-enacts the rejecting role. She saw in the bad manners of the customers an aspect of herself seen of 'bad stock' inasmuch as it had been rejected by her two mothers. In contrast, her healthy and sane part turned for help as there was the realization of such a need. This contrast was perceived in the customers who, notwithstanding their bad manners, were asking for good food.

In Ms. A's inner world, I could be experienced as good food, yet not good enough to change her. She described the customers as hopeless people who would never learn to appreciate good food. This material was understood and interpreted as her fear of never learning to appreciate the good food between both of us. At the same time, however, I was experienced as a spoilt/destructive customer because of my bad manners, represented by breaks and interpretations. She came to realize that to be adopted was something good, but would not be enough to rescue her. She slowly increased the acting out in her job, refusing to serve certain tables or leaving work before time. It became clear that violent and destructive attacks against the therapy and herself were hidden behind these bouts of acting out. When I tried to delve into these masking activities, Ms. A would become silent, her silence being understood as those aspects of herself linked with her desire to stop therapy and life.

Ms. A knew the difference between reality and the self-delusion that she could not get help. Despite such knowledge it was plain that she was repeatedly withdrawing into a delusional state. Her more healthy self would be seduced and overpowered by the delusional, which induced her to believe that all her difficulties and problems had not to be dealt with. When it was possible to examine why she so readily listened to delusional side, I found that Ms. A believed she was being promised a rebirth, free from the people who were believed to have caused her such misery. Thus she was aware of separation and feeling small and vulnerable, which for her was humiliating and painful and exacerbated the fear of myself as a potential attacker. By detaching herself from me she could convince herself that she was independent, and needed nobody.

Discussion

It would be impossible to deny that there is an organization which recognizes and stores memories or that part of what is stored is the

relationship with another person, in however rudimentary a form. Ms. A communicates that she wants something, food, which is felt to be good. Still her memory of food is a contradictory one. She faces a dilemma when attempting to build a human relationship, wanting therapy to create an attachment and yet simultaneously wishing to break off the possibility of a relationship. In trying to understand the vicissitudes in the development of her relationship with myself, I felt that Ms. A repeated endlessly the trauma of her adoption. In her case the process is very complicated as in her mind she confuses our roles constantly and both of us are being subjected to a rejecting object who is seen as not wishing to be attached or to accept dependency.

By focusing on the way in which interactions of the past are re-enacted in the present, it is possible to see how her pathological organization protected the patient from anxieties of a paranoid nature. It offered the comfort of withdrawal to a state in which she was not fully alive, but was not dead either. The latter provided her with a state of mind free from pain and anxiety. At times this state was idealized and allowed her to be cut off from me and from her feelings. The changes that she could not master represented a breakdown of her defensive organization. There were times in which it was possible to see a move towards change, such as when she expressed some recognition of being helped by me. The confusion between reality and phantasy led her to a regression to concrete thinking although I think Ms. A retained some memory of me inside herself, a memory which she nevertheless suspected did not 'belong' to her.

Mr. B

Mr. B came to therapy at the age of twenty-four. A student of biology, at the time of consultation he was struggling with his second attempt to stay at university. He complained that he was finding it difficult to study and that he could not concentrate. He impressed me as a very intelligent young man. Mr. B was half Scot and half Chinese. He was adopted at the age of two. When he was four his adoptive parents divorced and he remained with his mother. He described his parents as mean people who had adopted him for two main reasons: 1) family pressure, and 2) a determination on their part to transform 'a little sod like me into something big'. Not surprisingly, he took great pleasure in disappointing them. He told me that he disliked them because they were Jewish. Mr. B did not have information about his

placement prior to adoption, having been told only that at that time he was in a state of malnutrition and suffered from chronic diarrhoea. He mentioned on different occasions that the issue of his adoption had never been properly discussed at home. However, this was not actually the case as during the course of his therapy Mr. B said that his biological mother was still alive, but that he had no intention of making contact with her.

From the very beginning of the therapy Mr. B spoke mainly in monologues, in a monotonous voice. When I introduced any awareness of separation it would lead to feelings of intense anxiety. In fact he had several anxiety attacks during which he would stay at home in bed for a couple of days. There were as well periods of abstinence from food, as he felt food was not good for him. The abstinence would coincide with his complaint that my consulting room was smelly. During these periods Mr. B would spend long intervals in my lavatory, sometimes up to ten minutes. This action served to reinforce a feeling of terror on his part of my retaliation, which he associated with having evacuated everything bad from him into me.

I shall now describe a period in which Mr. B experienced tremendous anxiety because his academic career was coming to a standstill. There were many crises in connection with his studies as he felt that nobody including myself, would accept him as he was; he felt that his tutors wanted to change him to suit them.

During this time Mr. B had failed two important examinations. His tutor had explained that his failure was not because he lacked ability, but because he was relying too much on himself. Mr. B was furious and angry at the tutor, becoming arrogant and sarcastic. He would repeat many times in our sessions 'how dare he talk to me like this'. The tutor had explained to him that of late his standard had deteriorated and the head of department had voiced some concern about him. They had decided to give him another chance; they allowed him to retake the examinations. On the morning of one of these, the session was devoted to his impending failure. He felt triumphant. He believed that he would fail again, therefore that I had failed him.

He reported a dream in which he was walking in open fields and fell into a reservoir of faeces. A girl passing by went to help him; he realized that she was Jewish. His association were that he hated Jews and that he was sorry that not all of them were cremated during the Nazi period. He told me that he frequently imagined how it would have been if the Nazis had won the war. He went back to the dream to tell me that while she was pulling him up he managed to pull her

in. He hated the girl in the dream, myself, for helping him, but he hated himself for dreaming his own need for help, or, indeed any reference for help, especially the help given by his tutor and the head of department. He then assumed a superior role, symbolized by the reservoir. He felt grand. The faeces in his mind were his own product, but in the dream he had fallen victim to his own grandiosity. He did not need me as an external helper, he had his own reservoir. Nevertheless, the dream showed his own need, although perverse, for help. For him this became the unbearable side of himself.

Mr. B had established a narcissistic object relation to defend himself against separation and the need for the object, myself. He had incorporated me in an omnipotent way, his self becoming identified with the object so that no separation was allowed. Thus, I was perceived to be part of his own possessions, represented in his dream by the reservoir and the girl.

During this period he became increasingly insistent that the therapy was no good for him. He constantly reported that he was not progressing and that I could not possibly understand him. He accused me of leaving him 'in the shit'. The next few sessions were characterized by his conviction that I did not understand him, was not listening, and that I was talking to him in academic jargon to show my superiority. During this time I felt under attack simply for being there. Gradually I became aware that when I spoke he would forget what I was saying; this evacuation process brought back old memories connected with his schooling. His mother had moved him six times during secondary education due to her conviction that if he found school easy it meant that he was not learning. This was interpreted as his fear that I could evacuate him for understanding. In not listening or forgetting he could secure a place in his therapy school. Parallel to this conscious understanding Mr. B actually identified himself with a narcissistic mother who recognized neither his needs nor his attachments. He wished to change me so that I should correspond with the contradictory evidence which surfaced from him, particularly when we managed to achieve some measure of mutual understanding. The work was designated by his belief that understanding is easy, thus perverting the truth of his feelings and my intentions.

