BULLETIN

THE BRITISH ASSOCIATION OF PSYCHOTHERAPISTS

Number 18 July 1987

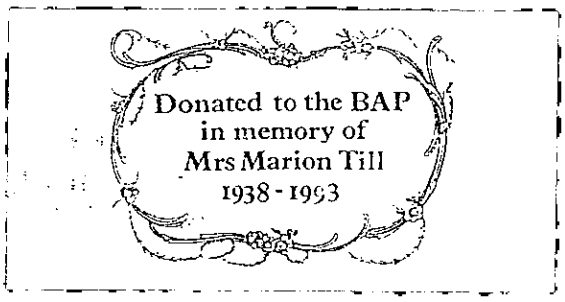
BULLETIN

of

The British Association of Psychotherapists

Subscription Enquiries:

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



BULLETIN

No. 18 July 1987

BOOK REVIEWS

ATTACKS ON LINKING

Or Imaginary Companions Grow Up

Jill Walker

First Contact: *Preliminary Impressions*

This paper is based on two years of work with a training patient.

When I first met Miss P., she was dressed in a tracksuit, having jogged to my house (her usual way of reaching me). She comes from an 'intact' academic family, having been brought up at home amongst her siblings, leaving first when she went to University.

Miss P. gave the impression of health and vigour; at the same time her body seemed curiously undeveloped and I felt the presence in it of an awkward child. So too, in contrast to her good mind and articulateness, there is a striking tendency in sessions to superficial "headline" thinking which she sometimes expressed in pseudo-poetic descriptions. (She received a good honours degree at University and now works in a well known publishing house, so she is capable of much better forms of expression). In one session, an instantaneous response of my mind to a long and sentimental description of a perfectly blissful "glowing autumnal" weekend, which she had just spent with one of her current boyfriends was: "crap!". I think this response of mine highlights in a succinct and accurate way the sense in me, at the beginning of her therapy, of the fraudulent nature of Miss P's idealised words, appearance, relationships, which belied something very different which operates in her internal world. This kind of superficial thinking, in which she indulges, I experienced as a kind of "lying", and in my counter transference feelings, could cause me at times to feel both useless and puzzled. MELTZER'S interpretations of BION'S ideas on the development of the mind have been helpful to me in understanding what turned out to be a dominant feature of Miss P's therapy: her consistent attacks on authentic mental activity, on linking and understanding.

> ".....in BION'S scheme for describing thinking processes, parts of the personality that are bound in dependence, and potentially in a love relationship to the good object, are constantly being pulled away by lies to abandon their relationship to truth. . . . . if truth is the nourishment of the mind and lies are its poison, then the mind, given the truth, is able to grow and develop itself, while conversely, if poisoned by lies, then it withers into mental illness....."

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

In other words, not having a relationship to truth, Miss P. does not have to have a relationship to me (the good object), and in this way she defends herself against the possible experience of separateness from me as a good object. She holds on to a confusing combination of a dreamlike and, at the same time, stereotyped world which is so contrary to what MELTZER describes as a true development of the mind which ".....derives from intimate relationships in which primordial events are emotional experiences ..... which have to be thought about and understood if the mind is to grow and develop". In her stereotyped world with its powerful dreamlike quality, she indulges in a kind of pseudo-emotionality. As BION says: "in this state of mind emotion is hated; it is felt to be too powerful to be contained by the immature psyche, it is felt to link objects and it gives reality to objects which are *not self* * and therefore inimical to primary narcissism. .....attacks on the linking function of emotion lead to an over prominence in the psychotic part of the personality of links which appear to be logical, almost mathematical, but never emotionally reasonable. Consequently the links surviving are perverse, cruel and sterile".

In Miss P's world, she indulges her longing to be fused forever with an object who will never leave her. These fusional wishes result in her having a repetitive series of interpersonal relationships, in which her objects can be defined as replaceable, primitive objects. In this way she reduces the specific and separate reality of them, and thereby controls the possibility of any real separation from an absent object. This mitigates against the development of mature relationships with a good and loved object, and maintains her in an "as if" personality, exhibiting a pseudo-maturity which is as GALLWEY says: "a false personality organisation covering an essential hollowness of properly developed ego resources....."

Acting-out and Perceptualisation as Habitual Defences

It was only gradually that I came to understand that despite the successful and attractive external appearance and performance, Miss P. does not really use thinking or knowledge but functions in almost a dreamlike way; using acting-out and the perceptualisation of her emotions as habitual defences against experiencing and understanding her emotional experiences. The kind of regressive mental functioning she employs is nearer to primary process thinking and I have come to realise that only through monitoring my counter transference feelings could I truly be with her. But the subtle attacking quality on both me and the meaning of our sessions could cause me to feel belittled and useless. So at certain times, instead of staying with her and sustaining the repeated attacks, in order to be rid of the useless feelings she pushed into me, I could react and press interpretations at her, as a relief from the powerful feelings she set up in me. So my unconscious counter transference feelings at

*my italics

times obstructed the therapeutic process, but I will show how in particular I came to understand how she perceptualises her emotions in her disturbed body image through my strong counter transference feelings.

The acting-out in this case has been continuous. It is not used as a discharge of instinct but as a defence against the experience of separateness. She splits off feelings and emotions that might find a place in a dependent transference relationship with me. More often than not, her continuous underlying sense of starvation, her feelings of poverty and unworthiness, propel her into this defensive acting-out. She distributes into different objects outside the sessions, various feelings belonging to her dependent transference relationship. For example, a repetitive pattern was her continual use of the telephone to contact family and friends. She would seek relief in getting comfort or advice. Three months ago, feeling an enormous sense of loss and panic because of the possible break-up of her present relationship with her current boyfriend, she said she longed to ring me. In the end she rang her mother who consoled her and, she reported to me, ended by criticising me for my cold and unhelpful stance. SOLOMON'S idea that "those who go through life with the umbilical cord in one hand looking for a place to plug it in", is apt here. I think this is a clear example of how in not being able to tolerate separation from me, she "unplugs" from me. It is she **herself** who sees me as cold and unhelpful, and she fastens her "cord" to another object which she hopes will provide her with immediate and always available comfort and advice. In doing this she also unplugs, or disconnects any emerging understanding in her own mind of the meaning of her transference feelings to me and the importance of the therapy for her.

The content of the early work was, as I have said earlier, somewhat repetitive, focused on what felt like rehearsed complaints, insights about her relationships to her family, friends and boyfriends. I can now see that in some ways we were trapped in the early sessions in a world of stereotypes which had a dreamlike quality. In retrospect, I feel that this perhaps needed to happen, and this early stereotyped communication was a pointer to the later repetitive attacks during the sessions which she made on meaning and understanding and the "linking" function of emotionality.

Two Stories Illustrate Defence Mechanisms

Miss P. will not let herself experience or think about separation. Unresolved conflicts with mother (the feeding breast) which were transferred to her father (penis), resulted in a stunted development of her healthy bi-sexuality. The present situation that she and I have been exploring shows her use of the 'penis' (in all the forms this takes bingeing, masturbation, smoking or drinking, sexuality etc.) as a manic defense against the loss of the breast. For

instance, she will generate sexual excitement to maintain within herself the feeling that "mother is still here". The intensity of her "father fixation" rests on the original failure with the mother. As she has never separated from her mother, she now cannot tolerate any separation nor think "of" or "about" an absent loved object. She attempts to maintain fusional relationships and constantly acts out to either maintain and control such a relationship or deny separateness. Two striking stories that she brought in the first six months of therapy illustrate the defence mechanisms she uses to act-out rather than maintain and understand strong emotional states connected with the issues of separation.

The first was a lighthearted story which she delivered with bravado and a certain sense of power, about two imaginery boy playmates she "created" when she was six years old. This gave me further understanding of her inner world. " 'They' did whatever I told them and I always came out on top!" She describes herself as very solitary at that period of her life and realised herself that her daydreams protected her against feelings of loneliness. But the story of her two imaginery companions pointed to something more hidden and important and so I interpreted to her that despite several ongoing sexual relationships over the past ten years, her capacity to make mature object relationships and establish a true sexual identity had not really developed since her escapades with these two imaginery companions.

The unconscious significance of this childhood game was twofold. She could control these phallic objects: cause them to appear and disappear at will and omnipotently direct their every move, their very existence, in relationship to herself. At the same time, in identification, she could be a "phallic" girl and so in fantasy have possession of "mother". In both ways she is omnipotently in charge of the mother; by either creating the exciting playmates for herself she denies the mother's (breast) absence or she hallucinates the mother (breast) which then can be attacked or controlled by her in the guise of her imaginery companions. The two years of therapy have shown that throughout Miss P's development, she has been so absorbed in this drama, controlling the "mother" that real complementarity and differentiation of male and female (part objects: penis and vagina) have remained latent and by implication so has her heterosexuality. Up to the present time her healthy bi-sexuality remains undifferentiated. In psychic reality she is neither heterosexual nor homosexual yet.

The game also has implications for the transference. Through interpretatations I have made, we have been able to look at how she could want me to be the idealised ever available breast (part object) to her young self, or she will create imaginary companions, exciting herself with a continual succession

of "penises" so she does not have to feel or think about me or my absence at weekends or during breaks in the therapy.

Through counter transference feelings I began to understand that her inability to think about me and my absence was an attack on the meaning of the therapy and also an attack on "me". Gradually I became aware of a denigrating quality in sessions, partly through her superior, scathing attacks on her mother whom she characterised as a frightened animal or as an intrusive creature with hungry eyes; also I could momentarily panic for no obvious reason and thus feel a significant anxiety before occasional sessions. I considered this to be a counter transference reaction on my part to a hidden intrusive greedy aspect of Miss P. who was in anger and frustration evacuating, and spitting out me and the work we were able to do in the sessions. At this early stage of the therapy I did not interpret this directly to her, as the 'attacking' I was experiencing was still hidden behind a deceptively cooperative attitude on her part, and I was unable for a time to gather my counter transference feelings into words, to make an appropriate transference interpretation. However, a dream highlighted this subtle denigration and anger which were around in the early sessions. In the dream, I indicate, as we stand together at the end of a long hallway leading to my consulting room, which is at the back of my house, that she should avert her eyes away from an envied female friend of hers (with whom she once had an intense relationship and with whom she broke off because of fears of possible homosexual attachment) and who now emerges from my consulting room. At the time she brought the dream, I addressed my interpretation to her fear of thinking about her attraction to other women. She had experienced this "attraction" when she first began to attend school at the age of 5. I also pointed out how she feels that I might need to be protected as a "scared animal" from such thoughts and feelings towards me that are in her mind. As therapy progressed we returned to the dream and I interpreted to her how it also demonstrates that she wants me to spare her the necessity of thinking and to protect her from understanding her own powerful intrusive wishes in relation to me. We have looked at how her refusal to think about her feelings can destroy any possibility of a situation in which I would be experienced as a firm supporter (mother or father) offering strength, constructive criticisms but not blaming her for her feelings.

The second *"story"* came into the beginning of our work. In our second session she announced its importance: "something you **must** know about me".

The something was related to her attraction to other women. She said that she had always had deep attachments to older women, usually teachers;

she would long for their special attention. However, these attachments manifest themselves in a triangular situation: a loved teacher, an exciting confidante, and herself.

The most longstanding and complex triangle developed in her last years at school. She fell in love with her history teacher and was "obsessed" by her for two years; writing secret poetry and love letters, thinking about her incessantly: "I longed for our bodies and minds to mingle together as one in heaven". The 'confidante' in this triangle was her form mistress. She would manipulate or intrude to gain attention and time from the confidante in order to talk about her longing to get the love and attention from the idolised teacher. She explained to me that she always felt she had to earn attention by producing a crisis situation: producing mildly delinquent behaviour which demonstrated in different ways feelings of depression or despair. She would also manipulate situations wherein she would remain outside school hours, hoping to gain more access to the teachers by being present when more time might be available for her.

So Miss P. and I have been aware from the very beginning of our work (namely the second session) of both a fear and a muted belonging in her that I could be part of a new triangle: that she could manipulate me into talking with her in the sessions about other ideal lovers; or, that I could be the teacher with whom she would desire to fuse leaving others on the outside. The triangle highlights her deeply conflicted relationship with her mother in which she longs for a fusional state in order to deny separation at the same time as being filled with anxiety about the possibility of real contact with a real mother. It also shows her habitual use of acting-in, within the therapeutic situation, rather than of being mindful and attempting to think about the nature of her desires and feelings.

Beneath the attractive, successful, young career woman, but hinted at perhaps in the curiously undeveloped neutral atmosphere she can convey, there is still a hidden "child". After the first six months of therapy, the "pseudo cooperation or helpfulness" that MELTZER speaks of, was replaced by a different kind of acting-out and acting-in in the sessions. So the little girl, who in the first six months spoke of a longing to "mingle together in heaven" with her history teacher, in the next six months was in constant search with different men of what she called the "never ending cuddle". As I interpreted to her at the time, it was as if she was looking for the exciting "companions" in order to defend herself against the terror of being alone and exposed to me. However, when she becomes frustrated, when her fantasies and acting-out flag or are frustrated, there appears another mode of functioning indicating another partial identity: a "dirty little girl" who engages in shameful, secret activities: bingeing on chocolate, cigarettes or

wine. As GALLWEY says: this can be linked to her "sense of sensual starvation..... profound loss with hopeless feelings of poverty and unworthiness accompanied by a deep sense of having been cheated". She told me in great embarrassment and shame in one session, of bingeing on a large amount of chocolate in a public lavatory. She also has reported a recurring dream of the past, where she continually finds herself in a dirty lavatory from which she desperately tries to get out. This profound sense of being starved and unworthy and dirty is ever present with Miss P. I interpreted to her that it seems like the slightest feeling of rejection or of being left by either me or friends or family leaves her defenceless against panic and escalating anxiety. This leads to, as GALLWEY says, "incontinence of imposed control instead of adaptive responses".

Relationship with Jean Paul: Imaginary Companions are Together

I would like to convey the quality of one of her usual relationships with men. In this particular case she first hinted of there being a new "man". This was towards the end of the first year of therapy. For a long time she did not tell me his name (and even when she did it was obscure and took me several sessions to understand what name she was saying). This demonstrated a vagueness which reinforced my impression that such objects are quite interchangeable and replaceable in their significance for her. As the name turned out to be a compound, "Jean Paul", it seemed as if the imaginary companions of her youth were together again and I could expect that the relationship would provide another situation when issues of separation and control would be intensified for Miss P.

She spoke of her intense longing and dreams about this man Jean Paul and inevitably and quite quickly she entered into a sexual relationship with him. There followed a time of struggle when she tried to control her longing for total merger, reassurance and endorsements from him. These fusional wishes seemed to create almost a situation of addiction; of having to merge with the man in order that she should not experience being separate from him and in this way he would be controlled by her. A day without a telephone call from him she seemed to experience as torture. This had (as before) the effect of seemingly frightening the man away, leaving her feeling dirty, inadequate and unlovable.

Ongoing transference and counter transference issues were highlighted by this "affair" I have described. Without an affair on the go, she feels empty and exposed, both to herself and to me. Any sense of real attachment to me makes her very uncomfortable; though at some levels she toys with fusional feelings for me, I interpreted to her that these feelings are a defence against experiencing me as a specific person whom she cannot control and

from whom she could therefore be separated. At another level she knows that real attachment to me would upset the usual arrangement she employs for emptying her mind. So she continually withdraws her commitment to me, engaging instead in a kind of promiscuity which fills up her inner emptiness with either men, food, wine. So I received a phone call one Sunday from one of her family saying that Miss P. would not be coming to the next session because she had gone with Jean Paul to Scotland for the weekend. Then on returning to our sessions, she wanted to leave the incident in obscurity and complained of my attempt to take the incident seriously, struggling hard to rid herself of awareness of what she had done. I experienced in my counter transference, pressure from her to engage with her in this "fraud"; almost "binge" with her about this "spontaneous and romantic" weekend, without understanding the incident or making it clear in our work together what she had done and what were the implications of her actions, both for herself and our relationship.

This sense in the counter transference of being mystified, engulfed and unclear can be, as I have suggested, a reflection of her desire to be "mindless" about both the child parts in her: the secret dirty little girl who does not want me to see what she is up to, and the girl who would want to fuse with me so that there could be no control issues between us and no possible separation.

There is however a sense in her that the part of her that does want to know, to be mindful, to grow is dangerous and persecuting and needs to be cut off; so that I can feel cut off by her and also from myself in sessions; "persecuting" myself and my lack of mindfulness. The fact that in reality she is promiscuous also in asking and receiving copious advice and comfort, from a large network of relatives and friends, underlines, as I have said above, this experience in the counter transference: that she will listen to anybody, go to anybody but me. In my interpretations I have tried to show her time and time again what she is doing, but she continuously evacuates any understanding of her behaviour. However on the positive side, this particular acting-out did move the work forward, as she was finally able to begin to understand more clearly the fraudulent aspect of her intrapsychic world; of what she does and how she uses men and other "supplies" to empty herself and also to keep herself safe from me.

An important dream which emerged when she was without a boyfriend, feeling exposed and childlike, points, I think, to some of the deep underlying reasons for her defensive emptying of herself.

> "I am standing on an escalator which has no steps but only a slope of plastic bubbles; in front of me an old man holds the hand of a three year old girl. Suddenly the old man slips and falls to his death, being mangled by the escalator at the bottom. The little

girl is terrified and seems paralysed. What should I do? How can I help the little girl?".

We looked at the dream in terms of it indicating an early experience of her being let down by the moving and erratic plastic breast (mother) whom she then drops and rejects, so she clings to her father whom she can then experience as being destroyed again (by her own dirty, greedy teeth?). I thought of this as expressing the negative side of a narcissistic state when she experiences her anger at a primitive level as part objects: a dangerous mouth biting, damaging the breast or being attacked by the breast. At the time I showed her how she could have felt frozen and paralysed as the baby and as the three year old. I also showed her how the anxiety of the dream could be related to her feelings about me: what will she feel if what she fantasised had happened at the breast originally and subsequently again with her father (the object is dropped or attacked), if this happens again with me? Then all fails and **she** is left to drop, be mangled, attacked and die. I believe the counter transference feelings I had at the time, of feeling paralysed and useless were a direct reflection of Miss P's overwhelming fear of experiencing this kind of breakdown and loss. So perhaps it is not surprising that this dream, (which came shortly before the beginning of the second long five weeks Summer break) and the sense we were making of it together in our work, seemed to be "dropped and mangled" by a new relationship she entered into during the last week of the second Summer break. As if she said to me, that if I were such an erratic and unreliable mother (breast), she would return the same: not remain true to me but drop me. The work moved into a new and angry phase.

Perceptualisation of Emotion as Defence

When we resumed therapy after the second Summer break, our work was notable for an unusual number of late and missed sessions. (She missed about one fifth of the total possible sessions, whereas before she had rarely missed). This was usually due to her oversleeping and also suddenly taking extra weeks of holiday (one before Christmas and one before this latest third Summer break) with her current boyfriend. This acting-out fitted in with an overall sense of fragmentation, superficiality and lack of affect in the sessions.

My counter transference to the missed sessions included a highly unpleasant mixture of feelings: so I would regularly put down the telephone when she would ring to apologise (15, 25, 45 minutes into the missed sessions) feeling attacked, blocked and useless. I tried to show her how the fragmentation of our work through her behaviour and the missed sessions was robbing the sessions of their rightful place in her life and feelings. However, by her acting-in during the sessions with her superficial thinking

and dismissive attitude and her acting-out during weekends and the time when she was not with me, keeping herself busy with whatever substitute "supplies" she could find, she continually evacuated the sessions and me of all meaning. But it was my particular combination of counter transference feelings at this time, along with Miss P's lack of affect in the sessions, which stimulated two essential questions in me: where is the affect, and apart from the missed sessions, where and when were "attacks" on "me" going on? Being blocked and discredited in my counter transference feelings left me feeling "in pieces"; I conceived of this as a reflection of her early infantile fantasy life. So the different ways she could experience me dropping her, of us both being in pieces would stimulate frantic, fusional controlling wishes and her different "masturbatory" activities which MELTZER helpfully highlights in his work on "Anal Masturbation".

The fact that my response to these above questions emerged so gradually, was again as MELTZER has pointed out in the counter transference of this kind of case, as if my eyes could be turned away in embarrassment or distaste from the "dirty little worthless girl" (the partial identity of which Miss P. is so ashamed). "Dirty little girl" is one version of Miss P's body image and it is this body image which holds the key to both questions: where was the affect in the sessions and where were the attacks on "me" going on? A dream of Miss P. pointed the way to answering the question. The dream came at the end of a week in September after a year of therapy, when she was worried that she might have become pregnant from her latest relationship (begun during the last week of the five week Summer break) with Michael, a man twelve years her senior.

> "I am on a highway; the side I am on is filled with heavy industry, with noisy activity and fumes everywhere. Then I meet my friend, Valerie, who says "there is something very different down the road – on the other side".
> I don't believe her. She says, "just you wait and see! Bring your bikini".
> We walk down and cross the road. I can't believe my eyes – I blink! It is hot gleaming sand and blue water lapping onto a beach: a shimmering oasis. I put on my bikini and I am intensely self conscious and worried about my tummy and how I look. Valerie says, "there is someone here to see you". I look and it is my old boyfriend, Peter". He is in the water – he waves. I don't want him to see my fat tummy, but he comes up and acts naturally. He takes my hand and we walk together down the beautiful beach. I have the acute sensation of our fingers fitted perfectly together. It blocks out all else".

At the time the dream emerged it was not brought into the therapy, except that the word "oasis", like her earlier phrase "permanent cuddle", now stands in her mind for at one time an ideal solution that she longs for, but also now there is an emerging realisation that "permanent cuddles" and "oasis" situations are temporary, pseudo-satisfactions.

Miss P's associations to the dream were revealing and it became obvious that she has a very powerful charged perception of her body. The associations were to do with perceptions that she had at that time of her stomach being bloated and ugly, as if she was "four months pregnant" and the repulsion she feels if Michael (or anyone) touches or sees her "fat" stomach. She associated to the fact that in real life she'd never wear a bikini. She tries to keep her body "together" with a firm one piece suit. I think this is a present day reaction of Miss P's to a powerful primitive fantasy of her body not as a whole but in pieces. (Part objects: breast, stomach, mouth). All this became more clear when she reported "noticing in myself a state of mind which I would not have noticed two years ago". She had invited a friend to go on holiday over Easter. Two days later he told her in a pub that he could not afford the £40 she had calculated that he would need for the holiday. Instantly she felt "totally unattractive and big".

> "I feel that people in the pub would pick me out and see my unattractiveness".
> I asked her what her image was of herself in the pub?
> "With a lot of jagged edges".
> "So if someone touched you they would get hurt?" I asked.
> "Yes", she said. "And sitting there I felt as if I were being attacked by peoples' eyes".
> I said, "I think you are saying that after your friend disappointed you by saying "no", you felt very very angry and would have liked to attack **him** and you felt that people could see you as ugly and attacking".
> "Yes, that is just right". She said. Later in the session she added: "Funny, when I left my flat to go out with my friend, I knew by his eyes that I looked nice. But when I looked at myself in the mirror in the pub after he had said "no" to me, I was totally transformed – **ugly**".

I could now really grasp the primitive level at which Miss P. can operate so that when her friend disappointed her, she perceptualised her rage. I could also observe from her material how she can displace and make symbols of various parts of her body: visualising herself as "jagged", ready to bite and attack and so seen by others as ugly or conversely as there being teeth in the eyes of people in the pub, or as in the dream her fear of the bloated

ugly stomach which hides an attacked or attacking "baby"? She consistently scrutinises herself to be sure she is fresh and clean and also asks her boyfriends constantly for reassurance that she is clean and sweet. She is frightened that her dirty attacking "baby" self (who has so much power because she is not recognised by Miss P.) will be found out. Gradually (and my counter transference feelings were so important here) my eyes could "see" her body image and I understood more clearly where the affect resides and why her body perception and primitive baby feelings are so important to understanding Miss P. My interpretation to her of her feelings about her body and face in the pub, struck her forcibly at the time, but as with many insights and interpretations she appears to chew them over prior to secretly spitting them out. This was also true in relation to interpretations I gave in relation to her angry attacks against me. I conceived of "Peter" in the dream, as the "mother" the empty body, with no other "babies" inside her. Or if there are other "babies" present, they can turn Miss P. "ugly and dark" – an expression of her ugly and angry feelings. In exploring this idea together, she told me how once when an older envied sister, who was visiting from abroad and seemed to her to be "shining" for her parents, Miss P. felt herself to go all "dark". This happened at her family home when all the family were looking at photos of this sister. Miss P. had to retire to bed feeling sick and nauseous: another instance of affect expressed in body perception and primitive baby feelings. For a week in the late Autumn when I had to cancel a session or charged her for a missed session, I seemed for her, not to have an empty body but to have other "babies". In anger, feeling cast out completely because she could not have sole possession of me and be alone "inside me", she went to find an oasis in which she could feel safe. She can feel safe either "inside" herself or "inside" another by creating a feeling within herself that she is not alone or separate. I interpreted to her how she does this by means of various omnipotent replacements. But she can easily feel unsafe even when relying on different men to stay with her and reassure her. So, when she experiences her objects to be failing her and so her fear of dependency on me is heightened, she becomes depressed and feels as if she is "falling to pieces". At these times she has tried to supply **herself** with an "object", this has propelled her into visiting her G.P. to secure sleeping pills or anti-depressants at three different times during the therapy. I have interpreted to her how she must supply herself with comfort as a reaction to my separateness. GALLWEY'S ideas are illuminating in relation to Miss P.: "(omnipotent replacements) ..... can lead to a disguised parasitic reliance on a host structure. When less complete, such fantasies are supported in infancy and childhood by various forms of self stimulation, giving rise in later life to a reliance on the use of objects in a fetishistic manner or *a preoccupation with the body.....*" *

*my italics

So in the dream the sensation of the fingers fitting together that "blocked out all else" is related to her struggle not to think about or experience separation. A dream, at the last Christmas break when she suddenly and without warning took an extra weeks holiday with Michael, highlights the relevant issues:

> "You and I are lying on the couch in your consulting room. Our eyes are locked together. We feel there is no-one else around and we lie looking at each other undisturbed".

I interpreted this to Miss P. as another expression of her desire for fusion, with no threat of disruption or separation: perhaps an echo of an early desire to keep her mother continually in her eyes and so in her "power". I showed her that with the Christmas break coming she would want to act-out and demonstrate her power over me by dropping me – taking an early extra weeks holiday with another. At one level Miss P. appears to accept such an insight, but at a deeper level she evacuates it. So, in a recent session when I suggested (in reconstruction) that as a child feeling separate and alone she could have tried to comfort herself, she recoiled saying it was a "horrible thought", associating this in her own mind to experiences of masturbation when she tried to comfort and relieve herself of angry and humiliated feelings. It felt as if she could not contain this thought and its implications.

During a temporary departure of "Michael" to another country for two months in the Spring of the second year of therapy, I first conceived of the "fumes" of Miss P's oasis dream as standing for a "smoke screen of resistance" in the therapy. However, now I think it is an indication of more willingness at present on her part to work industriously to try to understand her feelings; although to leave the "industry" of psychotherapy for an "oasis" situation (by all the narcissistic and masturbatory ways she employs) is always seductive to Miss P. So she uses objects, as we have seen, such as boyfriends, family and friends in a social way to supply her with comfort. If they are not actually physically present entertaining and distracting her in different ways (through sexual or intellectual stimulation), she employs the telephone to stimulate herself, asking and giving advice and information or getting reassurance of different kinds. In isolation she stimulates or comforts herself by a variety of means such as food, alcohol, sleep, or medicinal drugs. She also weaves sexual fantasies about possible relationships; the material concentrating on fusional desires which she has described in sexual terms to me, but which have a curious asexual colouring to them. However, there seems at present to be slowly emerging a more healthy sane part who is now "blinking" and questioning her "oasis" techniques.

As feelings about herself and others are displaced to parts of her body, so in the transference, in body terms (reflecting primitive baby feelings),

feelings for me are displaced or attacked so that she is either longing to fuse with "me" (mother) or she is attacking the other "baby" inside me, or she herself becomes "mother", taking over my function inside or outside the therapy session.

In relation to this she described a revealing dream:

> "I come to your house, to your consulting room and I am late. When I get there I learn that you have already left. I feel upset. Your hallway is filled with mothers with their babies in pushchairs. I wonder when you will see them".

I interpreted the dream to her in terms of the different aspects of her "baby" relation to me: fused with me inside my womb (pushchair) or filling up my house with her baby and mother selves, or the reverse: feeling late and excluded by me and all the other babies that are inside my house; or again that she is me who has gone away from the consulting room and session; busy with others and keeping herself absent from our work while she takes over my function as mother and therapist. The dream illustrated what we were trying to understand at that time. How Miss P. has not been able to develop progressive psychic independence. As I indicated before, her imaginary companions and their present day counterparts, which we have discovered to be a series of fetishistic objects, have not grown up; neither has Miss P.

Miss P. feels, in relation to her objects, that she is either "all in or all out". So she would concentrate good mother feelings in me, but on her own terms. To be "all in": that there would be actually no difference between us and this would deny specificity and the possibility of separation. Her constant "acting-in, acting-out" in relation to the sessions, although carried on behind a "civilised exterior", hides an enormous rage with me that I will not make her special. Charging her for missed sessions, making clear and firm arrangements for my holidays, are times in the therapy when polite behaviour patterns, pseudo-maturity slips and the power of her anger is revealed. This is often followed by the show of cooperation and submissiveness but again my counter transference feelings of unease and being secretly attacked, indicates that the real affect is being perceptualised or dispersed into other objects or pseudo-feelings. Another response, as MELTZER suggests, of anger and frustration over the mother's separateness is an "identification of the rectum as a source of food". This results in what he calls "anal masturbatory activities". The incident which I related which caused her so much embarrassment to report to me of bingeing on a large amount of chocolate in a public lavatory, can stand as a typical example of anal masturbation for Miss P.: bingeing with men, food, advice in a place she somehow knows is inappropriate in an unsatisfying way. Or, as GALLWEY writes: "Emotional hunger and underlying sense of poverty give a vulner-

ability to sensation seeking, drug and alcohol abuse, grandiosity, and manic flight from misery, often only sustainable by continual exploitive behaviour and short term satisfaction".

A pointed attack on me came at the very end of the last session before the last four week Summer break. It contained all her ways of defending herself against a fear of dependency and separateness. So, as she walked out of my consulting room door, she smiled and asked when I would be resuming work? I told her the date again (I had previously made it clear when we would be resuming work). She responded that she would see me a week after that date as she was taking an extra weeks holiday then with "Michael". In this "attack" there was her habitual use of substitution, devaluation of me and the sessions, and the triumph which can accompany her attacks on me and the therapy. It also demonstrated her way of functioning in a concrete way, perceptualising her anger with me without trying to conceptualise what the coming break and being apart from me could truly mean to her and her inner world.

Because of the timing, this decision could not at the time be thought about or brought into the therapeutic dialogue and so I was left to understand more clearly myself how the crushes on women and the "triangles" that she had been involved with since childhood, point to what MELTZER cites as her "delusional identification with mother". This would be an example of what I have already mentioned earlier and of what SOLOMON calls a "..... lasting fixation .... thumb sucking should not be seen as a wish for the mother but as a displaced dependency which excludes the mother. It forms a closed circuit in self. Thus the child obtains the measure of self sufficiency and builds a primordial, self contained system. However the dependency remains displaced onto thumb or finger, and later to the teddy bear or security blanket". – Or in Miss P's case to her imaginary companions, series of female teachers, and now her replaceably libidinised objects: her continual series of boyfriends. All this was most pointedly emphasised to me by this latest bit of her acting-out.

GALLWAY looks at this fixation in terms of "a disguised parasitic reliance on a host structure .....the use of objects in a fetishistic manner".

The ending of the two year training period has been important in this context. Miss P. fantasised that I would tell her that she could finish therapy. When I said I felt this would be premature, she said she felt relieved. Perhaps a slight movement away from a habitual omnipotent avoidance of real dependency on me? However, for Miss P. to concentrate good mother feelings in one place (in me) will take time. So she has been saying over the past three months; "I know I am using my relationship with Michael, that I do not love him, but I do not want to be alone".

As I have indicated, Miss P. has shown strong anxiety related to the idea of becoming attached to me, fearing at the same time as longing for an involvement which she labels "lesbian". We are now, I believe, in a position to begin to understand what "lesbian" actually means to her in her internal world as she begins to experience fragments of a whole relationship with me and as a whole, real and separate person.

Many of the difficulties this case has presented are about Miss P's refusal to engage in the mental activity and process which is necessary if she is to make in her own mind the necessary mental linkages. If she could create these links, they would enable her to understand her emotional experiences: in a real way she will not allow herself to feel or to think. She insists that only an object which is ever present (like her imaginary companions) is tolerable to her, thus she can avoid feeling separateness or thinking about it. So, her attacks on me and the meaning of her therapy are attacks on the side of herself that recognises therapy and me as important and central to her growth. She repeatedly evacuates her own "sanity" and any sense of attachment to me; continues to use replaceable men (mothers) to avoid separation and anxiety; in this way she keeps things unchanged and so defends herself against what she feels would be the release of massive destructive feelings which could be liberated if she allows herself to experience real separation from her objects. Her repetitive behaviour indicates the life and death quality of her dilemma. Her lighthearted companions have not grown up; nor has she; and the masochistic quality of her lack of development is given a new and disturbing twist in the most recent material to emerge before the Summer break. She has described Michael (with whom she is now completing a year's relationship) as at times showing female personality features which are for me reminiscent of a male with identity problems concerning his gender. So she has told me that she has at times a powerful wish to terminate the relationship with him. However she stifles the wish, it seems to get evacuated and for a while she does not mention it. That she has chosen for her boyfriend an older man who appears to display gender identity uncertainty brings back to the centre of our work the imaginary companions of her youth, who symbolise her undifferentiated sexual identity and also her wish to control her objects which are fetishistic and unreal. In their fantastic and primitive aspect, they also symbolise the part of Miss P. that is "in the service of misunderstanding, of anti-thought, which is opposed to the discovery of truth and which is essentially a system for generating lies .....". (MELTZER)

Despite the ongoing difficulties of working with Miss P. when a good session is always followed by her evacuating the goodness due to her separation anxiety, I believe that a guarded optimism is justified about the

outcome of Miss P's therapy. The two years have been completed and perhaps this will begin to make the therapy more her own.

However, as she gets more deeply involved in therapy, so the separations at holiday time and at weekends are becoming more and more difficult for her to tolerate. Despite the pointed acting-out at the end of this last period of work in her therapy, I believe there is dawning the unconscious understanding of separateness and separation. Just before the break she brought this dream which points to the possibility of an ability to perceive me as a separate mother, relating to other children.

> I come to your house. You are not there. But I see a big noticeboard in your hall. I look at it and see it has a long list of childrens' names on it. They are bright Jewish children, but I feel they are deprived, handicapped or very needy in some way. I am amazed that you have so many children, and they have all been so quiet all these months. I have never heard them. They have been so quiet. I try to think where you keep them all.

If she can become at last my "deprived" and "needy" child, she can live in my house with my other "children". She will not have to persistently make attacks on linking and evacuate our sessions and thereby, in her anger and anxiety, devalue and dismiss me and our work together. Perhaps she will be able to begin to come to terms and accept me as both a present and absent object who is, nevertheless, an "integral part of her life".

O'SHAUGHNESSY's thoughts on the absent object are very illuminating in thinking about Miss P., and an appropriate way in which to end this paper. She speaks of the advance a child must make from experiencing "a bad breast present" (what she experiences when she is hungry, frustrated and feels she is dying) to a "critical advance":

> "For the wanted breast is in fact not a bad breast present, but a good breast absent when needed. ..... The infant has to advance from experiencing the needed absent breast in the fantasy of a bad breast present, to be able to **think of** the real missing good breast. This crucial advance in his development is hard since the bad breast, which in fantasy is present, is felt **au fond** to be starving him to death, and it is only by tolerating the pain and terrors of his frustration enough that he can put himself in the position of being able to **think about** them, to think, eventually that what he needs is the missing good breast. Such knowledge, in thought, of the good breast will also help him to endure his state of need. Since tolerance and frustration is essential for thought to develop, the infant, who predominantly avoids his frustrations and in fantasy simply gets rid of them, is employing

methods actively antagonistic to thinking, so that the development of his mental powers will be, at the least, inhibited and may be disturbed".

If this can be achieved in her therapy, Miss P. and her imaginary companions will grow up.

REFERENCES

BION, W.R. (1967). **Second Thoughts.** "Attacks on Linking". Maresfield Reprints. London 1984.

Gallway, Patrick L. G. (1985) **Aggression and Dangerousness.** The Psychodynamics of Borderline Personality". Edited by D. P. Tarrington and J. Gunn. John Wiley and Sons Ltd. London 1985.

Meltzer, Donald (1966) 'The Relation of Anal Masturbation to Projective Identification'. **International Journal of Psycho-Analysis** 47, 335. (1984). **Dream-Life.** "The Klein-Bion Expansion of Freud's Metapsychology". The Roland Harris Education Trust Ltd. London.

O'Shaunnessey, Edna (1964). 'The Absent Object'. **Journal of Child Psychology** vol. 1 no. 2. London 1964.

Solomon, J. J. C. (1978). **Between Reality and Fantasy.** "Transitional Phenomenon and Obsessive-Compulsion States". Edited by Grolnick and Barkin. Jason Aronson, London.

THERAPY AND ANALYSIS AS ACTIVITES OF THE SELF

Richard Carvalho

Introduction

The distinction between psychotherapy and analysis is more psychoanalytic then Jungian. Nevertheless, it is one that raise important technical questions, the answers to which suggest ways in which psychoanalytic thought can inform Jungian thinking, as well as ways in which Jungian concepts might shed light on a psychoanalytic dilemma.

I will start by stating the problem as seen from a deliberately simplified psychoanalytic viewpoint.

A psychoanalytic view

Attempts to differentiate between analysis and psychotherapy are frequently unsatisfactory and inconclusive. Essentially, the comnventional view is that analysis, particularly if seen as psychoanalysis, is a technique or a set of techniques aimed at a result of a certain kind. The **technique** excludes certain activities, particularly those activities that may "gratify" the patient rather than enable him to confront something problematic by, for instance, giving advice, medication or making personal revelations. The analyst's abstinence from such gratification invites the patient to confront issues of which he or she has hitherto been unaware. Implicit in the invitation is one to regress in a controlled manner in order to experience undifferentiated, primitive, and infantile aspects of himself. This process is fostered by the confrontation of resistances to the process, by examining dreams and by experiencing relationships that have not been worked out in relation to past figures. The person of the analyst is available for this, and his 'low profile' leaves him a relatively 'blank screen' for the patient's imagination to fill. Anxiety and pain are not mitigated by reassurance but confronted, and maybe augmented before they can be resolved. The frequency, 4–5 times per week, is such that the regression and the anxiety experienced within it can be supported and so that continuity is not lost as a result of the patient's need to resort to resurrecting his defences in the gaps between sessions.

Paper given at a Conference organised by the BAP Jungian section in October, 1986. The text is presented essentially unaltered.

The **aim** of this technique is a result whereby unconscious conflicts are rendered conscious and the structure of the personality is beneficially modified: if, for example, someone had an unconscious fear that their rage really could kill their mother, then they would need to develop a ferocious enough internal policeman to ensure against any experience or knowledge of the rage. Examining this fearful fantasy and making it conscious reveals it to be a fantasy and the policeman's ferocity becomes redundant. In psychoanalytic terms, replacing id by ego enables modification of the superego and the defensive structure of the personality can become less rigid.

By the same token, perception of those figures in the person's environment who have been used to personify aspects of his personality will be similarly modified. If his instinctive capacity, including the impulse to love, conjures up a damaged and therefore vengeful mother and if the father is used to personify a punitive and inhibitory impulse against it, the patient's external world will be impoverished by the consequent unavailability of a mother or of a mother figure who may in reality be nourishing and of a father or of a father-figure who may in fact be loving and enabling. The patient will experience his internal world as hostile and sterile. There is no way of comfortably imagining such fantasy figures mating and there will consequently be no other sorts of mating either, whether these be the matings between different aspects of the self, between different ideas which are the basis of any sort of personal creativity, or the mating of oneself with another in a loving relationship. Where analytic work is possible it will modify the perception of such a damaged mother and policeman father so that relationships become possible in both internal and external worlds.

The aim of analysis stated in these terms summarises the history of psychoanalysis itself and represents different conceptual historical layers. The topographic model implies the desirability of making the unconscious conscious, the structural model the desirability of modifying the structures of id, ego and superego, while ego psychology implies the modification of ego functions and finally object relations theory implies a modification of distorted objects.

Pyschoanalysis, both as technique and in its implied goal, may be seen in sharp distinction from something called psychotherapy, or both may be seen as lying at opposite ends of a continuum. At one end of this continuum there is something which is investigative and mutative called analysis and at the other end there is something that is 'more supportive' called psychotherapy. In this conception, psychotherapy will be undertaken without the expectation of fundamental change, perhaps to limit the damage of a crisis, or to keep someone out of hospital. Regression is avoided together with anything such as dreams or attention to the transference that might invite it. Sessions are less frequent than in analysis, perhaps weekly, two-weekly, monthly and so on. Freud's rule of abstinence is modified so that advice, medication and practical help may be offered where appropriate and the analyst or therapist

does not function as a screen.

These two positions or poles are clear enough. In between is something called analytic or psychoanalytic psychotherapy. This may be limited in aim as in some of the brief psychotherapies to tackle a particular focus or it may in practice be indistinguishable in technique and purpose from what is referred to as analysis, except that it is likely to be time-limited (2 years is often offered on the NHS for various practical reasons) and it is likely to be once-or twice-weekly.

The Jungian View

In many ways the whole problem as to whether work with a patient is called psychotherapy or analysis arises out of the term psychoanalysis itself. Jung tended to talk about psychotherapy and analysis indifferently and on the whole analytical psychology has not developed a vocabulary which differentiates between an activity called analysis and another called psychotherapy. Nonetheless, Jungians do in practice distinguish between different levels of work, at a greater or lesser depth and intensity with more or less frequent sessions. The fact is, however, that the terms psychotherapy and analysis lead to daily paradoxes; of analysis that takes place within psychotherapy; of psychotherapy that happens in an analysis; of personality transformation that takes place out of psychotherapy or of analyses that turn out to have been merely supportive. On the other hand, the activities that connote psychotherapy or analysis can be seen to arise from the combined endeavours of the therapist and patient within an endeavour which is able to be both analytic and therapeutic: That is if they can be **seen to arise from the alliance of the analyst's and patient's selves as the most appropriate activities in the circumstances then the dichotomy between analysis and therapy falls away and with it the apparent paradoxes.**

The Self

We need to establish the way in which the term 'self' is being used. Psychoanalysts tend to mean by the term an idea of the individual's identity. The concept in psychoanalysis therefore blurs with that of the ego, and this is particularly the case in Freud's writing. In Jung's writing, on the other hand, 'self' designates the whole potential of the personality both conscious and unconscious. The ego is simply that part of the self which has become conscious. In Freud's psychology, the unconscious is derived almost exclusively from experiences that have been repudiated by the ego so that the work of analysis is to regain them. Jung's idea of the unconscious, however, though it includes aspects of experience which are unacceptable to the ego, is more importantly seen as the ground out of which consciousness and ego arise. The ego is not the dominant centre of the self but its facilitating

executive. What is unconscious is that which is not yet become conscious, that which has neither been invoked nor provoked by exigency or crisis either environmental or internal. When it is, it is the ego's job to lend it its faculties so as to allow it to attain greater differentiation and consciousness and to become modified in the process. There is, of course, a danger of idealising the self in these terms, but they offer the idea of a wide resource of creative response to challenges whether familiar or unfamiliar if the ego as executive to the self can be alive to them. The picture is of the ego as a conduit through which the potential of the self is given reflection and realisation. This is in contrast to a more psychoanalytic picture of the ego which is required to reposses itself of what it has repudiated.

As Jung describes it, any aim whether of analysis or of psychotherapy cannpt be arrogated by either the conscious patient or the therapist. The aim is that of the self; this may be, though not necessarily, the realisation of the self that embodiment of it that can be apprehended by the ego. This is frequently expressed symbolically, and one of the symbolic forms of which Jung made an especial study was that of the mandala. The self has for instance been visualised as the centre of a circle and its circumference, a walled garden (of paradise) with its enclosed fountain. As a matter of interest, this imagery converges with the imagery developed by those followers of Klein, notably Meltzer, who see the achievement of the combined object as a crucial aim of analysis. The combined object is the achievement and admission of the fantasy of the breast (the circumference of the circle or the garden) which is watered and fructified by the penis (the centre of the circle, the fountain, etc.) so that the individual can be nourished, comforted and rendered creative by this presence of which it is also the servant. This "combined object" which is seen both as the individual's achievement and as his creative core, is the same paradox which the alchemists called the elixir, the stone, the master or the king: it was in fact an hermaphrodite figure, both male (penis) and female (breast) of which they said "philosophers speak of him as their son/And everything they do by him is done".