Discussion

Mr. B's sense of superiority, his appropriation of my comments and interventions made me feel robbed of my capacities, led him to experi-

ence an almost permanent alienation from the object. In Bion's word's Mr. B lived with the dread of annihilation, coupled with his intolerance of frustration. Having been a child of three when adopted, Mr. B had memories of panic, deprivation and pain. He found himself with an antagonistic environment which, according to him did not really want him. All along, I observed in Mr. B an irrepressible urge to destroy his internal objects juxtaposed with a desire to preserve them. In Mr. B's case it is essential to differentiate between the constructive and destructive forces. In considering his narcissism from a constructive aspect it was possible to see the over-valuation of himself, maintained by omnipotent introjective and projective identification with good objects and their qualities. In this way he felt that everything of value about the external object, his adoptive parents and the therapy, was part of him, or was omnipotently controlled by him. Similarly, his destructive narcissism played a central role, but here it is the idealization of the omnipotent destructive parts of the self which he feared most. His destructive narcissism was very powerful and in effect prevented him from establishing a dependency on objects in the external world which he devalued by treating them in a scornful way. When in need of help he felt humiliated and defeated by the revelation that it is an external object that comes to his rescue: his tutor, the girl in the dream and his adoptive parents. He cannot bear to accept that his adoption was an act of assistance. When faced with the reality of being dependent on his adoptive parents – particularly on the mother – he would prefer to die. Confronted with the recognition that external objects gave him support, the external object becomes the potential attacker.

Conclusion

Klein in her paper 'On Identification' (1956) says: 'A securely established good object, implying a securely established love for it, gives the ego a feeling of riches and abundance which allows for an outpouring of libido and projection of good parts of the self into the external world without a sense of depletion arising'.

Winnicott (1960) described very vividly the formulation of a 'false self' as a protection for a 'true self' that could not develop due to a maternal failure. He postulated that in an early stage the infant is usually unintegrated, and very rarely fully integrated. However, I would like to add that the infant, when not met by what Winnicott

calls maternal 'devotion', and what Bion would tend to call maternal 'alpha function' (Bion 1962), not only fails to integrate but is also exposed to active processes of disintegration. This said, I believe that there were two preconditions for the psyche of these adoptees to function as described in the clinical data: first, an adverse disposition; and second, its interaction with an adverse environment. Although the adoption is a traumatic event, these patients were born to mothers who already had a traumatic relationship with not only their unborn child but I believe with their own mothers. When talking of an adverse disposition one may recall Ms. A in the garden, spending long hours oblivious to the weather coupled with a mother who did not look for the child; Mr. B who could not eat, believing that he could survive without the help of his object, food, parents, tutors. Whatever the reasons these mothers gave their children for adoption, the adoptees experienced their mother's refusal to accept them, to take their projection, as a hostile defensiveness; their reaction was to 'assail' these mothers/objects with increasing hostility and frequency until in the end the meaning had been taken out of their projection. While many issues are common to all these cases, one stands out, I, as the object, am believed to be most of the time unavailable to receive projections thrown out by the infantile aspects of themselves. In turn, I am experienced sometimes as an additional external source of destruction of communication and awareness.

Hence these adoptees had encountered a mutually hostile and despairing situation between the infant who refuses communication and a mother who turns her back on him. In some cases the infant had survived such a situation by instituting a state of mindlessness.

Bion remarked that one of the many things that a patient wishes to convey to the analyst when they embark on treatment is what the object has failed to provide them. To generalize, I could state that most of the time the object was experienced as malignant. Nevertheless, I think in each adoptee there is a desperate attempt to search for an object that will understand them and give support, to find an object that will feed them, be able to communicate, and will not abandon them in times of 'war'.

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OBITUARY

HILDE ECCLES

Hilde Eccles, psychoanalyst, BAP member, died on July 8th at the age of 78. She had lived and fought with illness all her life with consummate courage and energy, but having learnt in these last months that no further medication was possible she decided to accept death in her own time and way, rather than struggle to maintain a life of increasing pain which would prevent her working. For Hilde, living was synonymous with working. The few patients she was still seeing in her house in Ampthill could be helped to leave her just before she left them. Patients she had worked with in the past and therapists and counsellors she had supervised, together with a great number of friends and colleagues, came individually and to two huge birthday parties in May to share times as enriching as any enjoyed in the past, despite the added poignancy of knowing that these times would probably be the last.

But they were not the last. Her beautiful funeral was the last occasion Hilde had planned to share with us: in a country village church with excerpts from the Jewish, Christian and Buddhist poetry, prayer, music and philosophy which she had integrated in her life. Some were read by the family of goddaughters and nieces who had replaced the biological children she had never been able to have. They included a reading from one of the many tapes which she had recorded in this last year, in long hours of conversation with a biographer who will now try to write a book about her life.

What a task! Can such an incredibly full, rich and varied life be drawn together in such a book? Andrew Skarbek, Hilde's close friend and psychoanalyst colleague of many years' standing, wrote a long moving account of her life, for the Independent, on August 13th (of which we should have copies in the BAP library). Every paragraph opens up another astonishing chapter. I thought that in twenty five years of friendship I knew most of the salient episodes of Hilde's life, but realise now that it was only a fraction of the whole.

There is however a central keynote to her life, which comes from her first all-important trauma of being the youngest of the large family of an orthodox Polish rabbi who had emigrated to Zurich, and whose poverty dictated that Hilde should be fostered for seven years from

babyhood with a wealthy Christian couple. Her subsequent return to her parents was deeply unhappy and embattled, but she never either gave in or rejected them. With the characteristic generosity which was probably as overwhelming to them as it was again and again to her friends, she was eventually able to fulfil their dream of living in the newly constituted state of Israel by buying them a house in Zefat from her earnings as a social worker.

This theme of working with enormous generosity, both from within but also against every 'Establishment' she has been involved with, is evident in her relationship with the psychoanalytic psychotherapy profession. At a time in the 1960s and '70s when there was a lot of doubt and critical uncertainty amongst psychoanalysts about supporting the BAP and what were thought to be its 'low standards' of training which could encroach on the limited psychoanalytic training resources, Hilde Eccles – with her great friend – Victor Kanter – were amongst the very first psychoanalysts, not just to give training therapy and supervision, but to join the BAP as Full Members. Furthermore Hilde was so concerned that there were no clinical seminars at that time when BAP students were training on a very low budget, that she gave seminars in her Central London flat for several years without getting any fee for her work. (She even made cheesecake for all her clinical seminar members.) She disliked committee work, but was hugely supportive of all our efforts to improve our professional standards; an enabling friend to the Association as a whole as well as to individual colleagues.

When she 'retired' to Ampthill she felt forgotten by the Association. But despite increasingly debilitating illness (heart, blood pressure, cancer and finally kidney failure) she built up a whole new practice of therapy and supervision of counsellors and therapists of many different disciplines, which was hugely valued in this area of scarce psychoanalytic resources. In her last months she was so appreciative of a letter from Hester Solomon who wrote as Chair of BAP to thank her for all her work and generosity to the Association – a letter she put in her 'comfort bag' of treasures she would open at night when she could not sleep. What Hester could not know was that amongst several generous bequests Hilde had left £10,000 to the BAP. We told her how much we would miss her. 'Yes of course you will' she said.

ELSPETH MORLEY

Notes on Contributors

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Janet Sayers, PhD	Associate member BAP. Individual psychotherapist for the NHS and in private practice. Professor of Psychoanalytic Psychology, University of Kent. Books include *Mothering Psychoanalysis* (Penguin 1991) and *The Man Who Never Was: Freudian Tales* (Chatto & Windus 1995).
Sally Hornby	Fellow of the BAP. Member of BASW. Retired, previously psychotherapist in private practice and in the NHS. Freelance consultant in interagency work. Author of *Collaborative Care: interprofessional, interagency and interpersonal* (Blackwell Scientific Publications, Oxford 1993).
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BOOK REVIEWS

How to Survive as a Psychotherapist

By Nina Coltart. Sheldon Press 1993 pp. 120 Pb £9.99

Ours is a curious profession. Where else is one considered young to qualify in one's mid-thirties? Where else does one reach one's prime in one's forties and fifties? And where else is one's knowledge and experience treated with such deference and respect after sixty, when many other professions force one to retire?

The psychoanalyst's and psychotherapist's training is arduous and demanding, often draining time, money and emotional resources from a young family, but it is a choice, sometimes a vocation. The training can infantilise and encourage idealisation and that is why many therapists, training in their thirties and forties, feel like children. Indeed, it takes time to evolve one's own style as a psychotherapist, and that is why therapists are often only really mature at a time when people in other professions are thinking of retirement.

Serving as a prelude to her own retirement, Nina Coltart's book deals in a non-dogmatic and highly readable manner with the *choice* in becoming a psychotherapist. Her use of the word 'survive' in the title is deliberate. She emphasises that it refers, not to survival in its grimmest desperate sense, such as of those who have been victims of the Nazi concentration camps and have somehow managed to come through, but rather to something lighter and more creative. She refers to the idea of surviving-with-enjoyment the whole experience of being a psychotherapist despite its occupational hazards of loneliness and emotional strain.

There are few specific rules laid down for therapists. Coltart sums these up by saying that, especially in view of our patients' vulnerability in the transference relationship, we should not exploit them in any way –emotionally, behaviourally, sexually or financially. Yet there are so many finer details of practice to concern us. Times have changed. For example, some of the previous generation of analysts, including Anna Freud, used to knit in sessions. So did my sister's analyst. She said it helped her to concentrate and my sister did not seem to mind.

Coltart tells us about *her* style of practice and how she has developed as an experienced psychoanalyst over the years. Each of us has to work out the 'apparent trivia' concerning the setting and management

of our practice so that we may feel as relaxed as possible about the day to day running of our professional lives.

Coltart tell us what *she* does but she makes it clear that we do not have to follow her. She is both a humane and independent thinking analyst. She sounds both formidable and fun so I was extremely interested in what she had to say about the 'trivia' involved in conducting a psychoanalytic practice. She discusses subjects such as greetings, finding patients, comfortable chairs and a couch, clothes, lavatories, waiting rooms, smoking in sessions, holiday dates, how to address patients and how they should address her, interruptions to sessions, telephones ringing, answering machines, gifts, missed assessment sessions; and she also covers more important issues such as acting out in sessions, is there a place for kindness in therapy, and suicides.

If we have not considered our responses to these and many other situations (for example the vexed question of tissues: do we have them in our consulting rooms? Do we offer them to patients or let them help themselves?), we are likely to be nonplussed and anxious at each decision to be made. Something which is hardly conducive to relaxed survival.

As psychoanalytic psychotherapists, we will find particularly informative Coltart's enjoyment of practising psychotherapy in preference to psychoanalysis. She says that psychotherapy involves her in engaging with her patient in the fullest possible way. She never thinks of her patients between sessions, concentrating on them fully while they are with her and leaving the rest to her unconscious when they are not.

She has a chapter on the similarities and differences between psychoanalysis and psychoanalytic psychotherapy. One of the main differences she feels is frequency, analysis involving 4 or 5 sessions a week (with someone who is a trained psychoanalyst).

Coltart is far from rigid. Even though she emphasises that it is crucial for someone to be 'psychologically-minded' in order to benefit from psychotherapy, she is able to appreciate that some people like her patient, Mrs A, full of denial and without insight or psychological mindedness, have managed to use her and her setting as a container and have benefited from the therapy in their own way.

She also points out that there is not always an obvious divide between psychoanalysis and psychotherapy. For instance, some patients formally having psychoanalysis and coming to see her 4 or 5 times a week, never became reflective or gained insight; whilst others,

on even 1 or 2 sessions a week, used the transference creatively and managed to keep the link and continuity going.

Of course, Dr Coltart has become known and noted in the psychoanalytic and psychotherapeutic worlds for her experience and skill in assessments. She writes of this work with verve and authority for she has been doing 3–4 assessments a week for the past 20 years. It is particularly in this area that her medical qualification has on occasion been invaluable. She has developed a list of nine pointers which make up a profile of 'psychological-mindedness'. Through her years of assessing she has found only about 5% of people unsuitable for psychoanalytic psychotherapy and these she may refer on anywhere else she considers appropriate, for example to a behaviourist, to the G.P. for medication or she may suggest no treatment at all, which can be a relief for the patient. However, although always ready to refer, she is refreshingly not one who sees analysis as essential for everybody. She is in no way a missionary for psychotherapy.

Ending therapy is another subject which is touched on. Coltart feels, that especially for the trainee therapist, ending therapy represents the last support to go before 'adult' entry into the big, frightening world. It can feel very much like a bereavement. Separation is such a painful issue for all of us. It is so important to end therapy in a considered way. I have noticed, through the years, that really disturbed people never end their therapy properly. Also, although therapy should not last forever, Coltart recognises that some people are so damaged they need to be seen, at least occasionally, for life.

The real measure of the value of any therapy is in the management of the ending. Here then comes the test of identification with the lost object which, Coltart stresses, is part of healthy mourning. Here, too, she says, comes a further test, this time, of Freud's view that analysis is not designed to shield one from reality but to make it richer and more meaningful.

In our work we learn to listen. Our training teaches us to be more objective. If we manage to approach our patients without any demands or expectations, (that is, 'without memory or desire', Bion's famous phrase which Coltart repeatedly quotes), we need to learn to sustain ourselves.

It is not easy to be a detached observer and yet emotionally alive and responsive to every nuance our patients bring. It is not easy to remain impersonal and hold back when ascribed so much power in the transference. It is not easy to refrain from getting caught up in our patients' idealisations. Coltart is all too aware of all this. She

believes that in order to keep healthy as a psychotherapist, one needs to have outlets which refresh and refurbish one. Although she, herself, has chosen to live alone, she stresses the importance to her of family, friendships, travel, music, gardening and Buddhism.

Each of us must find what nurtures us most. It is almost certainly this self-care and refreshment which enables us to survive our work with enjoyment and be alert to our patients' needs.

This slim book packs a lot of wisdom and experience into its pages. It is novel to have a seasoned analyst telling us, in everyday language, how she runs her professional practice and I read the book eagerly and quickly. In a sense it is like a recipe book from mother, there if you want exact guidelines, or to be used as a base from which to experiment and develop your own therapeutic style.

JUDY COOPER

A Woman's Unconscious Use of her Body – A Psychoanalytical Perspective

By Dinora Pines. Virago 1993 pp. 243 Pb £13.99

A topic of such importance requires the craft, creativity and clinical experience as presented by Dinora Pines. This book is a collection of her papers written over the past twenty years, which portray so vividly one of her main scientific interests related to some aspects of a woman's life, such as pregnancy. But she also includes case material and some theoretical points related to adolescence, childbirth, abortion and infertility, the challenges of the menopause and old age. Through her early clinical experience as a doctor, Pines observed and felt that she had to listen 'carefully to [her] patients, to what [her] patients were telling [her] or – even more important – not telling [her] as [she] examined their bodies'. The phenomena of relationship between body and mind and all its vicissitudes can be considered a complex one in the therapeutic handling of intrapsychic conflicts or character distortion in our patients, the more so in female patients.