This type of work is not necessary for everyone nor is everyone motivated or capable of the achievement. The self involved may not make itself available for the process and the ego may not have the capacities required to contain it. Jung talks of the "analysis" coming to an "end" before the sense of a "goal" (in the therapist's terms) has been reached, and of the patient leaving satisfied for a variety of reasons. His list includes the relief of having "made a full confession", having got a piece of advice or having been relieved of symptoms. In other words after a satisfactory piece of psychotherapy in psychoanalytic terms, but without the fundamental changes associated with the idea of analysis.

The point I want to make is this; **that the analyst with varying degrees of conscious cooperation from the patient serves a process in the patient and it is often only in retrospect that it is possible to say whether the "goal" has been achieved or what the "result" has been.** This is not to say that we must not make an initial assessment of what may seem desirable for a patient, of what may be safe and even of what may be possible; nor is it to say that one may not have broad strategic ideas within which to form interpretative tactics which may be more "therapeutic" than analytic or vice versa; nor is it to say that the process "happens" by itself without a great deal of skill and attention. Nonetheless, in the first place, there is no way of prejudging the result; the outcome of any undertaking with a patient may be analysis or psychotherapy or there may be no result at all. In the second place, activities which may be claimed as psychotherapeutic or analytic have to be seen as activities of the same self that determines the outcome. **This is because experiences of the analyst during the sessions, whether they are emotions, fantasies, or actions, must be assumed to be experiences of the analyst on behalf of the patient.** They are ways in which the patient's self can be presented to the patient's ego via the analyst. Obviously it is the analyst's job to be responsible, not to be crass, and to differentiate between what is his and what is the patient's. In Jungian terms the analyst is operating as a transcendant function, mediating between consciousness and unconsciousness. In psychoanalytic terms it is the experience of something on behalf of the patient by the analyst in the form of the counter-transference. Either way the analyst may be possessed by it and embody it malignantly or he may be concordant with it and embody it benignly.

Clinical Material

In the clinical material that follows I shall concentrate on one patient and the activities I found myself engaged in.

The patient I am describing has been coming for about five years. For convenience I shall divide the material into four phases.

Phase I

She was about 28 when she first came. Although I wanted to see her more frequently she could or would only come three times a week. She would not lie on the couch which she lounged on instead. This was a catagorical refusal based on her fears that if she "lay down" she would curl up, suck her thumb and never get up again. For similar reasons she was terrified of any affective contact with me, really with herself. If she once started to cry, she would never stop. She described experiencing herself as a little animal skimming across the pond through whose surface she would disappear if she rested for a moment.

She had read a lot of Freud and Klein intelligently some years before and would tend to bring material which she would interpret herself. Interpretations that I might make were usually presented in a quite intellectualised form.

I don't mean that I meant to so much as this is how they happened. The interpretations were aimed "deep" and at a primitive level but were floated in a "you might imagine ....." or a "it might make sense ....." sort of way. Even so, particularly if the interpretation was about her devastatingly destructive feelings about her mother, and especially if this were detected in the transference, she would become tremulous and tearful as if experiencing a catastrophe and beg for reassurance that it was "all right". This reassurance I found myself providing for some time like a kind and reassuring parent (which she had not in fact experienced) before interpreting the anxiety that had given rise to the tears and tremor. On the whole the transference was avoided and we tacitly agreed to ignore rather than to confront it unless it was unavoidable. Even then it was vigorously resisted and if it could not be denied she would dissociate herself from it emotionally.

After some months she reported with astonishment that she had suddenly noticed an absence of anxiety for some days. She realised that for as long as she could think she had been in what amounted to an un-noticed chronic anxiety state. Her husband confirmed that she had changed from a state of continual compulsive activity to one of much greater outer calm which he experienced with some gratitude and relief.

This marked the end of phase I.

Phase II

The year that followed was indeed marked by a great deal less anxiety and she settled down in her sessions though she would neither increase their frequency nor use the couch. The material deepened symbolically and in complexity. I found it very difficult to keep track of it, however, and the transference that might have given continuity to the material remained taboo. Essentially she continued to bring me material which she thought about herself. If she couldn't make sense of it herself, she didn't want me to. She became very anxious if she thought I knew something she didn't. Occasionally I would be tempted by my own sense of impotence and sterility into making an interpretation. But I do not think that these were important other than as examples of poor technique or loss of nerve.

Gradually, however, dreams began to emerge of gutted and derelict homes in front of which were cut down trees. This related directly to her fear that interpretative work would leave her in a similar state. There was an increasing sense of futility around. At one stage, I wondered with her whether she wasn't trying to tell us that she had gone as far as she felt it was safe to go

and that she wanted to end having at least gained some symptom relief. She continued, however, and came through this phase. One day she brought a dream which led me to say among other things that I thought she was telling me about her wish to relinquish the penis that in fantasy she possessed. She became quite enraged and insisted for months afterwards that I had told her to give up her penis which she had no intention of doing.

Phase III

There followed a year of empty sessions which I was surprised the alliance survived or that she endured. Initially she was silent, angry, contemptuous and distant. Gradually she thawed somewhat and became brisk and chatty. The sessions became filled with inconsequential small talk, episodes from her life and from those of other people close to her like a kind of Archers or Mrs. Dale's Diary which she called "gossiping". It was eventually quite pleasant but very frustrating, as you may imagine, though less so as it became apparent that something was in fact happening.

What changed things was my eventually being able to observe that contrary to her previous and oft stated wish to be a "good" or, in other words, a compliant analysand as in earlier days, she was now having the experience of being with me on absolutely her own terms. She was not "working" with the capital 'W' that she would previously have stressed, not bothering to think as she had previously felt compelled to, nor bothering to keep track of material between sessions and so on. What she had been doing for a year or so was ensuring that she could have a feeding experience that reflected her own rather than my identity. There was none of the old anxiety about this interpretation which was greeted with pleased assent. The next session, she brought, almost as a gift, a dream about being in a beautiful room with her sister, looking out over lovely trees.

Phase IV

Some time after this she developed a fantasy about having an affair with an absolutely unsuitable man. She got in contact with intensely frightening and excited feelings, mostly orally expressed and akin to previous material that she had presented about smoking. There were, of course, adult sexual elements. She knew that she would never get involved with the man but became defiantly secretive about it. She knew that it had something to do with me but we couldn't for a time understand what. Three sessions before a break, she flew into the room with a catalogue of impossible situations with which she had to deal. The last straw was that she had been given a tape to listen to: if she made the extra journey to fetch a suitable machine to listen on, her schedule would be impossible. Could she borrow mine? Without hesitation I got up and crossed the room to my desk where the one I just

happened to have brought home that day was sitting, and handed it to her. She was visibly relieved and was then able to tell me a dream which I understand to be her first experience of the "circle with a centre" personified by parental figures or by parts of them: it was an enormous achievement although (and because) it may contain defensive features. The dream was of being inside a house with many people. The house was on an island and there were huge waves from which the house was protected across a bay by a long spit of sand which was gradually being washed away by the waves. (This was an allusion to me as a protective analyst/penis who is however going on holiday). Then she was in a room like her parents' bedroom with a man and a woman whom she did not know. The man was leaning against the wall. She herself sat on the bed. (i.e. She was now located in the conjunctio as personified by her parents' intercourse). She realised that the waves were lashing against the house, but there was no fear. The (protective) man/father/penis registered the vibration of the waves' impact against the wall as he leant his back against it.

That is as much clinical material as I want to give now. I want now to look at this process from the outside as a set of behaviours before turning to the internal processes that give them coherence beyond descriptive phenomena.

External indicators of "a psychotherapy"

I have deliberately kept you in the dark about every significant aspect of this woman's life so as to force you to view the process I have sketched as a set of externals. Viewed in this way phase I is marked by every feature normally taken to indicate a "psychotherapy". It is three-times weekly, the couch is not used, regression is avoided, awareness of the transference is minimised, anxiety is reduced rather than confronted, defences, particularly intellectualisation, are reinforced, and reassurance is offered. Phase II was very similar in terms of my activity. The achivement of considerable symptom relief faced her with a dilemma as to whether to end in the way described by Jung or as to whether she could risk facing herself without devastation: there was little interpretative work I could do beyond containing her anxiety. Phase III was ushered in by the patient's sense of catastrophe and betrayal at what she thought she heard me say and this was followed by 18 months or so which felt sterile and arid and would have been hard to recognise as either therapy or analysis. As we have seen it nonetheless achieved a growing sense of containment following which in phase IV she could allow herself to notice previously warded off feelings of intense excitement which enabled her to achieve a novel ecstasy expressed in the dream described. There is a change in that the end of phase III and the start of phase IV are marked by a growing awareness of the transference and an evident ability to allow a deepening

regression. But in the tape-recorder episode there is an instance of practical help or of my acting out, according to your point of view. In external terms we may still be looking at something very like what is described as a psychotherapy.

Looked at in internal terms it looks rather different, though these are only beginning to be available and being in the dark has very much been my own experience over all the time I am describing.

A process of internal transformation

As Jung says in his "Psychology of the Transference", the parents are the first people ("objects" we would now say) available to personify processes in ourselves. Whatever the process is (the "archetype") that can be symbolised by the "circle and its centre" or by the room with its bed in my patient's dream ("archetypal images") can only be got hold of at first in relation to the mother and father or in more primitive (part object) language, the breast and the penis. If these are not available in tolerable form for bringing together, then the disparate parts of the self that need to be personified by them cannot be brought together either.

My patient's mother was a nervous and rigid personality who was not able to intuit her child's emotional needs, and who defensively compensated by knowing better than her child what she needed. Any protest was met by emotional frigidity and withdrawal, a disappearance which the child experienced as annihilating. Shortly after her birth her mother returned to work and when my patient was less than a year old a younger sibling was born. Father was emotionally violent and his own childhood deprivation made him competitively needy. There was no-one to embody her containing circle or her phallic centre. She was thrown back on the development of a compliant false self and the early development of a tom-boyish and later intellectual "phallic" identity.

What I am now retrospectively able to realise is that this woman has constructed appropriate parenting experiences out of her use of me and that I have sometimes despite a "technically correct" impulse to do something quite different, provided the experiences that she had needed. In phase I, because I did not require her to do more than skim the surface of the pond, I was the mother who did not swallow her, who did not confirm her fear that I embodied her unintegrated greed and rage and who furthermore would not behave angrily if she had an identity independent of the one I wished for her. This enabled her in phase II to face her anxiety that any revision of her phallic identity (the chopped down tree) would leave her as an empty shell (the gutted house). When she "heard me" telling her to give up her penis she was really hearing her own injunction and this enabled her in phase III to risk hating me and behaving destructively to me out of her true self. At last she

had a mother in the transference whom she neither need fear nor fear for, and from whom she could demand the sort of "unanalytic" mothering she needed without material destruction. She thus at last achieved an experience of safe containment by the breast.

But the dilemma was that it opened her also to the passionate and ecstatic feelings that she could not risk with her own mother except through the fantasy of stealing them in masturbatory fantasies which took the form of the idea of stealing an ecstatic intercourse with the penis she fantasied was inside the breast. This fantasy of stealing left her convinced that the penis was damaged in the process and therefore vengeful in its own right. Her father's actual emotional violence and damage appeared to confirm this fantasy. Working through these fears allowed her to have the dream about being safely inside me, about having a self; a circle and centre, personified by a mother-with-father which would not be shattered by the storms of her passion (despite my absence). Asking for the tape-recorder was asking me as mother for the penis. It had been essential, she explained later, that I either gave it to her or said that I couldn't **without interpretation** because an interpretation would have told her that her request was a damaging, greedy demand. In part-object terms, my giving it to her meant that the containing breast now had a penis and wished her to have the benefit of it. Her ability to allow them to relate now meant that they could nourish, sustain and protect her. But I couldn't know any of this until after it had happened.

I hope that you might see and accept that if at any stage I had insisted on being my own idea of an "analyst", the work of transformation called analysis could not have taken place. If however I had thought of myself "merely" as "doing" psychotherapy, I would have missed the point.

Conclusion and Summary

Perhaps I could conclude with the following observations.

1. Those activities seen as analytic or psychotherapeutic apart from very general strategic considerations at assessment, are more appropriately seen as part of the unconscious understanding between the patient and analyst who will between them work out the **optimal degree** of regression and anxiety, etc. within which to work. That is not to say that this understanding will always be benign nor is it to sanction destructive acting-out by either patient or analyst, nor to dignify the haphazard as technique.
2. This unconscious understanding will include a knowledge on the part of the patient of the object he or she needs for the assembly of his or her self and a response on the part of the therapist or analyst to provide out of himself the appropriate experience, i.e. to be the object that the patient creates from session to session, from minute to minute.

3. This may be understood, verbalised and interpreted, but often only after the event. i.e. Analysis as intellectual activity is often secondary to the transference/countertransference interaction.
4. It is only possible to assess whether analysis or therapy has taken place retrospectively in the light of the results obtained.
5. We seem to be looking at 'analysis' as the realisation, recovery and restitution of unavailable and maladaptive aspects of the personality. These may first have to be embodied "therapeutically" by the therapist/analyst before they are bearable enough for awareness or thought. This depends on the analyst's own integrative analytic achievements and ongoing potential for growth. Only these enable him to respond appropriately to the demands of his patient's self out of his own self in a benign form which may be later understood and made available to the ego.

SHOPLIFTING & BINGE-EATING – SYMPTOMS OF THE ANTI-SOCIAL TENDENCY

Elizabeth Bostock

Summary
This paper focusses on part of a patient's analytic psychotherapy linking shoplifting and binge-eating to the anti-social tendency as outlined by Winnicott (1956). Other important aspects of the treatment have been omitted to focus on this particular theme. The history of Winnicott's concept is reviewed, and issues of management, externally and within treatment are addressed (Winnicott 1961). Finally, work with this patient is linked to innovative studies on Pathological Shoplifting (Silverman 1987).

Although stealing and overweight were mentioned amongst the presenting symptoms of this patient, the severity was not immediately apparent. It was only after starting treatment that I learned that she was shoplifting regularly from stores and supermarkets, and later still before she acknowledged the reality of an eating/weight problem, which became increasingly prominent as the shoplifting declined. It was when I considered these two factors of stealing and eating disorder **together** that I recognised them as a manifestation of the anti-social tendency in the transference. Therapy gradually revealed pre-oedipal precursors and early traumatic loss, of which the patient was unaware when starting therapy.

In discussing the anti-social tendency, Winnicott distinguishes it from delinquency and stresses that it is not a diagnosis, and can occur at all ages. It develops instead of a psychotic illness and is compulsive. It can include incontinence and messiness, cruelty and perversion, but the main characteristics are stealing and destructiveness. It is linked to deprivation i.e. the experience in early life of something good which is then lost or withdrawn, when memory is insufficiently established to keep the good experience alive.

It is an essential feature that the stage has been reached of perceiving that the failure/deprivation actually lies in the environment. There is a continuous search, first with the parents and in the home, then in the wider sphere of society (school, authority) for a setting which can stand the strain of impulsive destructive behaviour. Repeatedly, potential situations for change are lost because of misunderstanding or intolerance. But if a stable and

Based on a Qualifying Paper for Associate Membership of the British Association of Psychotherapists

accepting environment can be found, the original loss and despair can be re-experienced and appropriate anger about the loss expressed and accepted, freeing blocked emotional development. Winnicott stresses repeatedly that it is the nuisance value of the anti-social tendency that implies hope and a favourable indicator of the potential for recovery.

Winnicott based his understanding on Freud (1917a) and Abraham's (1916) work on melancholia, Klein's (1937) theory of the depressive position and Bowlby's (1978) emphasis on deprivation in early life. The themes of the anti-social tendency are summarised in an article by Davis & Wallbridge (1981).

Background

Miss W is 30 and single, highly intelligent and articulate, with a responsible position in academic life. She is the eldest of four children. All the siblings have done well in their professional life and are married with children. Miss W always felt her parents would have preferred her to marry and raise a family, and they undervalued her professional success. Although there was an emphasis on education, Miss W reported a happy childhood. Her father worked long hours but helped with homework. Her academic achievements helped her to feel that she held her own in the family and was favoured above her siblings but they soon began to overtake her, apparently with far less effort and she struggled to stay ahead. At school she was in a class with children older than herself because of her intellectual ability, but she was physically and socially behind and felt gawky and inept at sports and gym. The school routine and rules gave her a sense of security and she withdrew even more into study. Imaginative creativity was inhibited (and discouraged by her parents in favour of examination striving) and led to a scientific bias in her studies. She liked art but preferred finely detailed, controlled drawings, to free expression paintings.

She gleaned something of the facts of life from library books, and her mother prepared her for menarche, but relationships and feelings were seldom discussed. She often cried as an adolescent, but did not know why and longed to remain a child. In time, she became rebellious with many stormy rows with her parents, her overeating, once attributed to anxiety about study, becoming the focus for contention. Relationships with the opposite sex were limited because at one stage she became over-religious, and in any case she was occupied with studies. Because of the continuous rows at home, she moved away to university, and lived in a flat-share during which time she has several uncommitted sexual relationships. In her late twenties, she had a brief but passionate love affair, which ended, she claimed, because of religious differences. A few months after the end of the affair, a holiday with her family and a visit to a relative in a psychotic state precipitated a period of

overwork, almost to the point of collapse which led her to seek treatment. Gradually, it became clear that the overwork was an unconscious attempt to ward off feelings of anxiety and fear which threatened to overwhelm her.

The Therapy

Although I was struck by Miss W's warm smile when we first met, our initial contact was marked by hostility and negativism. In fact, she asked for another therapist, but was persuaded to discuss her feelings further. She said she had disliked me within a few minutes of meeting me, that she didn't like my open-ended comments or my expectation that she should do the talking. She wanted questions with only one answer, and rational intellectual discussions. She relaxed slightly when I suggested that she was trying to recreate a student-tutor situation like the one she was used to at work.

She outlined several symptoms – self-destructiveness and self-punishment, gross overweight, rejecting religion, stealing and lying, over-dependency, bad memory, sociual ineptitude and general physical debility. She complained that I underestimated her difficulties about commitment to therapy. Although she desperately wanted help, she wanted it on her terms without emotional involvement with me, and commitment of her time or money. Her resentment at not being offered individual treatment in an NHS setting, masked her urge to steal and an attempt to get 'something for nothing'. We then reached an uneasy compromise about treatment but I later found out that for several weeks she continued to explore alternative sources of therapy. Once she had decided to settle into treatment, she used the couch without hesitation, attended regularly and punctually, and offered plentiful material.

Because of the risk that she might act out with increased stealing in the face of anxiety about conflicts in therapy, I felt it was important to understand the extent of the problem from the start and questioned her about this. The first time she stole anything was when she was six, and took money from her mother's purse on shopping errands to pay for bus-rides or cakes. She then revealed that she had been shop-lifting regularly, the most recent episode coinciding with the end of her important love affair – she absent-mindedly put something into her own shopping bag instead of the supermarket basket. Realising what she had done, she worked out how it happened, and was tempted to try again. Having been successful, she had continued ever since, taking items she could not normally afford to pay for. She took good things to eat, or gifts for herself because she felt no-one else loved her enough to do so. Her actions were totally ego-syntonic and guilt free but she was continually terrified of getting caught.

In working with patients with anti-social tendencies, it is important to be alert to the danger of the symptom being used as a means of interrupting or

terminating therapy at times when anxiety increases. Where there is a clear risk of apprehension, additional medical cover from a psychiatrist/analyst specialised in the forensic field should be sought. In this case, Dr. F interviewed the patient, confirmed psychotherapy as the treatment of choice and agreed to extend the existing medical cover. Through the transference, Miss W was compelling "someone to attend to management", another step in the search for a holding environment.

Although she mentioned it amongst her symptoms, Miss W was reluctant to discuss her weight. She did not consider she had a problem, as this was an attitude imposed by society, and her parents. Whilst conceding that she overate, she referred to herself as "heavy", and implied hereditary or metabolic causes beyond her control. She dissociated her eating habits and her weight as if she and her body were separate entities.

Winnicott (1960) comments on the split which occurs between mental activity and the psychosomatic being where there is a high intellectual capacity and the mind becomes the locasion of the whole self. Miss W's sibling rivalries and family pressures towards academic achievement had undoubtedly reinforced this separation of mind and soma.

Miss W was adamant that she would have no truck with anyone, including me, who might suggest that her weight was controllable. I felt that at this point in therapy, any comment would repeat her adolescent rebellion with her parents, and might lead to her terminating therapy. She effectively silenced me as she had her parents. Her degree of resistance to focussing on either stealing or eating was such that I felt to persist would result in her depature from treatment, as she had left her parents' home after repeated rows.

Apprehension and/or conviction for shoplifting would cause a collapse of her outwardly respectable way of life. The tension between maintaining "a false self" of respectability, and the compulsion to continue shoplifting created unbearable tension which she unconsciously tried to relieve through eating. Awareness of the risks she was taking with her physical health and through shoplifting gave rise to a counter-transference wish to "cure" her as soon as possible, and sometimes despair at the daunting task ahead.

The early months of therapy were dominated by material about external figures, in particular those in her working situation. The overall theme during this time was about her frustration and inability to control her colleagues and students. She attempted to dominate them by being bossy and became tearful and upset when she failed. This situation was re-created in the transference as she consistently tried to draw me into intellectual discussions or question and answer patterns, and derided me when I resisted this. She described a boss who shifted responsibility onto her for practical matters,

while he withdrew and enjoyed research projects. Resisting all my attempts to draw this material into the transference, she did accept other interpretations establishing links between the boss and her father, especially after a dream where she called the boss "Dad". This was the first time she accepted that her dream life had any relevance to present experience.

It is difficult now to convey the intensity of Miss W's ambivalence and testing out through simultaneously presenting plenty of material but repeatedly rejecting interpretations, particularly those related to the transference. Frequently, an advance was made only because she would explore material and interpretations from previous sessions, as a defence against dealing with the here and now. She prefaced most of her comments with "No....." and demolished interpretations with destructive comments. She said her mother was a stupid woman "who had to be trained". When I suggested this was how she felt about me too, she said she did not have any feelings that I was a real person and experienced me as "a letter-box" or a "waste-disposal unit". There were times when it seemed impossible to "become involved in the patient's unconscious drive ..... by management, tolerance, and understanding" (Winnicott 1956), and I resorted to angry counter-transference fantasies. Miss W sought to maintain control over her therapy (and therapist) by denial and splitting and concentrating on objects outside the treatment. However, unless the therapist is prepared to bear the brunt, Winnicott does warn against allowing the full weight of transference to develop within treatment. Once Miss W came up against her own blocks to progress, she would relinquish her control, although it often felt like a humiliating defeat to her.

In the transference, a pattern emerged of her stealing my interpretations, by first dismissing them but during later sessions feeding them back to me as if they were her own ideas. I tried to understand the feeding pattern in the sessions, and came to the conclusion that she was not so much refusing my "food", or taking it in and spitting it out, but it was more the absence of a feeding relationship at all. Although she was most generous in terms of quantities of material she gave me, she resisted dependency on me as provider, and went away to ruminate and digest my "food" on her own in an auto-erotic way – her anti-social tendency hindered the development of the transference. In passing, she said she had a tendency to "spoil" food with too much dressing – this was what she did to interpretations too, anything experienced as good had to be spoiled. Above all, she could not bear to experience "wanting" in any way.

Miss W tentatively began to acknowledge links between stealing and eating as a reaction to being rejected. As she became aware of feeling responses to loss instead of acting them out in stealing or overeating, she

recognised that the onset of her shoplifting coincided not only with the end of her affair, but also with the news of her sister's first baby. She also recalled some history of her over-eating. She started during adolescence, but did not really begin to put on weight until she reached her twenties. She hoped people would think she was pregnant rather than overweight, and admitted that she she had been compelled to binge uncontrollably at that time. In "Three Essays on the Theory of Sexuality", Freud (1905) mentiones the uniform childhood theory that people become pregnant by eating. Miss W was incredulous at my interpretation that her stealing and overeating were symbolic attempts to have father's babies, a kind of oral intercourse.

A lengthy dream involved her feeding her brothers and sister, who then died in a fire. In recounting the dream, she said she recognised the babies as those of her sister, of whom she is envious and jealous and from this material, we were able to formulate a reconstruction about her hatred towards her siblings and longings for the feeding situation enjoyed by them. Stealing money from mother's purse to buy cakes had been a compensatory attempt for her deprivation at that stage.

She continued to be sceptical about my "hypothetical theories", until she asked her mother about her reaction to her brother's birth, and learned that she had been very disturbed for a year after his arrival and medical help had been sought. This reality confirmation of my comments increased her willingness for insight. We were fortunate that during the course of Miss W's treatment, confirmation of reconstructed material was available from her parents. This is not of course possible with all patients, and it is then even more important to recognise the value of anti-social acting out as a positive patient communication.

Around this time in therapy, Miss W was apprehended for stealing some meat in a supermarket. It was not altogether a surprise to me and seemed almost inevitable as a need for punishment following our work on the unconscious meaning of her shoplifting. Because the shop staff had not followed correct procedures, they were unable to prosecute and let her off with a warning. I felt I had failed to provide "good enough" therapy and had let her down. In retrospect, I can now see that it was also an envious attack on me that she could not allow the therapy to succeed in stopping her theft. However, she did think long and hard about my comment that although she felt she was saving money by pinching things, she was paying in another currency – emotional stress. From then on, although she sometimes felt the urge to shoplift again, she actually resisted doing so.

The suggestion that the meat symbolised a penis, which could give her the longed-for babies, provoked associations about her father's genitals. A tentative reconstruction that when her brother had been born, she felt

abandoned and deserted by her mother, and transferred her oral belongings for breast-milk to the 'fluid' from father's penis, did not meet with the usual denial and afforded a sense of emotional relief. It lead to further memories about her wandering into her parents' bedroom, looking and searching for "something". Although there were pre-genital and oedipal themes to this "searching", I feel it also contained the impulse to return in memory to traumatic childhood precipitating events.

As Miss W stopped shoplifting, the urge to binge became more compulsive, accompanied by anxiety about her health. It became clear that there were two specific types of eating. One was a kind of comfort-eating, when she was feeling unloved and ate what was enjoyable and "healthy" although in larger quantities than she needed. On other occasions, she indulged in bulimic-type bingeing (although not accompanied by vomiting and purging). Supermarket forays and food preparation were part of the preceding ritual. She could not, of course, chew or masticate the huge amounts of food she prepared and would take large gulps, accompanied by obsessive thoughts, such as "This is what you deserve" or "You must do this to yourself". This behaviour reflected the way she felt I forced her to swallow uncomfortable truths about herself, and occurred at times when she was at her most self-pitying and self-hating, as a way of punishing herself, and at times me, to make me feel I had failed her. This cruel self-punishment and harsh super-ego manifestation contrasts with her mental state when shoplifting with an absence of guilt.

When she told me that the foods she used were always wet, greasy and slippery, I interpreted that this might be acting-out an early visual memory of the wet or shiny breast/nipple. She reacted with great anxiety and resistance and I felt that what I had said had probably been premature. In retrospect, I feel her preference for soft foods might have been a defence against biting and chewing (see Abraham 1916). Links with memories about weaning experiences and mother feeding her siblings afforded some relief and she progressed to recognising that she binged when she could not get her feelings into words. If she could achieve this, the desire to overeat diminished and there were occasions when she began to control herself.

Sometimes, bingeing would be replaced by psychosomatic symptoms – a contrast to internal dissociated effects from bingeing.

Her dreams began to demonstrate sadistic impulses towards her family and unable to ignore her murderous wishes any longer, she reacted with depression and despair. It was almost with relief that she dreamed of her own violent demise. This sacrificial reversion between sadism and masochism, inverting the roles between active attacker and passive victim could be seen, according to Klein, (1937) as reparative attempts. On arriving for one of her

sessions, she met another patient at the door, and these traumatic feelings about her siblings were seen in the transference. Interpretations about attacking me because of my other "babies" as she had once wanted to attack her mother were denied. At one time, she attacked nearly every comment or interpretation I made, so that in the end I found it difficult to maintain a consistent stance, and on occasions withdrew from further comment. I then recognised this as a counter-transference reaction in that her mother may have reacted towards the difficult child by withdrawal, and this helped me to persist with interpretations even when Miss W rejected them. I found myself increasingly able to tolerate her verbal destructiveness, as I recognised the alternative was to attack herself (by bingeing). I discovered that it was more productive to make remarks in an exploratory fashion, prior to making interpretations directly, which provoked "biting" comments, e.g. "Do you think there could be something here about the way your mother fed you?" I also wondered whether her mother urged her to eat food quickly, and she felt I was pressuring her to swallow interpretations – later it turned out that this was so.

Having worked on the conflicts about her siblings, Miss W began to focus on her feelings towards her parents, as individuals and as a couple. She appeared to be dominated by negative introjects that led to constant pre-occupation with them and prevented her psychic separation to lead a fully independent life. Initially incredulous at the concept of infantile sexuality and reactions to parental intercourse, she changed her mind after observing a friend's little girl's exhibitionist tendencies, and she learned from the mother of the child's disturbance and intrusion into the parental sexual relationship.

She began to recognise that her need to denigrate her own mother stemmed from the projection of aspects of her own behaviour which she disliked in herself (loud voice, messy eating, exaggerated stories), and determined to have a long and detailed talk to express her anger and to clarify memories and feelings. In return she accepted some of her mother's comments, and resolved some of her resentments. This was an important step in sorting out me/not me feelings, and although she continued to deny me as a person, I felt an increased closeness in the transference.

Exploration of the relationship with her father afforded much insight into the genesis and underlying development of her symptoms.

It emerged that he himself had always had a tendency to steal. His "theft" of food from the kitchen was a family joke, but he was also prone to stuffing his pockets full of food at social occasions for later consumption, and bringing home large quantities of useless odds and ends from work. His behaviour was attributed to material deprivation in his own childhood. Miss W identified with her father's behaviour in respect to food in that she

elaborated several rationalisations about **having** to eat more than was good for her, particularly in situations where food was free (conferences, social situations).

When her father announced his intention to visit and stay with her, Miss W's bingeing increased noticeably along with anxious attempts to accelerate treatment. Before his arrival, she was haunted by vivid images about "attack" and "power". She feared she might discover he had raped her. The impulse to steal re-occurred, together with the memory of her parents teasing her at age six to make her stop sucking her thumb – the same age that she began stealing from mother's purse. Later she explained that an important factor of both the bingeing and the shoplifting was the **secrecy**[1] which seemed to represent a symbolic withdrawal into a private world where helplessness and hopelessness ceased to exist, providing an omnipotent feeling of control over objects and situations.

For the time being, she gave up the effort to control her over-eating, and began to acknowledge and recognise other physical sensations connected with bingeing. Her ability to fantasise increased, and during one session, she "saw" a little girl crying. Weeping herself, she commented "I feel sorry for that child". I felt this response to the fantasy of the little girl, which she acknowledged as representing herself, was a marked contrast to her earlier denial about the existence of an inner world.

It became clearer how libidinal and aggressive drives were linked to the emotional significance of food within her family. She described what food meant to her in sexual, erotic terms – "security, sharing and excitement". As a child, she never ate with other families, and realised with some embarrassment as an adult how quickly she gobbled her food. In the family, the one who finished first got the second helpings, which she experienced as more love. There was never any choice of food, everyone being expected to eat what was put in front of them. If food wasn't eaten, it was dished up again until it was; she remembered with vivid hatred her father re-serving some food, trying to force her to eat it and only relinquishing when she vomited.

When her father arrived, she found him unbearable, and felt embarrassment and repulsion about his sexual innuendoes. She said he twice gave her a look "like a boyfriend undressing you with his eyes". It was difficult to know whether Miss W's comments were objective, or projected wishes, and her repulsion a reaction formation, but many sessions were used to pour out pent up anger and frustration about him.

While he spent a few days away, Miss W felt hesitant to watch a TV programme about incest, in case she discovered she had actually had sex with him. By monitoring her feelings while she watched, she decided this could not have actually happened, but was struck by the control the father in the film

[1] Also found with other patients – see page 46

exercised over the daughter. She felt this reflected what happened between her and her father, and decided to tell him that she was no longer prepared to continue handling numerous business interest for him (instead of doing so and feeling resentful).

When he returned from his break, she asked him about her adolescent problems, and how he felt they tied in with her childhood. He admitted that he felt he had pushed her too much academically, and then told her about a time when he and her mother had gone away for several days when she was 17 months old, leaving her with a neighbour. She was very well behaved in the neighbour's house, but after "You were never the same again" he said. "There were eating and sleeping difficulties, and the usual". She never elucidated what "the usual" meant. Apparently, she would never enter the neighbour's house again and screamed if she even saw the driveway.

After her father left, she kept on bingeing, but did not know why. "When I have thoughts in my head, I fill my mouth with food". She could not describe her thoughts, only feelings – of pressure and tension. My interpretation that she was bingeing to keep feelings out of awareness was at first rejected, but later in the session, she recalled a mixture of repulsion and excitement about her father's sexuality. This was an important part of the manifestation of her bingeing connecting with the exciting/disgusting father. It also represented him ramming something down her throat. Her conscious memory was that he forced food down her. Her fear is that father may have raped her. Her unconscious fantasy is concerned with father's excited/disgusting penetration.

A comparison between what she said about her father, and myself – that the same mixed feelings of excitment and repulsion and sexual implications, made her afraid of intimacy and closeness with me, provoked her first dream about me. We were having a therapy session in her home, but she could not hear me because of the doors and walls in between. Then her family arrived and took me over. My interpretation that it was **her** walls that kept us apart so that she lost me to her family reduced resistance to transference interpretations, but her response to a TV programme indicated her continuing unconscious fears of closer involvement. She thought she was upset by Jane Goodall's programme on chimpanzees because she identified with an animal crippled and isolated by disease. She did not remember that the programme also showed a young monkey attacking a sibling at the breast, and subsequently declining into fatal depression, and included comments on a mother chimp eating her offspring. Her unawareness of these parts of the film, mirrored the unconscious aspects of her eating problem – insatiable, uncontrollable greed, cannabilistic attacks on her objects, fear of retaliation and, in consequence, depression about her oral aggression, and a fear of starvation. (Abraham 1916).

She had not mentioned again the separation described by her father. I interpreted her denial, and reminded her of her obsessive pre-occupation with sexual matters during her father's few days away. This led to a reconstruction about angry, destructive reactions to her parents going off and enjoying themselves without her.

As she acknowledged the importance of the early separation, and I linked this with resistance to awareness of feelings about weekend and holiday breaks with me, fragments of violent fantasies began to erupt. She was terrified that if she gave them full reign in imagination, she might act on them. How could she express her sadistic impulses other than turning them inward on herself? She was tormented by imaginings about cutting slices off her body to "let out the other woman inside".

Winnicott says that in treatment the patient will attempt to reach back beyond the original trauma, and expression of anger related to it will free blocked maturational processes. I felt very anxious at this time about Miss W's material and her distressed state, but now and then a more "intellectual" session would indicate that she was managing to cope outside sessions.

The splitting and suppression of her fantasy life in the past hindered her ability to dissipate hatred and rage through fantasy, and she recognised why she constantly denied my existence in the transference – if I existed as a person, she might kill me off too – it was safer to keep me lifeless and inanimate.

News of yet another birth in the family provoked another depressive episode, but this time it was brief and dissipated quickly as Miss W found she could relish her sadistic id impulses through fantasy, and experience a release of tension, instead of the usual self-destructiveness and associated bingeing. Her fear and guilt about aggressive, negative fantasies lessened as she no longer needed to resist or repress them. Along with this, she began to recover, with some pleasure and excitement, memories of good experiences, particularly instances of imaginative play. Although there were still distressing sessions to come, there were long periods of time when she worked with the full capacity of the therapeutic alliance.

Concurrently, she recognised that it was not necessarily her weight that precluded her from relationships. She was able to joke with some colleagues about her difficulties of getting into a car, also acknowledging that her body image does not diminish her professional abilities. This indicates an improvement in her ability to integrate the experiences of her body image and so link up with her total identity feelings. She stopped using her over-weight as an excuse to prevent relationships developing into sexual and intimate situations, and shortly after started a relationship with a new boyfriend.

This heralded a new phase of treatment of working within the transference and a resolution of oedipal themes. Two years have passed

since she felt the inclination to shoplift, and the destructive aspects of bingeing have reduced. But the compulsiveness continued. In time, it clarified as a defence against primal scene memories and once these became conscious the compulsion subsided.

Discussion

The information about Miss W's separation from her parents at 17 months added a further dimension to understanding her anti-social tendency as repeated time and again in her life situations, and also in the transference. She related to me with her traumatised post-separation self, and showed all the signs of what John Bowlby (1978) has repeatedly presented as the sequence of protest-despair-withdrawal. After Miss W related the historical event of which she herself was unaware until her father told her about it, she became less resistant to transference interpretations, and altogether more co-operative in the therapeutic process. During her reporting of the self-absorbed pleasurable memories of childhood play, I felt she had brought her pre-traumatic self into the session. From then on, there was a stable therapeutic alliance which made further work with her far more hopeful. Around the age of 18 months, because object constancy is only just developing, the typical process of childhood mourning may be precipitated with even a few days absence by the parents. Bowlby says that due to the age-specific shakiness of object constancy, the capacity to believe in the parent's return may not be sufficiently established. Winnicott (1956) links the cause of the anti-social tendency to an actual deprivation occurring around the age of 1 to 2 years, when something which has been experienced as good is withdrawn over a period of time longer than the memory can be kept alive in the individual child. I have tried to show that Miss W experienced the early separation as a traumatic event, which undermined her stability. Shortly after the parents' return, she had to cope with the birth of a brother, and then a sister. Miss W gave plenty of material showing how she felt further and further distanced from her parents' attention, in particular her mother's care. Winnicott states that if the ego is sufficiently developed to establish that the cause is in external reality (rather than internal) the anti-social tendency will develop rather than a psychosis. Winniccott (1961) explains that when the continuity of the child's object relationships is disrupted, the maturational processes become blocked. In treatment, the patient needs to reach back to the positive experience which existed **before** the original trauma. Reproduction in the treatment, and acknowledgment of the actual environmental failure, **along with appropriate anger,** frees these processes once more towards a period of emotional growth in which the character is re-built positively without distortions. Whilst Winnicott refers here to child therapy,

similar processes can be assumed to take place in the therapy of adult patients.

In terms of infantile instinctual development, Miss W had reached the early anal phase, but it is likely that the separation experience as such threw her back into strong oral-sadistic primacy. During therapy, her cannabilistic and explusive sadistic urges were frequently expressed against me. Her incorporation of food during separation from me showed clearly what she wanted to do with the frustrating object. It is well known that appetite itself becomes involved in a defence against anxiety and depression (Winnicott 1936). Freud (1905) and Abraham's (1916) explanations about the pre-genital stages of libido development have helped me to understand Miss W's negative impulses towards me.

It will be recalled that for some time after she started treatment, I was considering Miss W's eating disorder separately from her shoplifting. A search of the literature on eating disorders offered possible avenues of exploration about the genesis of her illness. Her family features matched those of obese patients outlined by Bruch (1974), and some aspects such as the repression of desire and envy typical of anorexic patients (Boris 1984) applied to Miss W. Edith Sterba (1941) drew attention to the interrelations between habit training and feeding disorders. Crisp, Hsu & Harding (1980) report a distinct association between puberty and stealing in 14% of anorexic patients. Wardle & Beinart (1981) present a theoretical review, and the psychiatric and medical journals offer numerous and varied theories and findings on binge-eating. Miss W's material confirmed Anna Freud's (1946) comments that eating disturbances can stem from "conflicting emotions towards the mother which are transferred on to the food which is a symbol for her" and "eating may become invested with sexual and aggressive meaning, and therapy, secondarily, become the symbolic representative of id forces which are opposed by the ego". Although Miss W had a compulsion to overeat, she did not meet the criteria for bulimia nervosa proposed by Russell (1979) of a powerful and intractable urge to overeat, avoidance of the fattening effects of food by vomiting and purging or both, and a morbid fear of becoming fat. Miss W insisted that once she understood the roots of her problem, controlling her bingeing would no longer be problematic. Because of the destructive aspects of the bingeing, which seemed to me akin to patients who constantly overdose or mutilate their bodies, I was left with a constant feeling of incompleteness, which began to change when I saw the eating and stealing as related features. I believe that in the counter-transference, I reflected Miss W's various splits through which she sought to maintain control until she felt more trusting.

In outlining treatment with patients with an anti-social tendency, Winnicott described this as a reaction which took the place of growth and

"dammed up" the maturational processes. Therapy is an invitation to the patient to become ill instead of hiding the situation. In the counter-transference, any failures of the therapist will become real and will reproduce original failures in token form, but it is these failures which enable the patient to become appropriately angry instead of traumatised. The patient is in a regressed, dependent state and needs ego-support and, at times, environmental management, before a period of re-growth and building up the personality positively and without distortions. In some cases, treatment may be interrupted during a phase of manifest anti-social behaviour, because the positive value of the acting-out has not been recognised. There are of course situations where secondary gains are evident, and treatment may need to be provided in conjunction with a court order.

The progress of Miss W's therapy has led to an interest in other studies being carried out elsewhere, particularly innovative work by Silverman (1987). Silverman identifies a sub-group of pathological shoplifters, and outlines a well-defined psychiatric syndrome, the criteria being an absence of need or greed, an unconscious expression of emotions such as anger, frustration and despair, and an absence of delusional symptoms or cognitive impairment as casual factors. He reports a high incidence of depression (93%), phobic anxiety (agorophobia) closely related to marital disturbance (84%), and sexual conflict (97%). The experience of a "mixture of anger and despair" is common during the act of shoplifting itself. Intervention in court cases, group and/or marital therapy, a combination of management and holding in Winnicott's terms, offer a background against which further study is taking place. As it is commonly held amongst psychotherapists that sexual and marital difficulties in adults relate to the parental relationship and/or childhood experience, there would appear to be scope for further exploration of these areas, a point which Silverman makes himself. It is too early to comment knowledgably on my own work with these patients, but initial contact would seem to reinforce the themes of Miss W's therapy relating to the anti-social tendency.

REFERENCES

Abraham K. (1916) "The First Pre-Genital Stage of the Libido" in Selected Papers on Psychoanalysis London, Hogarth Press

Boris, H. (1984) "The Problem of Anorexia Nervosa" and "On the Treatment of Anorexia Nervosa" Int. J. Psycho-Anal, 65, 315-322, 435-442

Bowlby J. (1978) "Separation – Anxiety & Anger" in Attachment & Loss, Vol. 2 London, Hogarth Press

Bruch, H. (1974) "Eating Disorders" London, Routledge, Kegan Paul

Crisp, Hsu & Harding (1980) "The Starving Hoarder and Voracious Spender, Stealing in Anorexia Nervosa" **Jnl. Psychosomatic Research,** 24, 224-231

Davis & Wallbridge (1981) "The Anti-social Tendency" in **Boundary & Space,** Karnac Books

Freud A (1946) "The Psychoanalytic Study of Eating Disturbances" **Psychoanal. Study Child,** 2, 119-132

Freud S (1905) "Three Essays on The Theory of Sexuality" **SE7**

Freud S (1917a) "Mourning & Melancholia" **SE14**

Klein M (1937) **Love, Guilt & Reparation** London, Hogarth Press

Russell G. (1979) "Bulimia Nervosa; an ominous variant of anorexia nervosa" **Psycholog. Medicine,** 9, 429-448

Silverman G (1987) Submitted for Publication, **Brit. J. Psychiatry**

Sterba E (1941) "An important factor in Eating Disturbances in Childhood" **Psycho-Anal. Qtly,** 10, 365-372

Wardle & Beinart (1981) "Binge Eating, a Theoretical Review" **Brit J. Clin. Psychol,** 20, 97-109

Winnicott D. W. (1936) "Appetite & Emotional Disorder" in **Through Paediatrics to Psycho-Analysis** London, Hogarth

Winnicott D. W. (1956) "The Anti-Social Tendency" in **Derivation & Delinquency** 1984 Ed. C. Winnicott, R. Shepherd & M. Davis London, Tavistock

Winnicott D. W. (1961) "The Psycho-therapy of Character Disorders" in **Deprivation & Delinquency** 1984 ed. C. Winnicott, R. Shepherd & M. Davis London, Tavistock.