In the first paper of the book, 'Skin communication', Pines discusses a particular form of pathology in one of her female patients. She brings several relevant points including 'how women patients' bodies expressed pain that was unbearable and unthinkable about'. Because words were unavailable to them, their emotions had to be expressed

somatically and understood by a woman doctor who could think about each patient's predicament as if she were a mother, and try to bring relief. This helped her to understand the importance of transference and counter-transference. Later, when practising psychoanalysis, Pines gives us sensitive account of how she then saw the transference and counter-transference in that particular case.

In fact, all the papers focus upon one or another aspect of the therapeutic process, but Pines emphasises to the importance of sensitivity to the counter-transference.

Regarding the outcome of pregnancy and child-birth Pines says, 'One of the most impressive features to be observed during the analysis of pregnant women is the re-emergence of previously repressed fantasies into preconsciousness and consciousness – and their fate once the reality of the newborn baby has been established'. Within this context she carries on, 'These uneasy conflicts belonging to past developmental stages are revived, as they are at any crisis point within both her inner world and the outer object world'. She discusses and evaluates the role of conflict at different stages of emotional development during pregnancy, and all the defences that the ego mobilizes against it at various stages of its development. Pines added to our understanding of this issue most significantly in one of her papers, 'Pregnancy and motherhood', observing that pregnancy 'is a major testing point of the mother-daughter relationship: the pregnant woman has to play the role of mother to her own child whilst still remaining the child of her own mother. The early childhood identification with her own mother is reawakened and measured against the reality of her relationship to her own child'. Pines emphasises, 'The successful achievement of a feminine sexual and gender identity can be strengthened by the proof and confirmation of pregnancy, whereas the process of making a new form of object relationship – motherhood – can begin only once the baby separates from the mother's body, and emerges into the object world'.

By exploring the complex process of the female psychosexual development in relation to pregnancy, Pines extended her observations from her clinical experience with other women patients who have miscarried. Again in her view, 'Mind and bodily changes influence each other in a woman's monthly and developmental cycle, and the intimate link between them allows a woman unconsciously to use her body in an attempt to avoid psychic conflict'. In considering women patients in my practice who have had miscarriages, I have come to speculate on some possible unconscious reasons for some spontaneous abortions.

Psychoanalysis, in which the patient's unconscious reasons for miscarriage become conscious, may help her to retain the foetus during pregnancy and give birth to a live child'. Pines ends her book with two papers on Holocaust survivors, and on this painful subject I quote her:

'The Holocaust was an unthinkable experience until it happened in reality. The true meaning of what was accurately perceived was banned from emerging into consciousness in both patient and therapist, by mutual collusion'.

DINÉA HENNEY

Fairbairn and the Origins of Object Relations

ed. James S. Grotstein and Donald B. Rinsley. Free Association Books 1994 pp. 350 Pb £22.50

This is a seminal text on the development of Object Relations thinking taking Fairbairn's work as the critical starting point. It is an edited book of seventeen papers presented in four sections: I. Introduction II. Theoretical Overview, in two sections (A) Fairbairn and Object Relations Theory, and (B) Fairbairn's Endopsychic Structure III. Clinical Formulations and IV. Fairbairn's Contribution to Understanding Disorders of the Self; there is an Epilogue and three detailed appendices. Whilst the editorship is in two names the work was in fact undertaken almost entirely by Grotstein owing to Donald Rinsley's death in the early stages of work on the book. The whole text is an example of excellent and thorough scholarship.

I gained the distinct impression that the book was produced with an American market in mind with the implicit task of persuading the more traditional, diehard, classical American analysts of the viability of object relations thinking. It is worth noting that two years after the first appearance of the paper reproduced here Stephen Mitchell wrote 'Object Relations in Psychoanalytic Theory' (1983) with Jay R. Greenberg. This important text traces the development of object relations thinking through the ideas of the British School and Klein and Fairbairn and of the Americans Mahler, Hartmann, Jacobson and Kernberg in a thorough and substantive way. In his 1981 paper reproduced here 'The Origin and Nature of the "Object" in the Theories of Klein and Fairbairn', he begins with the following:

> 'Melanie Klein and W. R. D. Fairbairn have been two of the most significant theorists within psychoanalysis in the past fifty years. Traces of their influence are discernable in almost every area of contemporary psychoanalytic theory and practice. Yet, because of the politics and polemics surrounding Object Relations theory as a movement there has been little critical and balanced appraisal of their contributions and a tendency to blur together their very different and highly distinct theoretical systems.'

In Britain I think it is safe to say that the 'politics and polemics' are over and have been over for some time, and as a consequence of our greater familiarity with their work we would be less likely to muddle Fairbairn up with Klein. With regard to this, I am reminded of a BAP seminar given by Grotstein in 1989 to discuss his papers on the 'Black Hole'. In his introductory remarks he began to make an apologia for Klein and Object Relations thinking which had greatly influenced his own work; he then realised where he was and that in Britain such theories were not heresies.

The other factor that makes me think that the book is aimed primarily at the American market is that of the fifteen authors, which include Fairbairn, ten are American. Of course, it could be argued that writers such as Kernberg, Ogden, Mitchell and Grotstein, to list only those with whose work I am familiar, are sufficiently international to belong everywhere and to everyone, but it did make me consider again the parochial nature of our profession and our theories.

The introductory chapter by Grotstein and Rinsley is masterly in putting Fairbairn's work in context. The theoretical overview section is the most important part of the book and is essential reading. Much of contemporary psychoanalytic thinking is reviewed in the light of Fairbairn's work and the whole section enables readers to refresh their perception and understanding of current theory.

The book makes clear that there has not been a Fairbairnian tradition or school to test and develop these once near heretical ideas as there has been with Melanie Klein, for example. Whilst this may be regrettable, reading this book does bring home the extent to which Fairbairn's ideas are an essential part of psychoanalytic thinking, particularly of course among the Independent Group in Britain. A great deal of discussion in the book is concerned to differentiate between Klein's internal objects and Fairbairn's endopsychic structure and object relatedness. The book also shows the extent to which Fairbairn's thinking influenced Bowlby and Winnicott, an influence which was considerable and, it seems, sadly unacknowledged.

The editors make clear the central tenets of Fairbairn's ideas; the

advocacy of children; the idea of primary innocence and entitlement; infantile dependency as opposed to infantile sexuality; the true object relational nature of the self; the endopsychic structure as a closed system of egos and internalised objects (which Grotstein sees as Fairbairn's most innovative contribution) and finally the centrality of the schizoid domain which is, as most of us are aware, the coal-face of our work nowadays.

The section 'Clinical Formulations' is to my mind the liveliest part of the book; there is nothing quite like having real patients to bring the ideas alive. I enjoyed and learned from all four papers, particularly Judith Hughes on Fairbairn's analysis of Guntrip.