LOOKING AT.....

Masud Khan

Cameos from an experienced analyst's consultation work.

The established tradition of institutionalised international psychoanalysis is that it is a 'talking cure', and this is how I was trained – to listen and talk. The patient's speech is called 'free associations' and the analyst's, 'interpretations'. A vast literature exists on all these themes, yet I have found that, from the very beginning, even when I was a student, looking *at* the person of a patient has often given more clue to what the patient was saying than mere listening would have done. I will give three brief clinical accounts, which I hope will illustrate the point I am trying to make.

First case

A plastic surgeon rang me and asked me to see a patient who had been badly wounded, and whose face had been severely scorched by blast from a tank. I agreed to see this patient, who was a sergeant, about 43 years of age. His face was a patchwork, magnificently done by the surgeon, but unmistakably unnatural, and it immediately struck me that if I – a clinician – was curious about his face and commenting to myself about it, what would others do when he returned to ordinary living? He too was a Pakistani and, in our culture, people can be very cruel in their jokes about physical deformity of any sort. I listened to what he had to say. He was convinced that his young wife was having an affair with somebody – her brother-in-law, according to him – and he wanted justice done. I listened on, not knowing what to say, and made the interview short. I asked him to come and see me again in a week's time.

Meanwhile, I rang my High Commissioner because, at that time, Pakistan was still in the Commonwealth, and asked if the situation could be looked into. The report we received from Pakistan was that the brothers of the man's wife had decided that there would be no life for her with him, so they had persuaded her to go back home and seek a divorce. With this information, I met the patient the following week and I told him that I did not think there would be any point in his contesting the divorce. He was silent, then he asked me: "What do you propose, sir?' I replied: 'You know, in our culture what you fear is that, in spite of very successful plastic surgery, your face is not a natural face any more, and whoever you live with may mock you by the very way she looks at you'. He began to cry, and finally said: 'Please tell me if there is any solution to this'.

God knows how the idea came into my head, because I had not thought about it until that moment, but I replied: 'You know, in our country, there are many young girls, especially in your class – the higher peasantry – who either get measles or smallpox and go blind, and very few people want to marry these girls'. On that note I stopped the interview.

Three years later I was in my estate in Faisalabad, Pakistan, and my chief steward came and said: 'Somebody who says he was a patient of yours in London has come to call on you', and he gave me the visitor's name. I recalled instantly who the person was. The man I met was with a young girl in her early twenties, holding a baby of about two years old. She was blind. That is one way of looking and not looking.

Second case

What I am going to recount now is perhaps one of the half-dozen most bizarre clinical happenings that I have encountered. A colleague rang me from Rome and urged me to see a female patient of his who was American, and a model. Because of my relationship with my colleague, I agreed to this: he had been very accommodating to me about some of the patients I had sent to him over the years.

The woman who turned up was about six feet tall, blonde, wearing a three-quarter-length skirt. She sat down and said her problem was that she could not sustain a stable relationship with any man, and was compulsively promiscuous. She added, 'Of course, it pays me economic dividends but, as I am beginning to age now, I want to settle down'. She then told me something of her background: she was born in a very poor Irish quarter of New York and her father abandoned her mother, so her mother had to work hard day and night. I asked her what she meant by 'day and night'. She said, 'Well, during the day she did menial work and at night she brought home lovers..... there were five children in the family, and we had to sleep in one room – all six of us'.

There was something smart and smug about the narrative I was hearing, so I learned back in my chair, and she leaned back too. I noticed that she had the calves of a man, not of a woman, they were too heavily muscled. I decided to take a risk. I said: 'Listen, baby, you are having me on. It doesn't make any difference to me if you succeed in making a complete fool of me, but it will make a lot of difference to you if you let me help you with your *real* problem'. She got up and said: 'Please can I go to the toilet?' I said yes, showed her where it was, and came back and sat down in my chair.

I really couldn't believe my eyes when she returned, because the person who walked into the room was a man – with black hair, very clean-shaven, athletic, young – and he sat down. He was a transvestite, he told me,

and this had come about partly out of necessity, as he had a large family to support. According to him or her – whatever we may call this person now – most men who pick up women are 'ambisextrous', meaning both heterosexual, and homosexual, and so he or she took to this stance. I was totally lost as to how to proceed, and so, to get out of the situation, I said: 'If you have managed to find a way into living before, I am sure you are much more able to find another way of living for yourself in future, than I am to advise you about this'. He/she was silent, then asked me what my fee was. I said there would be no fee, because I had been able to do little.

Third case

A physician referred a young girl to me who was having, according to him, grave problems with her boyfriend. I agreed to see the girl. She was nineteen years old, a very lissom and wholesome-looking person. Her story, briefly, was that she had come to this country to work as an apprentice in one of London's most prestigious department stores. She had studied arts and crafts in her own country and was now a clothes designer. She was still a virgin, and the director of the department of the store in which she was working had fallen in love with her. She admitted that she had let it all happen and that, unfortunately, she could not stand being penetrated genitally.

As I looked at this young, educated girl, and from a very respectable family in her country, I asked myself: what will she gain from being penetrated by a married man who is certainly not going to leave his family? She will lose her virginity and, in the class and culture she came from, virginity at marriage mattered a lot. I listened further and suggested that she came to see me again the following week.

When she returned, I told her I had thought a lot about her situation. The appointment I had given her was at 5.00pm and it was summertime. She had come straight from playing tennis and the girl I now saw was wearing white shorts, white socks and shoes, and was giggling as she sat down. I asked her what was amusing her so much. She said: "My tennis partner did not turn up because he was detained at his office, so I went and sat down and a woman some ten years older came and asked me to play with her. We played, then we went and had a shower, and when we were both naked she started to cuddle me. I let her, so I had my first lesbian experience today, but the thing is, I feel I can shake off this man now. What do you think?' she asked me. I said: 'You know, my dear girl, sometimes the good Lord arranges things better for us than we can arrange them for ourselves, so I think you should stay with this lady for the remaining two months of your apprenticeship. That way, you will go home a virgin'. As I looked at her, she became embarrassed because she was sitting forward in her chair with her legs slightly apart. She could see that

I was observing her figure rather enjoyably. She got up. I continued: 'That's all, so far as I am concerned; there is nothing left to be done'. She wrote me a cheque for the fees and asked whether she could see me before she left England. I said: 'Certainly, but not as a patient. Come and have tea with me one Saturday or Sunday'. I saw her three or four times before her departure.

The relationship between this girl and her lady friend stabilised but did not become perversely lesbian. It stayed at the level of cuddling and kissing and touching. Five months after she returned to her country, I received an invitation to her wedding. For me, the moral of this clinical encounter is that, if we don't become judgmental and interfering, some patients can fare better with others, under our care, than they would if restricted to their clinical relationship only.

"I'M ONLY A LITTLE JELLY" – GENDER IDENTITY AND SELF ESTEEM IN A CHILD BORN WITH AMBIGUOUS GENITALIA

Barbara Gaffney

Introduction

In this paper I shall describe the impact of a birth defect resulting in sexual ambiguity, upon a four year old boy's development, as seen through two years' psychotherapy. There have been many factors interacting to modify this child's development: the genital abnormality and chromosome abnormality at birth (XO/XY mosaicism), the subsequent consequences including short stature and the repeated medical interventions, – all in the context of this particular family's style of coping. While bearing in mind the many variables, especially the chromosome abnormality and the short stature, I have emphasised the impact of the sexual ambiguity upon this child's object relationships and self image. I hope to show the growth of self esteem through a period of treatment that was incomplete and frequently interrupted. It is particularly interesting to observe how, despite numerous difficulties, this child had a secure masculine gender identity. Stoller (1965) points out that although "the sense of gender identity (that of being male or female) in the normal individual is derived from three sources: the anatomy and physiology of the genitalia, the attitudes of parents, siblings and peers towards the child's gender role, and a biological force that can more or less modify the attitudinal (environmental) forces, it is not easy to study the relative importance of each of these factors in normals because one factor cannot be dissected from another".

Revelant Research

A brief survey of the research relevant to this congenital abnormality shows how gender role differentiation is largely a post-natal, learned phenomenon, (Stoller 1963, Money and Erhardt 1972). Sex assignation at birth and the subsequent parental attitudes in selectively reinforcing certain behaviour while communicating expectations to the child is crucial. Labelling precedes identification. Stoller has shown how a "core gender identity" is established, perhaps irreversibly so, in the first two years. Rev-Ran in a study of "anatomically intersexed adult patients" in the Soviet Union, who did not have the benefit of corrective surgery, found that gender identity and behaviour corresponded with neonatal sex assignment and subsequent

consistent handling by the parents. Gender identity and sexual fantasies developed irrespective of incongrous physical appearance, absence of genital sensations and inappropriate hormones (Lev-Ran A. 1974).

In a review of X chromosome abnormalities and associated cognitive and behavioural development (Walzer 1985), it is suggested that much of the information about associated behavioural difficulties up till now has been "ascertainment biased" i.e. the samples were taken from populations already showing problems. There are, however, specific cognitive deficits seen in children with X chromosome abnormalities but these can also be observed in reading-disabled children with normal sex-chromosome complement.

The Referral

Owen was first referred one April to a hospital-based Child Psychiatry Department by a paediatrician from within the hospital. He had cared for Owen from soon after birth and planned to care for him through puberty. Owen was resident on the paediatric ward having grommets inserted to improve his hearing and Mr. and Mrs. A had requested advice about Owen's disruptive and aggressive behaviour in view of his need to start school in September. Owen had previously been asked to leave two nurseries because of his unprovoked attacks on other children and verbal abuse of staff.

The Family and Developmental History

Mr. and Mrs. A. were a young, attractive, well-dressed working class couple. They lived with their extended family some distance way on the outskirts of the city. There is little detailed information about them as they were very resistant to the weekly case-work offered throughout by a Social Worker.

Mrs. A. was a pretty woman. She was gentle, concerned and firm with Owen. At first she denied any difficulties at home but later revealed how she felt burdened and torn between the needs of her two sons and her husband. She worked part time while her mother looked after her two children. Her father had recently died of cancer.

Mr. A. was disciplinarian in the family. He appeared at times intrusive, demanding and threatening as well as concerned. On one of the few occasions that he met with the Social Worker he revealed how he regretted not having made better use of his educational opportunities. He now wanted the best for his children and planned to pay for private education. He was employed in well paid shift work. Both his parents lived nearby and often cared for the children.

Mrs. A. appeared to defer to her husband when they were together. However, much later she burst into tears protesting that she had to make all the decisions about Owen. Owen was the first born child. He had a brother

Gwyn, two years younger. He was a tall, healthy, boisterous toddler. As he became increasingly rebellious Mrs. A. commented that Owen had not gone through this stage at that age but only recently. Some developmental delay was suggested.

The early developmental history comes with little of its significance to the parents due to resistance. Mr. and Mrs. A's first baby was born after normal pregnancy and labour at the local hospital in October. On account of the baby's ambiguous genitalia they were transferred to a larger city hospital for tests and investigations. The baby remained unnamed for five weeks while the decision about the sex reading was made. The parents chromosomes were shown to be normal, but the baby was found to have the karyotype XO/XY mosaicism (70% XY 30% XO). At six weeks, the baby had surgery to remove the uterus, fallopian tubes and streak gonads. Baby A. could then be named as a boy called Owen. He was left with a recognizable phallus and one functioning testis, but appeared to have no vas deferens. His future sexual functioning is uncertain and there continues to be the risk of future malignant growth. Mr. and Mrs. A. were informed of the condition and given opportunities to talk with the paediatrician.

Owen had some breathing and feeding difficulties following surgery but he was taken home a week after surgery. Mrs. A. breast fed him happily for four months. By eleven months Owen was feeding himself, recognizing individuals and very active.

He had two further operations on his genitals at 11 months and at two years: first and second stage repairs of perineal hypospadias and urethroplasty and fixation of the testicle. There was uncertainty as to his genital sensation because of possible nerve damage. Mrs. A. stayed with him in hospital throughout and Mr. A. visited regularly. Owen was able to urinate standing up and without dribbling by two years.

The family then all took a trip to Disneyland which Owen was said to enjoy. While away he was sunburnt and had an outbreak of eczema having had patches of dry skin from six months. The treatment included restrictive bandages which he found very distressing. Sleeping difficulties followed for a while.

Around this time there were a series of family difficulties. Mrs. A's father died of cancer in hospital after a long illness. Owen had been very fond of him and was very distressed. Mr. A. had his leg in plaster from an accident in a football game, and he had hepatitis. He became unemployed. Mrs. A. returned to work and became pregnant. Owen was sent to nursery. Mrs. A. reported no separation reaction when Owen started at nursery but he began

to have a persistent cough, cold and frequent diarrhoea. At around this time also Mrs. A. reports that Owen was given an allergy test of many pricks, at the hospital, on what he expected to be a routine check-up. Mrs. A. dated his fear of hospital from this as she had felt unable to prepare him. A diet was also tried with no success. When he was three, Owen was asked to leave the nursery, because of his disruptive behaviour.

In January his brother was born. Owen was described as upset and disappointed because he had wanted a girl. In March intermittent deafness was noticed and soon after in June he had his tonsils and adenoids removed. He continued to have trouble with his ears including distressing bloody discharges while the family was abroad. Following the holiday Owen was sent to a new, more structured nursery. There they were worried about his distress, his behaviour and their inability to understand him. They suggested the family seek help but Owen was withdrawn.

Aged four, he had a second operation on his ears. With new grommets inserted his hearing was greatly improved. It was at this stage that his parents requested help.

Assessment

The staff on the paediatric ward concurred with the nursery staff in their picture of Owen's functioning and this was with the mother present. They also observed his poor manual dexterity and unclear speech. They were unsure as to how much he could hear. However, he could enjoy and respond to individual adult attention, showing himself to be curious and humourous. The play-leader described his immature play: he did not engage with other children or play alongside them, and came to be feared by them. His paintings were impulsive and explosive, tactile expressions rather than representational. He spent long sessions in solitary role play, especially occupied as father redecorating the doll's house. He could not tolerate help or advice from adults in a task which he found difficult and her poor concentration and a low tolerance of frustration.

During a long assessment, Mr. and Mrs. A. presented the problem solely as that of Owen's behaviour with other children. They felt he reacted to teasing for being short. In response to questioning, they conveyed some of Owen's distress. He threatened to leave home when his father punished him. He once pitifully commented "but I'm only a little jelly". The psychiatrist noticed that Owen tended to play the clown in the family interview, but also felt that Mr. A. had inappropriate expectations of his son. He called his son's scribbles letters, and he sent him to a variety of clubs and sporting activities beyond his capabilities.

It was only later that the parents expressed concern about his behaviour at home and his learning difficulties, reflecting an underlying fear of his also being intellectually damaged. Mr. and Mrs. A. had not told Owen about his condition and early surgery, as they did not want him to feel "different". They planned to discuss it at puberty if necessary with the help of the paediatrican. Meanwhile they attended several times a year for mreasurement of his growth.

The individual assessment sessions on the ward, Owen conveyed to me his difficulty in separating from his mother, fear of attack, and his poor self image as being unlovable, greedy, messy and destructive. He showed intense sibling rivalry and a lack of impulse control. Through the sessions he showed an ability to remember and make connections as part of an attempt to make sense of his experience and he showed increasing curiosity about me.

Owen needed help in many areas of his functioning, which raised the question as to the most appropriate form of treatment. It was also unclear as to the organic component in his developmental delay in social skills, object relationships, play and learning. Despite a recommendation to delay starting school, Mr. and Mrs. A. found a small, private, rigidly disciplinarian school for Owen. They were anxious lest he be left behind by his peers and so feel different or odd. This school was soon seen to be inappropriate, but Owen struggled there for eight months, becoming increasingly distressed, aggressive and often physically ill with asthma, eczema and upper respiratory tract infections.

When Mr. and Mrs. A. were later confronted with Owen's failure at this the school of their choosing they asked for help from the psychologist in our department who would liase locally. At this later psychological testing, age five, Owen was described as follows: "intellectual development within the normal range", "numerical and conceptual, paper and pen skills below average", "short attention span and easily distracted", "emotional and social development immature", "difficult to reach even through three individual testing sessions", "not yet able to dress or undress, or use the scissors". A similar pattern of functioning has been observed in many XO individuals.

Mr. and Mrs. A. requested help from within the hospital where Owen was cared for by the paediatrician, resisting referral to local resources despite the long distances involved, so indicating their own dependence upon the hospital's care for their child. Twice weekly psychotherapy was arranged for Owen. Once weekly sessions were offered to the parents by the Social Worker.

The Child and some aspects of his treatment

Owen was a very small, compact and attractive boy. He arrived fashionably

dressed, neat and well cared for, but gradually became messy. He had an appealing face with large eyes and smartly cut light brown hair. He often snuffled with a running nose and had sores around his mouth. When Owen came with his father it was striking that he appeared to be a smaller version of him.

During the early weeks of treatment the work focussed upon Owen's difficulty in separating from his mother and his fear of me. I will refer to this only briefly. He would only come into my room with his mother, sitting nestled on her lap, sucking his thumb and trying to avoid looking at me. Owen did not want to go to school which he saw as an aim of treatment. I addressed the pleasures and conflicts of the symbiotic closeness from which neither mother or son seemed able to progress. I spoke of Owen's feelings directly and in displacement using a rabbit puppet from his cupboard to verbalize this. The rabbit puppet was to be much used by Owen as a means of communication and a source of comfort.

Owen gradually moved from the lap to play with the toys I provided and relate to me, whereupon Mrs. A. left the room leaving Owen with some food to sustain him when he protested. He made frequent trips to the waiting room and to the toilet there. By the third week Mrs. A. had confidence enough in me as shown in her insisting to Owen that I could now take him to the toilet.

Mrs. A. continued to come into the room for the first five minutes until eighteen months later. Owen used this time for his mother to explain their current concerns or pleasures. Perhaps Mrs. A. also began to understand with me that Owen's confusing behaviour had a meaning. His inability to separate had the advantage of giving his mother insight into the function of treatment as well as being an enactment of his problems.

Owen showed how he needed his mother's actual presence as a source of comfort and containment. When she left, he gradually spun into a flood of noise, activity, rapid, primary process speech, along with messing and banging, and eventually hurling, spitting and biting at me. At times I felt overwhelmed and close to despair. This seemed a dramatic communication of Owen's confusing life experience. An unusal quality was the way in which he sometimes shouted and then whispered inaudibly and incoherently when talking with me. He would suddenly stop, startled by a noise, fearful of intruders, but also genuinely wanting to work out what it was. I wondered if this reflected his earlier intermittent hearing loss and the recent improvement following the insertion of grommets. (C.B. Therhune 1979).

I struggled to verbalize Owen's feelings, encouraging speech rather than action and introducing the possibility of reflection. This further frightened him. He felt my words as an attack and flinched when I moved. I then tried to sit quietly receiving his projections.

Amidst the chaos there were incidents which gave vivid content to these early intense anxieties and passions. Owen was seeing me within the hospital where he had received numerous investigations and surgical proceedures. I represented his brother and father by whom he felt prised from mother's lap. While in the maternal transference which quickly developed, he showed a longing for an exclusive possession of me with intense jealous protests at the end of sessions. In between sessions his anger turned me into a fearful monster.

In the first session, Owen showed his wish to please me and his fear of loss of love because of his jealousy and anger. Owen told me the rabbit puppet wanted to draw. He asked me what I would think of "bunny's scribbles" when he brought them home from school, also why did bunny like scribbling? He then ordered bunny to draw a house which he could not manage. I spoke with Owen about his wish to know what I would expect of him and his fear of my anger. He then went to paint at my desk. He dabbed at the table and looked at me provocatively. He told me he painted on mummy's kitchen units and then had to wipe it off before she saw it. He explained he did this while she was upstairs with Gwyn, his brother. Owen's feelings about the arrival of the brother and his longing for access to mother's supplies came quickly into the transference in his preoccupation with the other cupboards in the room.

Through the rabbit puppet, Owen tried to find solutions to his wish to possess and control me, and also to keep in touch with me as a caring mother. He pleaded and insisted that the rabbit should not be shut away in the cupboard but sleep in my room in between sessions. The rabbit became highly cathected for a while. Owen used it both as a source of comfort sucking its paw, and to express gentler aspects of himself. He named the rabbit "Bobo", from a comic story he had read on the train with his mother. (He called me Barbara).

Owen showed how he felt me to be preoccupied with someone other than himself in between sessions. He would refuse to say goodbye, to his mother's dismay, or else would say goodbye to "Mr. Rabbit", or "Mr. Sausage", "Mr. Bogeyman" or "Mrs. Knickers" with a snigger. Owen struggled with a sense of rejection that he could neither be the baby or the husband.

Competition with rivals, boys and father, created conflict with the wish to be included in their activities and the wish for friends. Here also Owen in reality relied on his mother. He conveyed this through a story (which was often to be repeated) enacted with male figures in the doll's house. Two men worked together on a scaffolding of bricks. The one on the roof ordered the other "pass the bricks up Charlie" and they take the work in turns. But

Charlie is not good enough, their co-operation breaks down and a physical battle with loud shouts follows. I spoke of how they seemed cross, disappointed and perhaps afraid of hurting each other. Owen, unusually, stopped shrieking. Charlie, now clearly the son, was ordered to "go away", build it up again or go to your bedroom". Then the mother doll came out of the house saying "tea darling, come on in now" and the conflict was avoided. Independently Mrs. A. later reported to the Social Worker that Owen had few friends at home. He always got into fights and so she extricated him every so often by going out to call him in for a drink.

His low self esteem and sense of humiliation was compounded by his small size. Owen expressed some pride that he was no longer a baby as this meant he could identify with his father, and work alongside him, while babies were shut out as nails and tools were dangerous for them. However his smallness presented him with the narcissistic blow of not being able to do as well as his father or his friends. He was the "Charlie" who dropped the bricks.

The Little Terror

Owen's fear of his loss of control became the focus of early work. Owen showed how impulsive breakthroughs threatened both his object relationships and his sense of integration. Reversal of role predominated. In the eighth session Owen brought this in the character of "Little Terror". It jumped about excitedly messing, broke things and tried to frighten me.

Owen pleaded for my help to control Little Terror. He told me to put him into a large wooden box in the corner of the room and shut the lid upon it. The symbolic communication gave way and Owen stabbed at the dolls' house windows with the soldiers' gun, tugged the chimney effort to repair the damage. He shouted at me that "Mr Big Willy" would "chop me" while he threatened to bite me, so revealing his fear of devouring and castrating retaliation.

"Little Terror" was a condensation of several aspects of Owen. (It was something which he may have been fondly called by exasperated parents). It was an attempt at displacement to avoid guilt and responsibility for his activity, but it also encapsulated the terror of his experience which he projected into me at times, and reflected an omnipotence and manic activity which defended against unbearable feelings of pain, loss and helplessness. Owen needed the ego support of an adult to assist him in containing his excitement, desire and fury. Without this he quickly felt persecuted by his own mess and inability to repair it and by a fear of attack.

It became clear that the continuing medical interventions were a severe strain upon Owen's ego resources. For example it was soon after a check-up

at the Ear, Nose and Throat Clinic that he spoke of "Little Terror". Owen was struggling with the frustration that I had not left his cupboard open all night to enable him to get his things "at any time". He enacted a fight with two dolls and then tore around the room on a horse. He slowed down to ask miserably "Why does Little Terror break things?" I wondered if he was angry or frightened. Owen told me that he also spat and demonstrated. He told me he did this because other people poked things into his mouth. I was then able to link this with his previous experience of the doctor peering into his mouth.

Owen used the sessions as a discharge of feelings evoked by these visits. After a later ENT check-up, where he as usual managed very well, Owen showed me I was to be "a silly girl" who was to scream and run away to hide terrified. I was afraid of spiders and mice which I could not see. I had my nose bitten off and sewn on again repeatedly by the doctor, conveying how his wish to retaliate for the medical intrusion which threatened his own self image as a brave boy. When I linked his actions with the visit, he spat on the floor saying "No mummy", revealing his internal prohibition and the self restraint he exercised to please his mother.

In submitting me to these unpredictable attacks, Owen was attempting to master his experience through repetition. He identified with the aggressor while I became the passive victim which he had felt himself to be. (A. Freud 1952). However he could tolerate for only brief moments my speaking of his past. The degree of trauma is reflected in that he only once opened the toy medical bag which I had provided. He refused to touch it after finding what was in it and frequently asked me to get rid of the bag.

His attacks conveyed his fantasies and fears of castration. He threatened to cut off my long hair, calling me "Mr. Big Fat Willy" or "Mr. Big Bum" when I restrained him. He was preoccupied with anything broken or damaged in the room. If I tried to speak of his own special willy and his fear of losing it, it seemed to increase his anxiety. He would resort to defensive omnipotent behaviour such as strutting about telling me "mine is a big one" or "you can't speak, there's a big willy stuck in your mouth". He frequently grabbed his genitals and needed to go to the toilet.

Changing Identifications

An important aspect of Little Terror was that in this enactment Owen felt powerful, so defending against his need, helplessness and inferiority. He began to find relief in identification with a variety of powerful phallic figures. At times these were more granidose and exhibitionistic than destructive. He was not little or dependent, but Super-Ted, Superman or a marching soldier under orders.

The identifications with the vicious aggressor where I became the victim of his attack frequently returned in response to external difficulties. As Owen was in increasing difficulty at school he tried to terrorize me. I felt his frustration and near despair. However he now wanted to manage at a school and sustained hope. He frequently asked not to stay at home, but that his mother find a new school for him.

Owen found some containment in the powerful identifications. He also sought concrete physical holding in the sessions without needing to resort to mother's lap. Whereas early on he asked me to put Little Terror into the box. Owen would now put himself in the box or his large cupboard, calling it his van, castle or house. There he felt safe and he would venture out in a variety of activities. These began with a constructive intention: he was a painter, plumber, builder or window cleaner. Here he identified with his father and showed both his reparative aim to clean up and repair, and his wish to impress me. This could degenerate into an angry or excited messing. However at other times it was his co-ordination difficulty which frustrated his intentions. I provided larger pieces of paper and protective containers but Owen felt humiliated, protesting that "daddy did not use them".

Owen progressed from the dominating concern with the contents of the cupboards as they represented my supplies and babies, to an oedipal rivalry. This was partly exacerbated by the arrival of workmen outside my window who came to represent my husband. Their work included boring holes into the room in which we were working. At times, Owen would speak longingly of his wish to use the builders' tools and gazed longingly at them from the window. He wished to steal their attributed as revealed in a scenario where he imagined the builder was stealing another's tools: "come on walkies" he giggled. The danger of this was in revenge. The robbed worker he now saw in the electrician laying a cable into an adjacent building so as to blow us all up.

Owen portrayed has sadomasochistic intercourse fantasies. It was not clear if the workmen would destroy or recreate something. His attacks on me could be seen as an enactment of this exciting sadistic fantasy. He spoke proudly of how his father decorated at home calling him a "Magic mender" who repaired things while he was asleep.

For moments I also began to see the despair and concern which the manic activity had defended against. On one of the few times he attempted to paint on paper he spilt some on the floor. He sighed miserably "where can I paint?" and moved to the table. He then told me to sit far away so I did not get spots of paint upon me.

After nearly a year's work, Owen began to play out his inner conflicts rather than experience me as a bad figure from his inner world, or to involve me in rule setting so he revealed some internalized controls. This benign ego

auxiliary was represented in the character of Badger from "The Wind in the Willows". Owen followed the story on television with enthusiasm and enacted scenes before me. The nasty weasels attacked with sticks as he often had done to me and Toad frequently got into a mess when along came Ratty and Badger to sort things out.

A more threatening superego representative was presented in the form of the police. After a misdeed Owen would phone them up or threaten me with them; for example, after spilling water on the carpet he growled "The police will take you away. You weed on the carpet". After a while I realised there was a reality aspect to this, that Owen was now taken out of school. His father had tried to cajole him into good behaviour warning him that if he was not good he would be sent away to boarding school. Around this time it was his brother's birthday. Owen was to go into hospital for a tonsillectomy and he was also taken to see the paediatrician by his father, who requested help with his son's slow growth. Owen struggled with intense envy, and fear of yet another hospital investigation. He conveyed that if only I could give him good enough supplies then his fury and fear of loss of love and punishment could be avoided. At a deeper level I stood for the mother who had failed to give him a healthy body, failed to protect him from surgical intervention and did not give him a new body. This was demonstrated in a session around the time of his brother's birthday. Now that his brother was no longer a baby Owen was confronted with a new rival who threatened to overtake him in size and manual dexterity. This meant that Owen could no longer enjoy the exclusive relationship with his father. Mr. and Mrs. A. tried to deny differences between the boys and avoid conflict by giving them identical things. Owen told me that his father had once thrown away a gun which he and his brother persistently argued about.

Owen brought these crises vividly into therapy arriving one day to display proudly a new toy plastic dagger. He excitedly plunged it into things and it snapped. He frantically asked me to mend it, blaming me for the damage. Eventually he told me that he was distressed because he had been looking forward to showing it to his father, but also his mother had bought a dagger for his brother: "Oh no, now I'll fight Gwyn for his and I don't want to".

Owen often seemed to behave as if he felt like the damaged, worthless penis vividly seen in the broken dagger. He blamed me as his mother, for failing to mend him. His excited attacks upon me and the room could be seen to represent the unconscious primitive fantasy of his being damaged by the penis while in the womb. This was demonstrated in the following session: Owen was eating a meat sandwich which his mother gave him as she stood up to leave. He demanded all my cupboards and began to act as Tarzan, then bit

into the sandwich. He stopped to look, asking his mother what it was, then said it was a "baby bird" with a giggle. Mrs. A. told me with disgust that Owen had been bringing her dead birds from the garden. It was springtime. She left. Owen ate and told me the bird was dead because daddy had shot it. He then told me he could see my knickers and began poking at me with a stick. The sadomasochistic fantasy is aggravated and given form by Owen's repeated passive experiences of attack and penetration in surgery and medical investigation. The fantasy also shows a failure to internalize a secure sense of a caring mother. She had not been felt to provide a "protective shield" in early infancy. This underlay subsequent difficulties.

The Growth of Self Esteem

Several important external changes facilitated Owen's development. With the help of psychologists, Owen was placed at a more appropriate local school in April, a year after treatment. He began to enjoy this although he continued to have difficulties. He sustained a few friendships and attempted to learn, accepting the help of the class teacher. His self esteem improved enormously, especially as he no longer lived with the fear of being "sent away". With the help of medication he also began to grow. He was still the smallest boy in his school, but his growth was visible. His mother needed to buy new clothes for him and took great pride in his achievements.

This improved self-image was reflected in his bid for my admiration in exhibitionistic displays. He proudly wore long belts or key rings and brought a series of lunch boxes. He frequently played with a gun which he brought in from the waiting room. With the key rings he emphasised genital differences and tested my envy. The gun became a focus of his concern. He frequently asked if the gun had changed in size since he last saw it. This reflected both changes in penis size and his own fluctuating self representation.

Now that Owen was settled at school, a year into therapy, he asked to stop coming to see me and became very resistant. This was both a transference repetition of fury with his mother for all the hospital appointments to which she had brought him, but also a response to his parents wish for him not to be different from the other children at school. After a meeting with Mr. and Mrs. A. and the school, Owen attended once weekly for a further nine months.

Owen continued to sustain an intense relationship with me. His wish to woo me, to repair damage and his exploration of phallic power were the central themes of the sessions. These are shown in his repeated enactment of "Mr. Thompson". This represented the person whom I would want for any occasion, to sort out any problem and provide anything (from the Thompson telephone directory). Most often Mr. Thompson enjoyed messily cleaning

my windows. In this Owen was a person who could achieve anything, so defending himself against narcissistic injury, oedipal rejection and also dependence on anyone.

However Owen also began to tackle the reality of being a little boy. With this reality testing he showed his vulnerability to his appearance, size and abilities. He was concerned not to look like a "clown" or a "rag and bone man" and asked me to help prepare him to enact the role which he chose to play. He tried out various roles showing a recognition of his need to practise and learn. He would ask me "What does a train guard do?", "Does Tarzan have a gun?" or asked me to make him a shield, a sword or some tickets. He seemed unsure if he had all the attributes needed to grow into a desirable potent man. In the repeated masculine identifications whe tried to find both what I appreciated but also to incorporate their strengths to enable him to feel intact.

His strong oedipal wishes were seen in his sleep difficulties at home. He began to climb into his parents' bed to seek comfort from nightmares where "strangers" were coming to get him. The wish to intrude and displace, as well as the feared retaliation, was projected in this dream.

Owen continued to be on the defensive. Medical intervention continued to heighten his anxiety so his ego was overstrained. In the last months of therapy Owen made two more visits for medical checkups of his hearing and growth. His response to these visits showed how the necessary medical care continued to be an interference in his development. In anticipation Owen resorted to an identification with the feared aggressor. He protected himself with an array of weapons at times attacking me. In striking contrast to my earlier premature attempts to verbalize rather than hold his fears, Owen now considered my interpretations of his behaviour. For example, when I spoke of his possible worries about the visit, he asked me "How do you know that?" and went on to tell me of a bad dream about monsters the night before.

Owen experienced the physical examination of his height and genital development as a humiliation; it went against his age appropriate modesty and served to overstimulate genital importance. After the visit to the growth clinic he conveyed this by telling me the TV story of a man who forgot to do his hair and had no trousers on. He then had to go to the doctor's to be given things "to make him better". Owen told me of his own dislike of having to wear the dressing gown which the clinic provided. It had no belt and he was anxious that it would fall open and expose his pants.

Termination

Mr. and Mrs. A., pleased at the progress that Owen had made, were increasingly concerned that his missing time at school was disruptive. They

planned to finish therapy after nearly two years. They made contacts with local services for remedial help. Owen had mixed feelings about ending, as I did, realising the work that remained to be done. The social worker and I planned to finish in a way which supported the parents' achievments and allowed them the choice of returning in the future.

I will briefly mention some aspects of the final three months' work. Owen felt he had grown in several ways as seen in his return after a holiday to prepare to end. He looked at the gun telling me he was now "too big" for it. Rather like the earlier much used rabbit it lay at the back of his cupboard. He began to attempt his first representational drawings and paintings of Porsche cars in particular. He oscilliated between noisy messy anger with me and unusually reflective moments. When I spoke with him of the possibility of remembering, he told me of his grandfather who had died, adding "He used to give me chocolate but now he is dead".

Owen prepared to manage without me in a variety of ways. At times he chewed food even more ravenously than usual. He recollected his activities, looking fondly at the rabbit. He planned to take a few things with him. He chose a ruler, rubber and pencil sharpener. He repeatedly measured things with the ruler. I spoke of his own sense of growth to which he proudly responded saying "Yes, and when I have learned my ABC then I can work on the computer". This reflected immense progress in a child who earlier had been unable to tolerate not knowing and had no wish to grow up or go to school.

In the penultimate session, Owen made a final bid for a continued relationship in asking me for the keys to my room. This failing, he was sad and subdued briefly. In the final session he touchingly conveyed his affection, gratitude and the wish to be remembered in giving me a pretty pink pen on a string by which I could wear it. He wanted me to keep it in my drawer. Perhaps it also represented the penis which he felt I did not have. Owen showed his anger by messing on the wall but in marked contrast to previous times he announced "I can stop myself now" and proceeded to clean up. He took away the things he planned after asking me to clean them and showed them to his mother in the waiting room. This was a concrete representation of what he felt he took from therapy to assist in his future development.

Evaluation

Despite uncertainty, interruption and illness, Owen used therapy well. He revealed his fantasies and experiences and began to explore and integrate them using my support. At first I was tested as an object who could receive, hold and understand his pain and confusion. He began to show the capacity for tolerating his feelings, with some reflection, understanding and concern.

pangs of conscience. I frittered away my time, but did not feel any happier for it. I had the obscure feeling that I was fleeing from myself".

"Then one day a friend called on my father. I heard the visitor saying to my father "And how is your son?" "Ah, that is a sad business" my father replied. "The doctors no longer know what is wrong with him. They think it may be epilepsy. It would be dreadful, if he were incurable. I have lost what little I had, and what will become of the boy if he can't earn his own living?"

Jung explains: "I forgot completely how all this had come about, but I pitied my parent's worries". He continues to describe what happened after he had heard the above conversation; "I was thunderstruck. This was the collision with reality".

"From that moment on I became a serious child. I went to my father's study, took out my Latin grammar, and began to cram with intense concentration. After ten minutes of this I had the finest of fainting fits. I almost fell off the chair, but after a few minutes I felt better and went on working" Jung goes on to describe how two more fits occurred. "Still I did not give up, and worked for another hour, until I had the feeling that I had overcome the attacks". (M.D.R. p. 46,47,48)

That was the end of these fainting spells, and a few weeks later Carl Gustav returned to school with a note from the doctor forbidding the boy to engage in gymnastics. An illness had been miraculously cured as far as the doctors and the parents were concerned, but Carl Gustav was far harder on himself. "The whole bag of tricks was over and done with". Jung adds: "That was then I learned what neurosis is", he continues: "Gradually the recollection of how it all had come about returned to me, and I saw clearly that I myself had arranged this whole disgraceful situation". He even excuses the schoolmate who knocked him unconscious "I knew he had been put up to it, and I have never been seriously angry with himn". "The whole affair was a diabolical plot on my part. I had a feeling of rage against myself, and at the same time was ashamed of myself. Nobody else was to blame; I was the cursed renegade! From then on I could not endure my parents' worrying about me or speaking to me in a pitying tone. The neurosis became another of my secrets, but it was a shameful secret, a defeat. Nevertheless, it induced in me a studied punctiliance and an unusual diligence". (M.D.R. p.48). Jung then describes the experiences that followed: "I had an overwhelming impression of having just emerged from a dense cloud". "I knew all at once: now I am myself. Now I exist". "Previously I had been willed to do this and that, now I willed". (M.D.R. p.49)

He discovers his own authority: "Then to my intense confusion, it occurred to me that I was actually two different persons. One of them was a schoolboy who was far from sure of himself; the other was important, high

will know the possibility or not of his future sexual functioning. Underlying sadomasochistic fantasies also suggest there could be difficulty in his sexual relationships and there is a continued risk of malignant growth.

Discussion

At assessment I was unsure of whether it was most helpful to view Owen's poor functioning as a developmental delay or a regression in the face of conflict. Through therapy I came to see him as a child traumatised by his experiences. The trauma perhaps originated in the inability of the traumatised parents to help their child with his experiences. Although there were no reported separations of mother and infant, Mrs. A. who felt unsupported by her husband, was perhaps not able to provide her baby with the necessary protection or later enable him to integrate his experience. This is described in Khan's concept of a cumulative trauma. (Kahn 1962). In therapy I saw a child reacting to a series of impingements, sensitive to change and wary of attack.

I have suggested how the physical defect organised Owen's experience from birth, modifying the mother-child interaction, his object relationships, self-image, ego development and fantasy life. At birth the parents were confronted with the shock and narcissistic injury of a baby with ambiguous sexuality who could not be named for five weeks. The hoped for healthy child had to be mourned and a new equilibrium established. (D. Mintzer et al 1984.) Mrs. A's competence as a mother was threatened by such a first child. She was rendered uncertain of her abilities and left dependent on an array of professionals. Mr. A. compensated for his fears about his son's sexual functioning in over-emphasising the need for intellectual development and sport activity. This was heightened by his own sense of deprivation and failure to achieve. His fear of femininity reinforces his son's tendency to aggressive assertion making anything which could be seen as passive or feminine, as "the dreaded sex". (Money and Erhardt). Owen himself, seems to blame his mother for his condition, which serves to heighten his ambivalent feelings towards her.

It is an achievement of the parents that their son has a securely established male gender identity. Classical psychoanalytic theory emphasises how male sexuality develops out of how the little boy manages the pleasures and dangers of having a penis in the phallic phase. Recent observational studies (Galenson and Rophie 1980) show how the infant boy becomes increasingly aware of his penis in the exploration of his body and the formation of a self image. They describe how boys are intentionally aware of urination from about 11 months. Interest in father's urination is seen from 13 months. In the second year there is recogntion of genital differences and by

18 months a clear identification with the father. In this sensitive early stage Owen's body exploration was interrupted by three operations on his genitals and he was not able to urinate standing up without dribbling until the surgery. Subsequent checkups erotized the genital area, heightening castration anxiety. I have also questioned the defensive function of the masculine identification for Owen in holding him together, keeping away more primitive fears of disintegration.

For Owen the continuing problem of his small physical size was the visible focus for his problem of self esteem. The significance of size was underlined by regular measuring at the hospital. At school he became increasingly aware of differences in size and ability so using maladaptive grandiose compensatory mechanisms. (Niederland 1965). These did not endear him to his friends, while the coincidence of the birth of his brother with starting at school further enflammed his jealousy and conflict over his death wishes.

Two subsequent hospitalizations, his small stature delayed co-ordination and the continued asthma and eczema have given rise to a further sense of delicacy and damage in Owen. This keeps alive in the parents the unworked through anxieties about the birth defect which remains almost unmentionable for them. It is likely that these parents would have managed very differently with a first child who did not present them with such problems. However, there remain several unanswered questions due to the reluctance of the parents to work closely with anyone and because of the interrupted therapy.

Acknowledgments
I would like to take this opportunity to thank Miss Fiona Abington and Mrs. Rosalind Brent, who worked with me, and Mrs. Pauline Cohen and Mrs. Sandra Ramsden who supervised my work.

REFERENCES

Freud, A (1952) The role of bodily illness in the mental life of children. **Psychoanalytic Study of the Child,** 7: 69-82.

Galenson, E. & Rophie, H. (1980) The preoedipal development of the boy. **J. Amer. Psychoanal. Assn., 28: 805-828.**

Kahn, M. (1963) The concept of cumulative trauma. **Psychoanal. Study of the Child,** 18:

Lev-Ran, A (1974). Gender role differentiation in hermaphrodities. **Archives of Sex. Behaviour,** Vol. 3, no. 5: 391-424

Lussier, A. (1960). The analysis of a boy with a congenital abnormality. **Psychoanal. Study of the Child.** 15: 430-453.

Mintzer, D. et al (1984). Parenting an infant with a birth defect: the regulation of self esteem. **Psychoanal. Study Child,** 39: 561-590.

Money, J. & Ehrhardt, A. (1972). **Man and Woman, Boy and Girl.** Baltimore: The John Hopkins Univ. Press.

Niederland, W.G. (1965). Narcissistic ego impairments in patient with early physical malformations. **Psychoanal. Study Child** 20: 518-534

Stoller, R. (1965). The sense of makeness. **Psychoanal. Quart.** 34: 207-218

Terhune, C.B. (1979). The role of hearing in early ego organisation. **Psychoanal. Study of the Child,** 34: 371-384.

Walzer, S. (1985). X chromosome abnormalities and cognitive development. **J. Child Psychol. and Psychiatry.** Vol. 26, no. 2: 177-184

A BRIDGE ACROSS A FALL – A CENTENARY

Arna Davis

"As a child I felt myself to be alone, and I am still, because I know things and must hint at things which others apparently know nothing of, and for the most part do not want to know. Loneliness does not come from having no people about one, but from being unable to communicate the things that seem important to oneself, or for holding views which others find inadmissible. If a man knows more than others, he becomes lonely"

Carl Gustav Jung, aged eighty three (Jung 1963)

Carl Gustav Jung – named after his grandfather – was born on 26th July in 1875 – sharing a birthday with my husband and a birthyear with my grandmother. His names are dear and familiar to me. Carl was my great grandfather's name, and the name of my grandfather was Gustav.

A hundred years ago in 1887 an event – a fall in the cathedral square in Basel – took place marking the end of the childhood of Carl Gustav Jung. Using that event as a starting point, I am, in this essay, attempting to return to a child Carl Gustav.

In telling Carl Gustav's story I have mainly limited myself to the first two chapters up to pages seventy of "Memories, Dreams, Reflections", Jung's personal myth told by him in his eighty third year, and as so often in sessions with individual patients or with families, I have been deeply moved by the uncontained suffering and pain of the child, whose communications have not been heard or understood. It is frequently the highly gifted children who are most capable of outwardly adapting themselves to an environment that does not meet their needs and a system that is unable to contain the child, thus forcing the child to take on the conflicting roles of both parenting the parents as well as parenting himself. The cost is loneliness, a deep sense of insecurity, a false sense of independence and a too early detachment from his own infantile needs.

Alice Miller states in her book "The Drama of the Gifted Child":

"The child has a primary need to be regarded and repsected as the person he really is at any given time, and as the centre of his own activity. In contradistinction, we are speaking here of a need that is narcissistic, but nevertheless legitimate, and whose fulfilment is essential for the development of a healthy self esteem. In an atmosphere of respect and tolerance for his feelings, the child, in the phase of separation, will be able to give up symbiosis with the mother and accomplish the steps toward individuation and autonomy. If parents are to furnish these prerequisites for a healthy narcissism, they themselves need to have grown up in such an atmosphere.