One of the themes of the book is, inevitably, Guntrip's relationship with Fairbairn and the espousal and development of his ideas. Kernberg argues in his paper, 'Fairbairn's Theory and Challenge', that whilst Guntrip's presentation of Fairbairn's theories is the most comprehensive there is and therefore is immensely important, particularly 'Personality Structure and Human Interaction' (1961), he finds that there are shortcomings, not least due to his inclination to idealise Fairbairn whilst subtly distorting his ideas. How he does this I leave the pleasure of finding out to the interested reader. I would add here that Kernberg advocates several critical review articles about Fairbairn's work by Sunderland (1963, 1965, 1979) and Wisdom (1962, 1963, 1971) which he sees as welcome in their brevity by the side of and further illuminating Guntrip's long book.

Guntrip's analysis with Fairbairn was not seen by either of them as particularly successful. Judith Hughes' paper discusses this with detailed reference to the three papers which Guntrip wrote about his analysis. She does this in an attempt to trace the effect on clinical practice of Fairbairn's revision of Freud's libido theory into that of internal object relations. She highlights Guntrip's difficulties in being tied, as he saw it, in 'rebellious bondage' to his unyielding and indifferent mother. This seems to have been reproduced almost exactly in the transference, with Guntrip complaining and critical and yet unable to leave his analyst as he was unable to leave his mother. Hughes makes a very powerful case for the viability of Fairbairn's ideas as they are reflected within this famous analysis. The analysis went on for eleven years and seems to have been in its later period a very frustrating experience for Guntrip. It only really ended when Fairbairn's health began to fail. It is interesting to reflect on the apparent strength and insolubility of Guntrip's ambivalence to his object in relation to the remarks made by Kernberg that Guntrip in effect idealised Fairbairn's

work to its detriment, another powerful expression of the same ambivalence.

I readily recommend this book. It has a place in the personal library of every thinking psychotherapist.

ANNA WITHAM

Narcissus and Oedipus: The Children of Psychoanalysis

By Victoria Hamilton. Karnac First Published 1987 Reprinted 1993 pp. 313 Pb £17.95

This book is hard work but not altogether *too* difficult. I found it inspiring and the clear and elegant writing makes it a pleasure to read.

The title tells us of the main themes: the myths of Narcissus and Oedipus Rex are used to explore psychoanalytic theories about primary narcissism and the search for knowledge. It is through this exploration that the author offers a revolutionary theory which is also as evolutionary as would be expected from someone who believes that progress, rather than sudden change, is the way to health. Her theory has evolved from the ideas of Freud, Anna Freud, Klein, Bowlby, Balint, Winnicott and others. Parts of old theories which are no longer useful are discarded and new ones take their place, the seeds of which were there already. For instance, Hamilton thinks some authors such as Anna Freud and Melanie Klein have, on occasion, ignored observation in order to maintain their theories: both these women observed a relational state in babies.

One of the most useful aspects of the first section of the book is a clear account of past theories of narcissism, beginning with Freud's 'egg shell' theory which saw pain and deprivation as the road to progress. Hamilton's picture is a different one; supported by observations made by several infant researchers, she views the baby as actively seeking a relationship with the outside world from birth. She finds no evidence for a wish to return to the womb or for a cocooned state of primary narcissism in which the baby is unaware of its surroundings. Instead of the unfortunate infant being tossed into reality by disillusionment or inevitable maternal failure, a positive process of separation takes place within a safe relationship.

The author considers aspects of narcissism in detail, giving the reader the opportunity to take a fresh look at what it means as well

as a new consideration of its origins. For instance she disagrees with Freud's view that narcissistic people are indifferent because they have not reached the capacity for object relationships. The narcissist she says, craves love and appreciation; his withdrawal and grandiosity, tyranny and possessiveness are all defensive: omnipotence only becomes necessary when holding fails and dependency gives rise to anxiety rather than to comfort. The primary relational tie, recognised by Bowlby, Winnicott (and even Klein) does not depend on seeing the mother as a whole person and it is only within this relationship that the capacity for such a whole perception develops.

Enveloped in his mother's doting view of him. Narcissus had no sense of self and was in love with his mirror image, which he needed to affirm his own existence and in fantasy his mother's too. To know himself and to try to step into a state of true relating signified death because there was no experience of differentiation or dependency and the broken life line with mother meant a broken self.

Hamilton points out that psychoanalytic theory concentrates on the building and maintenance of transference but spends much less time on its dissolution. 'The transference of difference' must be recognised in order to help the patient gradually to allow the consulting room to become part of the outer world occupied by two different people with lives of their own. It is only possible for a child, (analysand), to differentiate, however, if he/she is differentiated, and failure on the part of parent or analyst to allow this, leads to damage and restriction; the narcisstic pathology repeats itself.

I found the author's example about holidays particularly reassuring. Some patients *need* to take holidays when the analyst is in the consulting room; they need mother at home in order safely to explore. They also want to know if she will stay there if their attention is not exclusively devoted to her. Such holiday-taking can, therefore be progressive and to misinterpret it as aggressive or defensive is to perpetuate the narcissistic relationship.

Winnicott set out to make sense of what happens between the states of symbiosis and differentiation and his theory of the use of transitional phenomena is followed and expanded by Hamilton. She maintains that theories of containment beginning with Freud's egg shell theory and going on to Bion's container and contained, do not leave room for the development of transitional space. The child is tipped from one container to another without the availability either of 'mother's lap' from which he can come and go, or of play, through which toing and froing between inner and outer is made possible. Development of

transference is a playful process where the analyst is both me and not me and the not me becomes more possible as the analaysand becomes more certain of himself.

The author stresses that it is the use of the transitional object which is important, not the object itself. Playing can only occur within a safe holding relationship and when this is not available the parent's absence constitutes a frightening gap which the child may attempt to fill by compulsive or addictive games. Under these circumstances, teddy bears are not transitional objects but patches not dissimilar to the autistic objects described by Tustin which are used to obliterate the 'not me'. In a beautiful example of an adolescent girl called Jean, she shows how the capacity to play, to enjoy 'nonsense', changed the idea of growing up from a terrifying jump into the unknown, into a crossing of gaps with safe bridges.

Victoria Hamilton is a philosopher as well as a psychoanalyst and in the second half of this book she creatively shows the importance of appreciating the influence that our understanding of the world and of ourselves in it, has on our behaviour, expectations and capacity to enjoy life. She regards Freud's view that knowledge originates in the context of painful absence, as a 'tragic view' of human knowledge which is linked with what she describes as Bion's 'all or nothing' attitude, which implies that humans are in a constant state of frustration because they can never know everything.

Hamilton adheres to Kant's idea that noumena or ultimate truths are out of our grasp and we have to make what we can of phenomena which are never the whole truth but glimpses of it. It is only by constantly discarding half-truths that we can get nearer to the whole truth. However, rather than finding ourselves in a perpetually frustrating situation, if we accept the limitations, we can be free to enjoy what is available and to fulfil our limited potential, instead of searching after something impossible.

The author takes issue with Freud's inextricable link between sexual knowledge and learning. She regards sexuality as an aspect of exploratory behaviour, not its cause, and quotes Bower's studies showing that babies find problem solving motivating in itself. If parents, while providing secure holding, can encourage the child to venture out and discover, the search for knowledge does not have to be coloured by phantasies of voyeurism, intrusion or incorporation; there is no need for the child to break down their bedroom door. He can accept the limitation of never knowing what happens in the parents' bed and be free to learn.

Hamilton reinforces the importance given by Winnicott to the capacity to be alone. Without this aloneness success can be experienced as a kind of robbery; the mother intrudes on the child's achievements. The author sees the couch as a forerunner to being alone and recognises how frightening it is for those who could only experience a face to face relationship with their mothers.

The mother who holds back her child in an overprotective way is as castrating as the one who does not set proper limits and therefore puts an end to learning by imprisoning her offspring in confusion, guilt and illusion. The child who holds back from discovery and clings to mother, is as self destructive as the delinquent one who searches for the truth without limits.

The author discards the psychoanalytic interpretation of the myth of Oedipus Rex. It is not through guilt that Oedipus blinds himself but because, having been told nothing, he has been unable to accept the limitations of knowledge about his origins; his search has confronted him with his own helplessness.

An optimistic or pessimistic view of life, writes Hamilton, is determined on mother's lap. Hers is essentially optimistic; she fills the reader with hope that life need not be as arduous as Freud and many of his followers have presumed. I think that she risks imparting an idea of human development in favourable conditions taking place without pain, as if there might be some children who never have to deal with gaps arising from their mothers' failures. The author does, however, in the context of helping the child to separate, talk of 'loving rejection' which seems to concede room for loss. There is no discussion of mourning but perhaps it is taken for granted that true mourning can only take place within a safe transitional space as in the case of Jean, mentioned above.

Hamilton criticises Freud and his followers for formulating psychoanalytic theory from the study of pathological adults; adults who have had traumatic childhoods which perhaps have made them wish to return to the womb or forced them defensively to seek knowledge to fill frightening absences. As a child psychotherapist, she has observed many children outside her clinic and gives us a happier idea of growing up. One of the chief strengths of this book is the use made of observations by infant researchers.

I find it hard to understand why this liberating and exciting work was not given more attention when it was first published in 1987 and I recommend it to anyone interested in psychoanalytic psychotherapy.

ANNE TYNDALE

The Self in Early Childhood

By Joel Ryce-Menuhin. Free Association Books 1988 pp. 273
Pb £9.95

Published six years ago, this book retains its value both as a review of the literature on ego psychology and as an attempt, from a Jungian perspective, to fill an apparent gap in describing the early formation of the self. Ryce-Menuhin writes, 'In seventeen years of study and consideration of Jung's psychology I have never comprehended how ego function has been so little considered by Jungian analysts other than Fordham, or why the process of ego (as opposed just to a structural distinction) is almost unwritten about in Jungian literature. This surprise about omission of interest in ego stimulated my decision to write this book, which asks the reader to make a first step beyond the existing Jungian theoretical situation' (p. 201). Before arriving there, the reader is invited on a journey through thickets of theory not only Freudian and Jungian but into experimental psychology, physiology, philosophy, etymology and linguistics with frequent resorts to analogical thinking in support of the arguments. It is of some assistance that the reader is offered a 'map' to reach the promised theoretical leap. It consists of tracing the main pillars of theory and empirical research upon which is based current ego theory. Another, actual map, is a helpful folding out binary flow diagram on the inside back cover to follow ego processes as conceived by the author.

The book is clearly structured into a preface – threshold, and seven chapters, the last of which is a clinical illustration. It appears to be addressed to experimental psychologists and ethologists for whom a so far incomplete self and ego theory is laid out in detailed annotated historical perspective so that, with effective collaboration, 'it might be possible to begin to quantify depth psychology with carefully designed research and strictly controlled experiments.' (p. 4).

The first chapter is a survey of Jungian theories of the self, passing through the role of archetypes, culminating in Fordham's concept of deintegration. The second chapter reviews Freud and his predecessors followed by early and recent 'neo-Freudian' contributions towards a self concept. The third chapter is devoted to an examination of infantile autism since, 'The self theory can be sustained by looking at a failure of the self-function in childhood' (p. 131), on the grounds that autism distorts the development of the self as a disordered state of integration, which is said to fit with Fordham's deintegration theory. In chapter

four a consideration of a clear physiological self in the theory of infancy is posited as a basis to approach a further convergence of depth psychology and experimental psychology.

This recalls Ryce-Menuhin's earlier hope that, 'The postulation of my new theory requires a strong conjecture to be put forward as scientific and defended within the present knowledge of psychology. In the past experimenters have rarely been sufficiently close to the work of depth psychologists to comprehend what is being claimed in theories about self and ego and to determine if it is testable by experiment' (p. 3).

Chapter five reviews the role of behaviourism, falsifiability in depth psychology and the use of projective techniques in analytical psychology, concluding with an attempted synthesis of experimental psychology, neo-Kantian humanism with self theory. This serves as a preamable to Ryce-Menuhin's own original contribution in chapter six, the formulation of a theory of *con-integrates*.

It is accurate to say that Jung's concept of the self as representing the entirety of the psyche is not shared by psychoanalysts for whom it is a narrower concept linked to the functioning of the ego. Jung states: 'The self is not only the centre, but also the whole circumference which embraces both conscious and unconscious; it is the centre of this totality, just as the ego is the centre of the conscious mind' (Coll. Works 12). Fordham later extended Jung's concept of self to childhood which he had adumbrated in lectures but had never written down. The present con-integrate theory is proposed as an expansion of Fordham's deintegration and reintegration model whereby the ego develops through periodic deintegrative episodes leading to specialised centres of consciousness described as the self/ego *con-integrates*. Although the author highlights seven of these centres he does not preclude the possibility of others being identified. He enumerates; play, persona, defence, speech, shadow, ego ideal and aesthetic. He uses them to clarify what happens when a state of deintegration is reintegrated following the first ego-differentiation from the self in that any stimulus whether external or internal (including those archetypal stimuli emerging out of the collective unconscious) falls within one of the seven fields through which it can then either be matched and therefore reintegrated or if not matched, be expelled and therefore remain not integrated. How each field operates is described only briefly and we are given to understand that each is an *a priori* part of the process of early ego functioning. Unfortunately no examples are offered so that the construct remains as only a tantalising possibility.

When in the final chapter a description is given of sand-play work with a three and a half year old adopted boy, it is still not clear how this clinical example relates to the preceding exposition of theory. The case concerns a black child's disturbance on learning about his adoption by a couple who reflected the racial composition of his own original parents; a black African father and a caucasian mother. The brief intervention lasted six sessions which reportedly were helpful. Each session is given in some detail and illustrated with a colour photograph. No interpretations were made to the child, but the author commentates on each scenario in the sand. The four sided sand-tray is regarded as the holding *temenos* for the empty space of the boy's confusion about his adoption. The first sand-play ended in a seeming pile up of toys in the tray with a small yellow sailing boat, 'a self symbol', apparently going up from the lower unconscious towards a higher position, but blocked by chaotic object confusion. The author explains; 'In this repressed chaos projected within the first sandplay we can glimpse the shadow con-integrate revealing many of its nonconscious personality aspects, which (he) simply threw together into a shadow-filled box' (p. 240). A bigger and 'older, larger sailing ship' is understood as 'an ego-ideal con-integrate symbol, containing the parental archetypes.' The sand-play demonstrated the transformative possibilities for this child and within the chaos the two sailing boats gave a potential glimpse of developments observed in later sessions. The boats disappeared in the fourth session when a nativity scene appeared. It remained in the fifth session. The last sand-play empties the tray of all toys and concludes with a solitary half buried toy black cab. The ending of the sessions was interpreted as an uncovering of the boy's persona con-integrate and a gain in ego-power. No reference was made to how he may have experienced the loss of the therapist! One wonders about the therapeutic usefulness of such a theory.