Parents who did not experience this climate as children are themselves narcissistically deprived, and with this unsatisfied and unconscious need are compelled to attempt its gratification through substitute means. The most appropriate objects for gratification are the parents' own children. A newborn baby is completely dependent on his parents, and since their caring is essential for his existence, he does all he can to avoid losing them. From the very first day onward, he will muster all his resources to this end".

Miller goes on to say: "This child has an amazing ability to perceive and respond intuitively, that is, unconsciously, to this need of the mother, or to both parents, for him to take on the role that has unconsciously been assigned to him". "This ability is then extended and perfected. Later, these children become confidantes, comforters, advisers and supporters of their own mothers, and eventually develop a special sensitivity to unconscious signals manifesting the needs of others. No wonder that they often choose the psychoanalytic profession later on". (Miller 1983).

Carl Gustav – a sensitive and highly gifted child, safely protected by his firm roots in the Swiss soil, but uncontained by his warring child-parents – was driven to a lifelong search for meaning, understanding and truth. We have harvested the fruits of his search; he ends "Memories, Dreams, Reflections":

"It seems to me as if that alienation which so long separated me from the world has become transferred into my own inner world, and has revealed to me an unexpected unfamiliarity with myself", a statement though sad also indicating man's eternala search for the "undiscovered self". (Jung 1958).

For over nine years Carl Gustav was the only child of Pastor Paul Jung and his wife Emilie. Both parents came from large families. Grandfather Carl Gustav – a professor of anatomy and later a professor of internal medicine – was married three times and had thirteen children. Paul was his youngest son. Maternal grandfather, Churchwarden Samuel – an administrator of the Basel church, a visionary and a Hebrew specialist – was married twice and also had thirteen children, Emilie being the youngest. (McGuire 1980)

By the time Carl Gustav was born all four grandparents were already dead. The young family did not have the benefit of mediating grandparents; instead there was a forest of uncles and aunts hovering over them, offering their brotherly and sisterly guidance. Two spinster aunts took a special interest in Carl Gustav and eight clergymen uncles visited the home quite frequently.

Family Jung moved twice during Carl Gustav's childhood. The first move from Kesswill on Lake Constance took place when baby Carl Gustav was six months old. The early months were a happy time, and Jung recollects the visit he made with his mother a few years after the move: "I could not be dragged away from the water. The sun glistened on the water. The lake

stretched away and away into the distance. This expanse of water was an inconceivable pleasure to me, an incomparable splendour. At that time the idea became fixed in my mind that I must live near a lake; without water, I thought nobody could live at all". (M.D.R. p.22)

The three years spent in Laufen, a village next to the Rhine Falls, was a time filled with unhappiness, frightening happenings and illnesses. The vicarage stood quite alone in the meadows above the village, near the castle and so near the Falls that their muted roar was always audible. All around them lay a danger zone. People drowned, bodies were swept over rocks. The bridge was dangerous to cross. (M.D.R. p.24)

In 1879 the family moved to Klein-Hüningen, a village near Basel. The eighteenth century parsonage had many rooms and old furniture. Carl Gustav's favourite one was a dark room with paintings on the walls. "Often I would steal into the dark, sequestered room and sit for hours in front of the pictures, gazing at all this beauty". (M.D.R. p. 30,31). At the age of six Carl Gustav started attending the village school, and then, in his eleventh year, he was sent to the Gymnasium in Basel.

1887 – The Event

Jung tells: "One day in the early summer 1887 I was standing in the cathedral square, waiting for a classmate, who went home the same route as myself. Suddenly another boy gave me a shove that knocked me off my feet. I fell, striking my head against the kerbstone so hard that I almost lost consciousness. I was only half unconscious but remained lying there, chiefly in order to avenge myself on my assailant. Then people picked me up and took me to a house nearby where two elderly spinster aunts lived. From then on I begun to have fainting spells whenever I had to return to school, and whenever my parents set me to doing my homework. For more than six months I stayed away from school.

My parents consulted various doctors, who scratched their heads and packed me off to spend holidays with relatives. But when I returned home everything was as before. One doctor thought I had epilepsy. My parents became more worried than ever. I knew what epiletic fits were like and inwardly laughed at such nonsense". (At the point of the fall the thought had crossed Carl Gustav's mind: Now you don't have to go to school). "School had become a bore to me. It took up too much time which I would rather have spent drawing battles and playing with fire".

"Staying away from school was a picnic. I was free, could dream for hours, be anywhere I liked, in the woods or by the water or draw. Above all, I was able to plunge into the world of the mysterious. To that realm belonged trees, a pool, the swamp, stones and animals, and my father's library. But I was growing more and more away from the world, and had all the while faint

pangs of conscience. I frittered away my time, but did not feel any happier for it. I had the obscure feeling that I was fleeing from myself".

"Then one day a friend called on my father. I heard the visitor saying to my father "And how is your son?" "Ah, that is a sad business" my father replied. "The doctors no longer know what is wrong with him. They think it may be epilepsy. It would be dreadful, if he were incurable. I have lost what little I had, and what will become of the boy if he can't earn his own living?"

Jung explains: "I forgot completely how all this had come about, but I pitied my parent's worries". He continues to describe what happened after he had heard the above conversation; "I was thunderstruck. This was the collision with reality".

"From that moment on I became a serious child. I went to my father's study, took out my Latin grammar, and began to cram with intense concentration. After ten minutes of this I had the finest of fainting fits. I almost fell off the chair, but after a few minutes I felt better and went on working" Jung goes on to describe how two more fits occurred. "Still I did not give up, and worked for another hour, until I had the feeling that I had overcome the attacks". (M.D.R. p. 46,47,48)

That was the end of these fainting spells, and a few weeks later Carl Gustav returned to school with a note from the doctor forbidding the boy to engage in gymnastics. An illness had been miraculously cured as far as the doctors and the parents were concerned, but Carl Gustav was far harder on himself. "The whole bag of tricks was over and done with". Jung adds: "That was then I learned what neurosis is", he continues: "Gradually the recollection of how it all had come about returned to me, and I saw clearly that I myself had arranged this whole disgraceful situation". He even excuses the schoolmate who knocked him unconscious "I knew he had been put up to it, and I have never been seriously angry with himn". "The whole affair was a diabolical plot on my part. I had a feeling of rage against myself, and at the same time was ashamed of myself. Nobody else was to blame; I was the cursed renegade! From then on I could not endure my parents' worrying about me or speaking to me in a pitying tone. The neurosis became another of my secrets, but it was a shameful secret, a defeat. Nevertheless, it induced in me a studied punctiliance and an unusual diligence". (M.D.R. p.48). Jung then describes the experiences that followed: "I had an overwhelming impression of having just emerged from a dense cloud". "I knew all at once: now I am myself. Now I exist". "Previously I had been willed to do this and that, now I willed". (M.D.R. p.49)

He discovers his own authority: "Then to my intense confusion, it occurred to me that I was actually two different persons. One of them was a schoolboy who was far from sure of himself; the other was important, high

authority, a man not to be trifled with. This "Other" was an old man". (M.D.R. p.50) Jung then gives a vivid picture of the inner struggle with God that followed: "from the moment I emerged from the mist and became conscious of myself, the superhuman majesty of God began to haunt my imagination". "God himself was arranging a decisive test for me and everything depended on my understanding Him correctly". (M.D.R. p.55), he comes to the final settlement "The greater my inferiority feelings became, the more comprehensible did God's grace appear to me". (M.D.R. p.58) He adds: "When my Mother once said to me: "You have always been a good boy" that was quite new to me. I often thought of myself as a corrupt and inferior person". (M.D.R. p.58)

Jung concludes: "My entire youth can be understood in terms of this secret. It induced in me an almost unendurable loneliness. My one great achievement during those years was that I resisted the temptation to talk about it with anyone. Thus the pattern of my relationship to the world was already prefigured: Today as then I am solitary, because I know things and must hint at things which other people do not know, and usually do not even want to know". (M.D.R. p.58)

The fall in the cathedral square was a turning point in Carl Gustav's life. With it collapsed his childhood world and his trust in an outside authority. At the age of twelve the child Carl Gustav had become THE AUTHORITY, wiser than the doctors and his parents, but at the same time feeling a cheat and carrying a guilty secret. "I found myself being guilty and at the same time wishing to be innocent". (M.D.R. p.61) In his omnipotent and childish thinking he took the blame for his own fall as well as his parents' lack of understanding of his true communications. By doing this, the child Carl Gustav made an erroneous assumption, turning the failure of the environment to contain a child to be his own fault. Thus leaving him solely responsible for his own fate "in all decisive matters I was no longer among men, but alone with God". (M.D.R. p.65)

C.G. Jung – one of the great thinkers of this century – was not able to fully correct in his lifetime this error in the child Carl Gustav's thinking, as "A strict taboo hung over all these matters inherited from my childhood" (M.D.R. 58) and as for him – the pioneer – there could not be the experience of a containing "Other" outside himself.

1987 – The Fall Reviewed

I would now like to take a leap in time, and using our present day understanding both about individual development and family systems-understanding which we have thanks to the search started by Freud and Jung – review the fall.

It is not uncommon even today for worried parents to contact their doctor concerned for their eleven year old child, who is suffering from fainting spells linked with the inability to attend school. An enlightened G.P. – after eliminating any possible physical causes – would in his turn refer a child like Carl and his parents to a specialist for a psychiatric assessment. The sympton has now been labelled "School Refusal".

I shall simply use the facts available in "Memories, Dreams, and Reflections" in attempting to gather the kind of information a therapist would need in order to understand the meaning of the symptom for Carl and his parents.

Jung saw a symptom as having a communicative meaning which needs to be understood, and rather than ask why something happened, he asked "What did it happen for?" Though the language of the modern systems theory was not available to Jung, his ideas about the dynamics of mental phenomena came quite close to the systems view, where every illness is in essence a mental phenomena. Jung saw the psyche as a self-regulating, dynamic system, characterised by fluctuations between opposite poles. (Jung C.W. 8) Systems view looks at the world in terms of relationships and intergrations. Systems thinking is process thinking. (Capra. 1982).

Jung states: "The psychology of an individual can never be exhaustively explained from himself alone; as a living phenomenon, it is always indissolubly bound with the continuity of the vital process, so that it is not only something evolved but also continually evolving and creative. (Jung C.W.6).

The Assessment

When a child is the identified patient one would need the parents' full co-operation in the assessment process to find out what is going on collectively in the family system. Jung has very similar thoughts: "A collective problem, if not recognised as such, always appears as a personal problem, and in individual cases may give the impression that something is out of order in the realm of the personal psyche. The personal sphere is indeed disturbed, but such disturbances need not be primary; they may well be secondary, the consequence of an insupportable change in the social atmosphere. The cause of disturbance is therefore, not to be sought in the personal surroundings, but rather in the collective situation. Psychotherapy has hitherto taken this matter far too little into account". (M.D.R. p. 261)

In the assessment session the therapist's task is both to listen to the story told by members of the family as well as observe the interactions and the nonverbal communications in the here and now. The therapist makes silent hypothesis of the dynamic processes that are going on in the family and

it's individual members. In fact this same way of listening is as valid in a session with an individual patient. (Langs 1973)

For example one could say: Carl's accident was the trigger opening up the vulnerability in the Jung family, and brought in the experts. The family system was no longer in balance. The hypothesis would be: The holder of the balance in this family is Carl. In assessing the communicative meaning of the symptom and why it happened now, the therapist would attempt to find answers to questions like: What is going on at school making it a place to avoid? What is going on between school and parents? What did the fall mean to Carl? What to parents? What is going on at home for the child to feel that he need to be there? What changes have taken place for Carl, for parents?

School

As the manifest problem is Carl's inability to continue with his life task, which is to be a schoolboy, let's start with asking: What was school like for Carl? "Soon after I was six my father began giving me Latin lessons, and I also went to school. I did not mind school, it was easy for me, since I was always ahead of others and had learned to read. (M.D.R. p.32) "At school I discovered that my rustic school-mates alienated me from myself. It seemed to me that the change in myself was due to the influence of my schoolfellows, who somehow misled me or compelled me to be different from what I thought I was. My inner security was threatened". (M.D.R. p.34)

The therapist would make a mental note about this feeling of alienation and inner security being threatened, but would now want to know what the transfer to a secondary school was like. It is after all recognised as one of the major crises in a child's life. From my experience it is a time when outside help is frequently required to help the child in this transition to a new less secure system.

How did Carl cope? "My eleventh year was significant. I was sent to the Gymnasium in Basel. Thus I was taken away from my rustic playmates, and truly entered the "great world", where powerful personages lived in big, splendid houses, drove about in expensive carriages, and talked a refined German and French. Their sons, well-dressed, equipped with fine manners and plenty of pocket money, were now my classmates. With great astonishment and a horrible secret envy I heard them tell about their vacations in the Alps. Then, for the first time, I became aware how poor we were, that my father was a poor country parson and I a still poorer parson's son who had holes in his shoes and had to sit for six hours in school with wet socks". (M.D.R. p.40) "Divinity classes were unspeakably dull, and I felt a downright fear for the mathematics class. The teacher pretended algebra was a perfectly natural affair, to be taken for granted, whereas I didn't even know

what numbers really were. I was so intimidated by my incomprehension that I did not dare to ask any questions. Mathematics classes became a sheer terror and torture for me. Other subjects I found easy, but my fear of failure and my sense of smallness in face of the vast world around me created in me not only a dislike but a total despair which completely ruined school for me. In addition I was exampted from drawing classes on grounds of utter incapacity". "To my defeats in mathematics and drawing there was a third: from the very first I hated gymnastics. I could not endure having others tell me how to move. As a result of previous accidents, I had certain physial timidity, and this in turn linked with distrust of the world and it's incomprehensible perils". (M.D.R. p.43,45)

The family and the school

The therapist notes the child's sense of utter failure and the enormous loss of self esteem. Carl, the leader of his rustic schoolmates, the bright, intelligent boy, was suddenly faced with a new world where he was a nobody. Questioning the communications between the parents and the school, the therapist might discover that the parents were totally unaware of the deeply stressful school situation. Carl had for years been seen as a boy who managed his life on his own. "Naturally, I could not talk with anyone about these things". (M.D.R. P.65) "I had a secret world of my own". (M.D.R. p.69) "My mother usually assumed that I was mentally far beyond my age, and she would talk to me as to a grown up". (M.D.R. p.69) "Naturally I compensated my inner insecurity by an outward show of security". (M.D.R. p.61). The serious learning difficulties in one of the major subjects- mathematics- would be dismissed as the family norm with a quote from Carl's grandfather's diary: "As soon as anything in the world has the slightest connection with mathematics, my mind clouds over. I haven't blamed my boys for their stupidity in this respect. It is their inheritance". (Ernst Jung: 1910 in Maguire 1980)

Family myths and secrets:

The therapist would note the myth of Carl being a little grown up and managing on his own, and would also want to challenge the myth that understanding mathematics can not be done by a member of the Jung family. Are there other family secrets and myths? One of them is the story that grandfather Carl Gustav was not the son of Franz Ignaz Jung, the medical advisor and court doctor in Mannheim, but that his wife had an affair with Wolfgang Goethe, and grandfather Carl Gustav is the illegitimate son of Goethe. (M.D.R. p.52 footnote). What effect this might have had on him is uncertain, but he was deeply concerned for retarded children and founded the

Institute of Hope, lavishing his personal care and love on these children. (McGuire 1980)

Maternal grandfather Samuel on his side was famous for his visionary experiences and his ability to converse with the ghosts. (McGuire 1980). This might lead to the family sharing the many mysterious and religious experiences, and the years in Laufen near the Rhine Falls would be re-remembered as a time of disturbing happenings.

"At that time I had vague fears at night, I would hear things walking about in the house". "People drowned. In the cemetery nearby, the sexton would dig a hole. Black, solemn men in long frock coats with unusually tall hats and shiny black boots would bring a black box. My father would be there in his clerical gown, speaking in a resounding voice. Women wept. I was told that someone was being buried in this hole in the ground". (M.D.R. p.24) "Lord Jesus" took people to himself, and this "taking" was the same as putting them in a hole in the ground. I begun to distrust Lord Jesus. He became associated with the gloomy black men who busied themselves with the black box". (M.D.R. p.25)

There was the frightening memory of:: "Strangers, bustle, excitement. "The fishermen have found a corpse- came down the Falls". The body is put down in the wash house. I want to see the dead boy. My mother holds me back and sternly forbids me to go into the garden. When all men had left, I quickly stole into the garden to the wash house. The door was locked; at the back there was an open drain, and I saw blood and water trickling out". (M.D.R. p.22) By stealing into the garden little Carl, not four years old, has both a very frightening experience and a guilty secret that cannot be shared. Will it be acted out?

Accidents, separations, illnesses

There was a mention of previous accidents linking them with physical timidity. It would be interesting to know more about Carl's experiences as a small boy.

"Perhaps the earliest memory, I am lying in a pram, in the shadow of a tree. I have just wakened to the glorious beauty of the day, and have a sense of indescribable well being". Another memory: "I am spooning up warm milk. The milk has a pleasant taste and a characteristic smell". (M.D.R. p.21)

At the age of three: "I was suffering from general eczema. Dim intimations of trouble in my parents' marriage hovered around me. My illness must have been connected with a temporary separation of my parents. My mother spent several months in a hospital in Basel, and presumably her illness had something to do with the difficulty in the marriage. I was deeply troubled by my mother's being away. From then on, I always felt mistrustful when the word love was spoken". (M.D.R. p.23)

Who took care of Carl? "I am restive, feverish, unable to sleep. My father carries me in his arms, paces up and down, singing his old student songs". "An Aunt, who was a spinster, took care of me. Also our maid looked after me. I still remember her picking me up and laying my head against her shoulder". (M.D.R. P.22,23)

What about the accidents? "What follows now are more powerful, indeed overwhelming images, some which I recall only dimly. There was a fall downstairs and another fall against the angle of a stove lef. I remember pain and blood, a doctor sewing a wound in my head". (M.D.R. p.24)

"My mother told me, too, of the time when I was crossing the bridge over the Rhine Falls to Neuhausen. The maid caught me just in time – I already had one leg under the railing and was about to slip through". (M.D.R. p.24)

The therapist would remember the guilty secret, the dead unknown boy in the wash house and ask was this little Carl's way of communicating his secret terror that he would be punished by having disobeyed his mother and would also have to drown?

There was another drowning incident when the family lived in Klein-Hüningen. "There was a great flood, a bridge had collapsed. Fourteen people were drowned. I actually found a body of a middleaged man, in a black frock coat". The dead man was associated with a pig being slaughtered and both were simply matters of interest to me". (M.D.R. p.30, 31)
The fascination with blood and death, and the detachment of feeling neither shock or fear would be noted by the therapist.

Carl remembers still another fall. He was six years old; "My parents took me on an excursion to Arlesheim. We came to a Catholic church. My curiosity, mingled with fear prompted me to slip away from my mother and peep through the open door into the interior. I suddenly stumbled on a step and struck my chin on a piece of iron. I remember that I had a gash that was bleeding badly when my parents picked me up". "For years afterwards I was unable to set foot inside a catholic church without secret fear of blood and falling". (M.D.R. p.32)

The Marital Relationship

What is going on in this family to make Carl so accident-prone and so uncontained? (He steals to the wash house, slips away from his mother) In my experience as a therapist I have learnt to look for a marital conflict when a child has no firm boundaries. The couple are not working together as parents, or more often actually using the child to meet their own unsatisfied needs. There is already confirmation that at the age of three Carl had "Dim intimations of trouble in the parents' marriage", and the consequences of the

long separation from mother Carl had experienced as "being deeply troubled". (M.D.R. p.23) There is further evidence. From the age of six comes another memory: "I was sick with pseudo-croup, accompanied by choking fits". "The nocturnal atmosphere had begun to thicken. All sorts of things were happening at night, things incomprehensible and alarming. My parents were sleeping apart. I slept in my father's room. From the door to my mother's room came frightening influences. At night Mother was strange and mysterious. One night I saw coming from her door a faintly luminous, indefinite figure whose head detached itself from the neck and floated along in front of it, in the air like a little moon". "I had anxiety dreams of things that were now small, now large. For instance, I saw a tiny ball at a great distance growing steadily into a monstrous and suffocating object". (M.D.R. p.33,34)

There is also another dream Carl has never forgotten, dreamt when they lived in Laufen. "In the dream I was in the meadow. I discovered a dark, stone-lined hole in the ground. Then I saw a stone stairway leading down. At the bottom was a doorway, closed off by a green curtain, I pushed it aside and saw a chamber. The floor was laid with flagstones, and in the cnentre a red carpet ran to a low platform. On this platform stood a golden throne, a real king's throne in a fairytale. Something was standing on it. It was a huge thing. It was made of skin and naked flesh, and on top there was something like a rounded head with no face and no hair. On the very top of the head was a single eye, gazing motionlessly upwards. The thing did not move, yet I had the feeling it might crawl off the throne and creep towards me. I was paralysed with terror. I heard from outside and above me my mother's voice "Yes look at him. That is the man-eater". That intensified my terror, and I awoke sweating and scared to death". (M.D.R. p.27)

The therapist would remember all the frightening happenings in Carl's life at that time: the deaths, blood, burials, and would also wonder, if the child had actually been frightened by seeing his father's erect penis and witnessing a brutal intercourse?

The birth of a sister

For every child the birth of a rival is one of the major traumatic events. How was Carl prepared for this? "When I was nine years old my mother had a little girl. My father was excited and pleased. I was utterly surprised, for I hadn't noticed anything. I had thought nothing of my mother's lying in bed more frequently than usual, for I considered her taking to her bed an inexcusable weakness in any case. My father brought me to my mother's bedside, and she held this little creature that looked dreadfully disappointing: a red, shrunken face like an old man's. Had it been intended for a monkey? I was shocked and did not know what to feel. They mumbled something about a stork which was

supposed to have brought the baby. I felt sure my mother had once again done something I was not to know about. This sudden appearance of my sister left me with a vague sense of distrust which sharpened my curiosity and observations". (M.D.R. p.40,41) Is Carl becoming inquisitive about what is going on between his parents in his absence?