As a reference to the literature on theories of the self this is a *tour de force*. As an aid to clinicians, I suspect it may primarily hold the attention of those who have a particular stamina and an interest in integrating disparate disciplines. This volume can be read as Ryce-Menuhin's attempt to bring together the divided states all around of the different dynamic schools and in particular that which exists between clinicians, theoreticians and experimental psychologists and other human scientists. This desire is expressed also in the choice of a mixed race patient who himself experienced divided states.

The style of writing is frustrating in that it intersperses close academic argument with polemic and a very personal conversational

approach which at times borders on the patronising. This is a pity for two reasons. Much of the valuable material may not be taken up by the very readership the author hoped to stimulate to dialogue and experiment. More seriously, it risks the criticism that Jungian concepts are sometimes presented in a 'mystical' way. Moreover the paucity of direct clinical illustration in the body of the book, fails to engage the aesthetic and play con-integrates of this reader and I fear may cause the theorising to remain outside the self. Could it be that the author is more at home with ratiocination than relating as a clinician? Some of the presentational difficulties may be the result of converting an academic thesis to a publishable text. If a further edition were to be contemplated, resolute editing would be required. Let this be a challenge!

ANN KUTEK

Unimaginable Storms. A search for meaning in psychosis

By Murray Jackson and Paul Williams. Karnac Books 1994 pp. 248 Pb £17.95

Murray Jackson, psychiatrist and psychoanalyst, first trained as a Jungian analytical psychologist and subsequently as a Freudian psychoanalyst in Britain, where he was particularly influenced by the work of Melanie Klein and her followers, such as Herbert Rosenfeld and Wilfred Bion. His clinical practice has been greatly inspired by the work of Henri Rey who was one of the first analysts to introduce some of the basic ideas developed by the Kleinian pioneers in working with psychotic and borderline patients in the difficult and resistant conditions of the National Health Service.

The book is essentially a compilation of consultations and clinical interventions with severely disturbed patients attending the specialised unit at the Maudsley Hospital. The descriptions and formulations are based on many years of work at the unit in which psychotic patients were treated with a combination of psychiatric and psychological treatments based on psychoanalytical principles. Jackson, assisted by his colleague Paul Williams, seeks to show that there is meaning in psychotic phenomena and that comprehending the code of primitive mental mechanisms can lead the clinician to understand and translate the psychotic communication in order to help the patient.

The first six chapters are sequentially entitled: 'Paranoid schizophrenia: 'the radio loves me', Schizophrenic self-burning: which self?, Psychotic character: 'a bit of an old rogue', Catatonia 1: psychotic anorexia, Catatonia 2; 'imitation of Christ and Manic-depressive psychosis.' In each, the author reports and discusses specific consultations and interventions, both individual and institutional, with patients falling within the above mentioned diagnostic categories. Each chapter includes a discussion of the dynamics involved in the case, thus offering the reader a unique insight into the patient's experience and an understanding of some of the powerful and disturbing underlying processes of psychosis. The final two chapters of the book, 'The treatment setting' and 'Integration' are devoted to discussing the philosophy underlying the institutional psychotherapeutic approach applied at the unit at the Maudsley and a theoretical discussion about psychosis and its etiology and evolution.

Chapter one clearly explains the mechanism of projective identification used by Sally, a paranoid schizophrenic young woman, and the states of frail ego boundaries in which this unfortunate patient finds herself. The reader can for example recognise the phenomena of excessive projective identification in which the patient expels unwanted aspects of her mind so violently into her mental representation of another person that, according to Jackson, 'it creates a boomerang effect'. Practitioners will readily recognise this from their practice, when for instance, a patient feels very greedy or envious but will project this into the therapist and then experience the latter as becoming envious and greedy towards the patient. Bion's concept of bizarre objects due to uncontained projective identification is useful to explain the bizarre bits experienced by the patient as if they were floating in space and concretely persecuting the patient. Detailed clinical description and ensuing discussions show that the resort to, and development of psychosis is often a preferred lesser evil for the patient, rather than being subjugated to terrifying nameless dreads with concomitant unbearable mental pain. Psychosis is both a defence system and an attempt to reach someone who can contain chaotic unconscious elements or as Bion calls them, beta elements.

Chapter two examines the complexity of motivational patterns in a case of repeated self-burning by a schizophrenic patient. Each act of self destruction is a response to a hallucinatory command to pursue a course of self immolation. The patient, suffering from violent persecutory feelings, uses splitting, projective identificatory mechanisms and delusions as defences. He is able, after a period of long term psycho-

therapy, to understand how his unconscious childhood phantasy of his wish to kill his mother's babies, together with his identification with a baby sibling who died when he was a child, was related to his present wish to self immolate in a building. The building is equated concretely with the insides of his mummy's tummy. The dynamics involved in this case, beautifully described by the author, reminds us of Bion's experiences when he advises that it is necessary to work with the non-psychotic part of the personality which is seeking to develop capacities to understand the psychotic part which both attempts to communicate and to defend against understanding and thinking.

The third chapter of the book deals essentially with borderline personalities which Jackson calls psychotic characters. He defines these patients as people whose sense of self is not coherent enough because their development has been arrested at a very early level. The borderline condition is one in which a narcissistic structure has been constructed by the ego in order to ward off disintegration. In these personality configurations, the individual regresses to a pre- projective identificatory stage in order to defend against a state of uncontained dread, reminiscent of Rosenfeld's descriptions of an organisation which serves to fend off florid psychotic manifestations. In the clinical description of Rick, the borderline 'immature personality disorder' who developed obsessional behaviours, Jackson demonstrates that it is the fear of his own deadly envy and incipient jealousy which prevents the patient entering and resolving the oedipal situation and accepting triangularity. Envy feeds strongly into the triangular configuration thus increasing Rick's defences which are essentially omnipotent and have a two dimensional quality to them. This person is intractable and incapable of psychological mindedness.

Jackson sees the problem in these cases as due partly to an incapacity for the mental apparatus to pass from a concrete to a symbolic way of thinking and also that they oscillate, but are never fully positioned either at the psychotic or the neurotic end of the spectrum. These types of pathologies are essentially defending against the onset of psychosis or of total disintegration. They are stuck between a fear of disintegration on the one hand and a fear of integration on the other. The special intractability of such cases is based on a perverse addictive quality of these characters, who would rather become parasites than suffer the pain of the depressive position.

Chapter four deals with anorexic psychotic conditions. The author usefully distinguishes between anorexia psychosa, which is the result of psychotic depression, from anorexia neurotica, where there are body

image delusionary tendencies based on unconscious phantasies. Greed is often at the basis of many forms of anorexic disorders, but the problem becomes more severe when it is accompanied by a breakdown of the mental apparatus so that what is intensely desired or hated returns via unmodified projective identification. The patient is afraid either of being poisoned or devoured. Psychodynamic intervention reveals attacks on any form of linking and meaning as based on envious elements which are prominent at the point of awareness of any separateness. The mind, like the nourishing breast, excludes and therefore is feared and is also envied because it excludes in a possessive way. The psychotic part becomes a structured entity in time, a defensive organisation which is ultimately based on an identification with the envied object and imprisons the patient's dependent and needy self.

To show the reader how concreteness of thought is one of the main components of psychotic experience, the author presents the case of a religious man who was training to become a priest, but becomes psychotic by enacting through physical catatonic behaviour, the punishment of the crucifixion. The patient is unable to distinguish concrete from symbolic thinking and following Segal's concept, he produces a symbolic equation. His need for punishment and expiation stemming from severe superego elements is enacted in a concrete form.

Chapter six explains and formulates the dynamics involved in manic-depressive illness, starting with the contributions of Abraham and Freud, through to Klein and Bion and presents clinical examples. The equation underlying manic depressive psychosis is a regression to primitive processes of identification as a defence against one's own aggression towards the loved object which is considered to be too vulnerable. This is partly due to the patient's devaluation of the object and partly as a defence against separateness. Nicola, the presented patient, is described vividly, and the reader is able to follow closely the oscillations from mania to depression. One can see the fluctuation between omnipotent triumph and depressive subjugation of the patient's psyche to an inner cruel and punitive organisation. Psychotherapy helped the patient improve and the changes were related to the gradual internalisation by the patient of the capacity to contain the needy deprived parts and therefore diminish the gap between euphoria and psychic collapse.

The final two chapters are devoted to presenting Jackson's ideas and philosophy of care and treatment. Based on his conviction that there is always a rudimentary ego ready to develop which is the non psychotic side of the personality, Jackson rightly reminds us that this

fact permits us to be hopeful in terms of treatment possibilities. He emphasises that psychotics have a much greater chance of being helped from a psychodynamic point of view if the treatment is carried out at an early stage. Psychosis is a defence organisation which becomes structured into a system which, in turn, becomes endemic and more intractable as time goes by. The psychotic defence organisation is a protective shield against 'unimaginable storms', but perhaps also becomes addictive with time. Jackson carefully illustrates through the case material how patients sometimes have to be treated with behavioural and cognitive methods first, in order to alter very entrenched psychotic systems of defence, thus allowing mental pain to emerge which then can be approached psychodynamically.

A major theoretical and clinical question that arises from Jackson's formulations pertains to the evolution of the personality in psychotic patients. Some readers may wonder whether he is right in thinking that psychotic patients are suffering from changes occurring in their personality as a result of their unconscious defences against unmanageable anxieties bound up with separateness and loss. Jackson's view is that these patients have suffered a deterioration in their personality from a structural sense, and therefore a loss of their mental abilities. An alternative viewpoint could be whether psychotic patients are suffering from the result of a personality which has never had a chance to structure itself in the first place. Perhaps an arrest in development has occurred, rather than a loss of functions which are presumed to have existed before. This, I think is an important theoretical distinction, because of its implications for the course of treatment. It is not the same thing to restore in patients lost parts of themselves, which have been projected into the other, but rather to help patients develop a mental apparatus which is capable of creating an image of 'an Other' which then in turn, is capable of containing the patient's projections.

The author reminds us that the aim of the analytic cure is a search for meaning and to help the patient's mind to acquire an interest in how his mind works. Jackson says: 'we must try to find out why a part of his mind has become psychotic and why he maintains a preference for the psychotic world with all its confusion and sometimes terror to the pains of the world of dependent relationships'. Jackson gives support and adds strength to Bion's discovery that every individual has a psychotic and a non psychotic part, and that the latter attempts to create symbolic meaning to counteract the former through the working through of the depressive position. Alternatively, when this is not possible, the ego institutes defences to keep the psychotic

part in check. I would have liked the author to elaborate more fully on the process of mourning, which is crucial in my view to the reason why psychosis develops as an alternative mental system to pain.

In the concluding pages of his vivid and moving book, Jackson explains his philosophy regarding the understanding and treatment of psychosis, again emphasising that if psychosis is not treated early, then the patient will remain chronically in the paranoid- schizoid position. Jackson condemns the politics involved in mental health care from both a financial point of view and in terms of lack of coordinated central policies. He is in favour of psychiatric hospitals because he believes that they are the place where central policy for treatment gets instituted. However, one wonders whether a good community care well applied and programmed might provide better psychodynamic care for patients. Psychiatric hospitals tended to institutionalise patients for life and create a futile parasitical dependence in patients due to the very specifics stated by Jackson namely that most psychiatrists will look at the problem from a biological point of view.

Jackson criticises psychiatry's work with mental patients because of their emphasis on form and diagnosis and their tendency to ignore psychological meaning. At the same time, however, he does not put into question the use of ECT. He also criticises inaccurate wild psychotherapies which lack scientific rigour and precision when dealing with emotional and psychological issues. Both disciplines can go wrong if they disregard the contributions of each other to the understanding of the phenomenology and evolution of mental disorder. Using the Scandinavian mental health care system as an example, he puts forward the case for both more resources and for better psychodynamic training for psychiatrists who can lead teams which evaluate and implement treatment programs which treat the whole person.

The book achieves its aims as an in- depth description and evaluation of cases from the clinic, and offers itself as proof that the psychodynamic systems helps and is better in the long run for some cases, both from clinical and health cost effective aspects. The book's strengths lie in its clinical rigour. In effect, it clearly shows how the knowledge of primitive mental mechanisms such as splitting and projective identification enables us to understand the search for self and meaning and the forces activated against them in people who have lost their sense of ego boundaries or are searching to create them.

I would recommend this book to all those interested in the functioning of the primitive mind and its concomitant defence mechanisms. The book offers an opportunity to compare our own work with that

of clinicians who are working with very disturbed individuals, thus opening up a greater understanding of the psychotic transference in all our patients. The book is not a treatise of new theories or discoveries but it does offer an honest and interesting account of the work done at the pioneering Maudsley unit and as such can be used as a basis for study and further thinking.

RICARDO STRAMER

Clinical Klein

By Robert D. Hinshelwood. Free Association Books 1994 pp. 260 Pb £16.95

This important volume continues the work of Hinshelwood's *A Dictionary of Kleinian Thought*, 1989 (Revised 1991). This book brings together the ideas of Klein and the post Kleinians in a comprehensive way from an historical and clinical perspective.

Kleinian and post-Kleinian ideas, concepts and thoughts have emerged out of detailed observations in the clinical encounter. Hinshelwood tries to demonstrate exactly how the formulation of theoretical concepts have been constructed using clinical material; in other words to put the human being into the theoretical idea. Hinshelwood uses at all times clinical examples to demonstrate the theoretical concepts.

In this volume the cases are scrutinized and examined on what the clinician noticed in the patients and how the concept has been shaped, coupled with, in some cases, the historical background of the patient. The author discusses the patient as well as the clinician to explain the processes of the working minds of patient and therapist and how Klein and her followers specifically make sense of material.

This book consists of three parts. Part I may be considered the foundation from which concepts are formed with an historical perspective and what Hinshelwood considers 'main issues' beginning with Freudian origins. In Part II, key Kleinian contributions are described, how these concepts have developed, but perhaps most interesting are the detailed examples which allow the reader to follow the emergence of the theoretical concept. This part of the book I found invaluable, dispelling as it does the myth about where concepts come from, coupled with an explanation of how the interpretation has been

formulated, as well as its response in the patient. Part III is devoted to the analytic relationship and the intimacy that develops between patient and analyst. The work of Bion, Rosenfeld and Joseph to mention but a few, are described in some detail and demonstrate how they have expanded the discoveries and used Klein's contributions to enrich our understanding of emotional contact. I would say that most of the key Kleinian psychoanalytic concepts have been explained and will make the reader think about his/her personal practice. While the reader may not agree with some of the interpretations of the theoretical concepts, nevertheless it is very thought provoking.

Hinshelwood has a specific way of writing which gives the reader the impression that he is talking directly to him. It is undoubtedly a training text and will be a great help to those who are engaged in teaching as well as to those who do not fear to look at their own work and understanding of the psychoanalytic process.

CLAUDIA KRAMER KLICH

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