Carl's relationship to his parents

In an assessment session it is easy to see and recognise the interactional patterns between a child and each parent, and also note which parent allies with the child against the other, or observe the child's loyality conflict and his balancing attempts. "My mother early made me her confidant and confided her troubles to me". "She was telling me everything she could not say to my father". (M.D.R. p.69) "My mother's attitude towards me was above all one of admiration". (M.D.R. p.65)

"My mother was a very good mother to me. She had a hearty animal warmth, cooked wonderfully and was most companionable and pleasant". "I was sure that she consisted of two personalities, one innocuous and human, the other uncanny. This other emerged only now and then, but each time it was unexpected and frightening". (M.D.R. p.65, 66)

Carl's father had taken care of him when he was ill as a small boy. What is their relationship like now? "At that time there arose in me profound doubts about everything my father said". (M.D.R. p.59) "For my father in particular I felt compassion, less, curiously enough for my mother. She always seemed the stronger of the two". "Nevertheless I always felt on her side when my father gave vent to his moody irritability". There was a necessity to take sides: "In order to liberate myself from these conflicts, I fell in the role of the superior arbitrator who willy-nilly had to judge his parents". "That caused certain inflatedness in me; my unstable self-assurance was increased and diminished at the same time". (M.D.R. p.40)

Carl's self balancing processes

By now there is evidence of the lack of parental containment of Carl. How did this child manage? How did he solve the threat to his security created by the sudden birth of his sister?

"My disunion with myself and the uncertainty in the world at large led me to an action in my tenth year. I had a yellow pencil case with a lock and a ruler. At the end of the ruler I now carved a little manikin. I coloured him black and sawed him off the ruler, and put him in the pencil case, where I made him a little bed. I even made a coat for him out of a bit of wool. In the case I also placed a smooth, oblong blackish stone from the Rhine, which I had long carried around in my trouser pocket. All this was a great secret.

Secretly I took the case to the forbidden attic (forbidden because the floor boards were rotten, A.D.) and hid it in one of the beams under the roof. I knew that not a soul would ever find it there. No one could discover my secret and destroy it. I felt safe. In all difficult situations, whenever I had done something wrong or my feelings had been hurt, or when my father's irritability or my mother's invalidism oppressed me, I thought of my carefully bedded down manikin and his smooth, prettily coloured stone. The safety of my life depended on it". (M.D.R. p. 36, 37)

As an only child for nine years Carl, had a secret life. "I played alone, and in my own way. I did not want to be disturbed. I was deeply absorbed in my games and could not endure being watched or judged while I played them". "I was passionately fond of playing with bricks, and build towers which I then rapturously destroyed by an "earthquake". (Carl was 6-7). His games then changed, "I drew endlessly – battle pictures, sieges, bombardments, naval engagements. I filled whole books with ink blots". (M.D.R. p.33)

At school he found playmates for the first time. "I was fond of playing with fire. No one but myself was allowed to tend my fire. Others could light other fires in other caves. My fire alone was living and had an unmistakable aura of sanctity". (M.D.R. p.35)

Carl also had his stone: "Often, when I was alone I sat down on this stone, and then begun my imaginary game: "I am sitting on top of this stone and it is underneath". But the stone could say "I" and think: "I am lying here on this slope and he is sitting on top of me". The question then arose: "Am I the one who is sitting on the stone, or am I the stone on which he is sitting?" "This stone stood in some secret relationship to me". (M.D.R. p.35,36) That relationship continued: "I was brooding on the secret. At such times it was strangely reassuring and calming to sit on my stone. It would free me of all my doubts. I was but the sum of my emotions, and the "Other" in me was the timeless, imperishable stone". (M.D.R. p.59)

The Summing Up

From the information gathered in this imaginary assessment session, the therapist would now have confirmation to the initial hypothesis: the child Carl is not only the holder of his family's balance, but has also for years contained his own inner terrors and outside threats to his security, and has created a sophisticated network of safety objects and rituals as a defence system. He has been deeply affected by his parents' marital conflicts, and has been forced into a position of a confidant and advisor at an age when he has no understanding of the true nature of their conflicts. His relationship to his mother is coloured by separation anxiety, and I suspect mother's mental

disturbance affected her relationship to Carl from his infancy onwards. The move at the age of six months from Kesswill to Laufen was a disturbing one. (Francis Tustin in describing a depressed mother's effect on her baby states: "A mother who feels lonely and unsupported may be unable to respond adequately to her baby. She will not be able to absorb the inevitable shocks with impinge upon him". In these she includes removal from one house to another (Tustin 1986). The long break lasting several months – at the age of three – is the final confirmation of a mother who cannot be trusted. His boundaries are blurred and he feels both omnipotent and deeply vulnerable.

He has suffered several bodily traumas with serious head injuries, he has witnessed frightening happenings – people drowning, deaths, blood, – and has almost drowned himself. He is confused about his own identity; is he a special child, is he a wife to his father, sharing the bedroom with him, a lover to his mother sharing her secrets or is he a single parent of two helpless children, or is he an old man, wiser and with more authority than the 'important people', is he his grandfather Carl Gustav (M.D.R. p.51) or is he a stone?

To the questions what does the symptom communicate and why has it occurred now, the therapist has gained several illuminating facts. Carl has had to cope within a short timespan – and without preparation – with two massive changes in his life. The arrival of a baby sister took away his by then guaranteed special position as an only child. Her presence also altered the family dynamics and marital conflicts flaired up anew, leaving Carl to cope with this double threat to his security. Instead of having time to adjust and regress he was pushed forward to a big, new world. Already the walk to Basel is long and in the Gymnasium he is seen as a nobody. It is a personal shock to his self esteem – to him the leader of his rustic schoolmates. It is also a downfall of his clergyman father, who is reduced to a poor country parson.

Being pushed down and knocked nearly unconscious in the cathedral square is the final humiliation and his defences are broken. He can no longer cope unaided with the total collapse of his familiar childhood world. The actual head injury triggered off memories of earlier traumas. It also gave him an honourable way out. His injury enabled him to receive his parents' care and attention. They in their turn could call in the experts for advice and containment of their fears. (Carl still had a visible scar from his fall at the age of three M.D.R. p.24)

A therapeutic view: a hundred years on

Carl, aged 11, referred by the family doctor for 'school refusal' is seen with his parents for an assessment by a therapist. The following help might be offered in 1987 as a result of that assessment: **family sessions** to help parents

gain trust in themselves as able and needed mediators with the school and the outside world, and to aid parents and teachers in establishing a containing network. Carl needs to be put in his place as still only a child, though highly gifted. An assessment of his educational needs would be considered.

After the return to school has been successfully negotiated, the next task would be: to free the child from him being the stabliser of the parents' marriage. I have frequently experienced the child's relief and gratitude when he can hand over this responsibility.

This might lead to: **marital help** for the parents where the inherited inbalance – their own unmet needs – would be worked with. One can imagine the confusion and collective oppression these parents carry, both the youngest children of their own families. There are the unresolved sibling rivalries with no containing parents alive, there are the five dead mothers and mysteries about fathers. What of all this had been projected into the partner and the one child. Carl most likely is both the special child and the envied child for both parents. His best adaptation has been his ability to be contained by his inner archetypes and the collectively containing nature and rural life. "I feel very strongly that I am under the influence of things and questions which are left incomplete and unanswered by my parents and grandparents. It often seems as if there were an impersonal karma within a family, which is passed on from parents to children". (M.D.R. p.260)

The child might be offered **individual pyschotherapy,** where in the safety of a therapeutic relationship the "Hole in the mind" (Warren Kinston and Jonathon Cohen 1986) could first be understood and barriers built around it gradually removed. The Monster Mother, who left her child unprotected and wounded, and whom the child from then on had to both fear and protect, would need to be re-experienced and mediated with a safe "Other" for the repairing and healing process to take place.

Return to 1887

In 1887 the experts were helpless. Carl Gustav – aided by his great creativity – made the best possible adaptation to a system that failed to understand his needs or his attempts to communicate the imbalance in his personal as well as in the family system. By becoming his own authority inwardly, and outwardly – after a rest of six months and a return to childhood plays – he was able to tackle his task as a schoolboy with increased determination and conscientiousness. He was left with a guilty secret and an inner conflict – the neurosis – and a mystery that had to be solved and covered up. By solving it he would need to remember the hurt, wounded child, unprotected by a Mother who abandons him; whilst by covering up he ensured the child's

encapsulated safety in the pencil case in the attic until on day it would be safe to go and search for that child.

His natural physical maturation process, his increased understanding of his parents' weaknesses and his exceptional giftedness were on his side in the adolescent struggles that followed.

Conclusion

I have in this essay described a fateful event – in Carl Gustav Jung's life – a fall in the cathedral square in the summer 1887.

By listening in 1987 to Carl Gustav's story as told by C.G. Jung in his eighty third year, I have seen a bridge that Carl Gustav – a child of his time and a child light years ahead of his time – had to cross. In that crossing the wounds of the child had to be safely sealed for C. G. Jung's journey as the lonely, self-providing and self-governing explorer to begin. His journey was a circular one, leading back to the flowing waters and the dangerous bridges to be crossed. The child who nearly drowned was never forgotten. After the parting of the ways with Freud, Jung knew: "The small boy is still around, and possesses a creative life which I lack", and he wanted to find a way of bridging the distance to his eleventh year. (M.D.R. p. 197) On the 12th December 1913 he had a vision: "At first I could see nothing, but then I saw that there was running water. In it a corpse floated by, a youth with blond hair and a wound in the head (M.D.R. p. 203). But that is another story.

C. G. Jung has led me back to a bridge over the roaring Falls where the wounded Child, with a healing gift and the Wise Old Man are walking safely hand in hand. It is a bridge that needs to be crossed again and again. It's name is the Healing Process.

REFERENCES

Main Reference:

Jung, C.G. (1963) **Memories, Dreams, Reflections,** London, Routledge and Kegan Paul. The edition used (1979) Collins Fount Paperback p21 - 70, 197, 203, 381, 391, 261, 260.

Other References

Capra, Fritjof (1982) **The Turning Point** p. 396-401 London, Wilwood House

Jung, C.G. (1982) **The Undiscovered Self** London, Routledge and Kegan Paul

Jung, C.G. (1961) **Collected Works** Vol. 6 par. 717 (196) Collected Works Vol. 8 "On Psychic Energy" London, Routledge and Kegan Paul

Kingston, W. & Cohen, J. (1986) Primal Repression: Clinical and Theoretical Aspects **International Journal of Psycho-Analysis.** 67:337

Langs, Robert (1978) **The Listening Process.** New York, Jason Aronson

McQuire W. & Hull, R.F.C. (edit) (1980) **C.G. Jung Speaking. Albert Oeri: Some Youthful Memories.** p.25 - 31. London, Picador Pan Books

Miller, Alice (1983) **Drama of the Gifted Child** p. 21-23 London, Faber & Faber Paperback

Tustin, Frances (1986) **Autistic Barriers in Neurotic Patients** p. 61, 95 London, H. Karnac Books Ltd.

HOW MUCH TIME DOES IT TAKE TO ESTABLISH CO-OPERATION IN PSYCHOTHERAPY?

Herbert Hahn

Introduction

Many of us begin our work as psychotherapists under the aegis of a training programme which requires us and our first patients to be in three or more times weekly psychotherapy. However from my experience and from the reports of many colleagues over the years, many in voyages into what becomes "good enough" therapy have begun on a relatively infrequent or even sporadic basis.

This paper explores and reflects on the initial process of establishing co-operation for the psychotherapeutic journey. It includes examples from practice, focussing in particular on five preliminary sessions with Mr. Taylor which were spread over several months. Reference is also made to some of the literature. The stimulus to write the paper has partly come from the work of transfering a practice from London to the provinces, and encountering an environment in which there appeared to be hardly anyone in need, who could envisage the prospect of more than once weekly therapy. It became important to resist the pressure to dilute the work, yet hardly possible to insist on frequent regular sessions from the outset.

The Work with Mr. Taylor

The contact was initiated by a mutual acquaintance who had met both Mr. Taylor and myself, and had a very vague notion of the kind of work which I did. I was asked whether I would be willing to meet Mr. Taylor who needed some kind of personal help about his career and himself. I suggested that he write to me briefly about his situation and that I would then arrange a meeting. He wrote as follows:-

"For some years I have become increasingly dissatisfied with certain aspects of my inner life – apparently unstoppable but self-indulgent mental dialogue, uncertainty about the direction for my career – recurrent lows (? depression), a slightly trapped feeling reflected in many dreams – a general feeling that I am under-achieving because of being out of touch with myself in some way – a certain inability to live fully here and now".

When we met some days later, he looked healthy and strong, and after firmly shaking hands, went on to tell me about his job and his family. He has

been successful at work, and also recently initiated a project which particularly interested him. It went well. Now its over, he's wondering if he could do more with it.....he knows he is a dreamer. His head of department thinks he should be looking for promotion, ... he wonders whether this is an objective view – perhaps his boss is just being "taken in". If he changed career direction, that would mean a possible loss of income. His wife has been supportive when he has discussed possibilities with her, but he should not expect her to make such sacrifices. He is quite close to his children. They do get on his nerves (implying they shouldn't). He likes his work most of the time, ... there are some of the administrative bits he finds a chore (implying he shouldn't). In his account, he seemed to put more emphasis on what was wrong, or not "good enough", than what was going well. I said to him that in listening to and thinking about what he had been telling me about his work and life at home, there were many positive aspects such as his successful project, his boss's encouragement, the things he enjoyed at work, his good relationship with his children, and his wife's support, but that he seemed more concerned about the aspects which were unsatisfactory in these situations. He looked surprised then after a pause said although my summary was accurate, it came as something of a shock to hear me say it, because while he had been talking to me, he had felt that he was simply being logical. I asked him about how he understood this "logic" and whether it was a type of logic which he had met elsewhere. He was silent..... then said it reminded him of the long talks he and his mother used to have years ago when his father was away. She used to respond to various thoughts and ideas he put forward with a very powerful logic which always showed where the flaws were. He was amazed, he said, to discover that he had been talking today in a way that she used to with him.

Then, apparently satisfied that we had dealt with an issue, he asked if I could help him to understand some of his dreams. He said he did not attach much importance to them, but one day he caught a snatch of a radio programme in which the word "anxiety dreams" was used, and he immediately thought that that would be a relevant description of some of his dreams.

The time for the meeting was running out. I said that I had some experience of working with dreams, and that as time was running out, perhaps we could arrange a second meeting to take things further. Although this meant leaving the contract open, I felt that it was important for me to tolerate this rather than risk imposing clearer arrangements when he did not seem ready to do so. I felt I could work with him, but felt it important for him to have time to get more of his measure of me, as part of the process of his deciding what he wanted.

Second Session

He arrived on time, eagerly opened an exercise book, and began by saying: "I'm sorry, although it's been a fortnight, I've only managed to bring twelve dreams". He also apologised as he had not been able to recall them completely. I suggested that we see what we could make of what he had brought, and he proceeded to read the notes of his first dream rapidly – for the next fifteen minutes! When I asked whether the dream evoked associations for him, he readily produced numerous memories, thoughts and feelings, going on speaking for several minutes more.

I felt overwhelmed, wondering what to do with the mass of material he had already produced, and sensed that alongside his own apology for the limitations of his own efforts in bringing fewer and less complete dreams that he thought were expected, was an enormous expectation as to what I would be able to do with them. As he seemed keen to go on reading from what he had brought, I decided to stay with his orientation, and hardly prompted by me, he went on to read two more (somewhat shorter) dreams, also producing his associations to each of them in turn. As he spoke, I noticed under the surface of his pressure of words, that the dreams varied considerably in content, but had similar themes: Thus the content related to academic work; a very long journey; and a complicated project, but in every case there was an atmosphere of doubt/uncertainty/anxiety that in spite of very considerable effort, failure or disappointment were a strong possibility, and that trying harder did not reduce the risk of for example failing the exam, missing the connecting train, etc. I was reminded of his telling me in the previous session that the phrase "anxiety dreams" would fit his dreams well. Also, with regard to his associations to the dreams, they often concerned events in his childhood, particularly in relation to his parents.

One of his more vivid associations was his memory of the way in which his father taught him to row when he was about 8 years old: Father would put son in the rowing boat, swim out pulling the two rope until the boat was far from shore, then swim off at a distance and leave son to row himself in. Although father remained in view, son **felt** uncertain whether his father would come to the rescue if need be. In another association, he remembered when as a schoolboy, he had excitedly told his mother that he had achieved the bext exam results for the year, and she had responded: "But you're not the best all round sportsman as well, like your brother was".

I noted aloud then to Mr. Taylor that many of his associations to his dreams (and there were more), related to memories from his childhood. I did feel that there may have been some special significance for him – both anxiety and excitement perhaps – in the long talks he had had with his mother while his father was away, and there were other clues about oedipal conflicts, and

sibling rivalry, but I did not think that the evidence was convincing enough to put it to him. He responded to my comment about the frequent childhood memories in his associations to his dreams by saying that he had noticed this too. In fact he had gone on thinking after our last meeting and had come to the uncomfortable realisation that experiences going back to his childhood were still affecting him strongly. He had known for a long time that his brother still suffered because of childhood experiences, but he had thought that he himself had left these behind ages ago.

I then went on to comment about the session as a whole, observing that while he had said he had communicated the feeling that he had not brought enough dreams, nor remembered then sufficiently well, he had in fact brought twelve, and virtually filled an exercise book with them. Indeed there was very much more than we could attend to, and I wondered whether we were seeing one way in which he still set himself impossibly high standards, in a way which might link with the enormous expectations his parents sometimes had of him as a child. He laughed, saying "It's amazing how it all seems to fit together ..... I feel a sense of relief".

It was time to stop and when I said so, he said that a lot had come up which was interesting and that needed time to think through. I asked whether he would like any further meetings, and he said he would like to come again in three weeks and that was what we arranged.

Session Three

He began by saying that he felt a lot clearer in relation to the dissatisfaction and dis-ease he had brought to me at the beginning of our first meeting. He said more particularly what he had come to understand was that he was still being very much influenced by his experience of past events in his life. He then narrated the following dream: He came with his family to visit his parents, but he was also a little boy. His mother greeted him and he said how lovely the garden looked. She said "Yes, but you should have seen it last week". Her tone of voice was one which he recognised as telling him both that he was missing out and that his judgment was not quite right. His two siblings were there, and a dark bearded slightly bald stranger who seemed to be observing and friendly. Then one of his brother's suddenly produced an object from the garden which was claimed to be an amazing archaeological find – millions of years old. Another brother suddenly swooped out in a helicopter and rescued someone who was drowning. There was mention of lightning in the distance and he found himself claiming both that he had done something amazing on his bike, and also that he could see the lightning, even though it was several miles away and no one else could see it. The amazing event on his bike was something that he was making up, made to impress, but

seeing the lightning felt as if it was actually a great achievement in seeing something no one else could see. However both his communications were totally ignored by the family.

Then he was eating a meal at the table with his family. To his surprise his mother was lying under the table and was somehow positioned with her head just below his chair. He without particularly meaning to was scraping off the left over bits of the fish and fish bones onto her head.

With the help of his associations we became clear about his rivalry with his brothers, for mother's attention; his failure to get it and his unconscious (accidentally on purpose) hostility to her. This led him to a whole series of memories. It also was confirmed that the friendly bald stranger represented me. As these links emerged via the associations, I went on to refer to his "internal family", i.e. significant people in his inner world, and his need for a friendly person there in his inner world to work with and monitor some of the more painful and conflicting inter-actions between the members of this internal family. It was time to stop and he left saying that he felt able to proceed with things on his own. A few days later a postcard arrived, on the front was a picture of the actual place where he had visited his parents when he was the child, and where the dream reported in a previous session had also taken place. Accompanying the postcard was a short letter which read as follows: Am enjoying facing my "inner parents", with the real ones – though I haven't yet revealed to them that I am doing so. I feel an enormous weight of inertia has been brought into motion – however slowly it may move, the difference between no motion and any motion is infinite – it gives me positive feelings: change is possible, understanding is possible – the emotive, child-like feelgings which appear, are real and acceptable and therefore faceable ..... sometimes cycling home seems a long way, its raining, I'm tired. Once I've actually set off, I don't mind. Feels a bit like that now – I didn't know how to set off, what equipment I needed and so on. Now I feel as if I've set off – long way to go perhaps, but I'm glad to have set off what ever the weather may turn out to be like on route. Thanks for the space.

My feeling was, that although Mr. Taylor claimed he had a new sense of how to work with himself devised from our co-operative work together, I wondered how well this would stand up under pressure from external and internal processes and events. We had not had much time together and it remained to be seen how well the 3 meetings – perhaps we could call them therapeutic consultations – could give him enough basis for developing ongoing work with himself. It all seemed too good to be true.

Two months later he contacted me for a follow-up session. He began by telling me that since our last meeting he had visited his parents and had been able for the first time ever to have a serious discussion with them about

the family and its way of dealing with things. He began by talking to his father, and then when his mother came in with the next course of the meal, she joined in and they got so engrossed in discussion that they didn't eat the next course until 2 hours later. He had found it more difficult talking to his mother, but once they got going it had been extremely useful to him, because he had not only found that he was able to have a sense of being **present**, and putting forward his own point of view, but also that he was gaining new insights about the way his family dealt with things. It was also the first time in his life that he'd been able to hold on to his own point of view and disagree with his father, and had found, to his surprise, that his father was able to accept this. He said that on oncoming back from visiting his parents he had had one of his "lows" but had found, again to his surprise, that he was able to lessen the intensity of this. He did this by the realisation that the low was to do with what was going on inside him, and that he had a choice about the extent to which this was allowed to dominate and overwhelm him.

He also reported that he had many dreams, and had been reading some of Jung's work avidly, particularly his writings on dreams. He seemed to imply that my own work with him was similar to what he was wlearning from reading Jung. He then proceeded to narrate many of the dreams he had had at great speed. What seemed important to him was that I should simply receive them as his experience, and at a different level that he was himself admiring his performance and also seeking my admiration and applause. However, he also paused at various points, noting that as he had had the dream, it said something about what was going on inside himself and he noted in passing that certain aspects were interesting or exciting to him. There were moments when his sense of the amazing quality and uniqueness of the dream recalled the way he had been in one of his dreams in the previous session: having to produce the most brilliant and amazing feats in competition with his siblings in order to gain attention. However, there was not the time and space to share this observation with him. He also spoke with some anxiety, particularly when he noted that in some of his dreams he was in states of undress or in "sexual" situations with people with whom he had professional rather than personal relationships. At the same time he also sustained an attitude of interest and curiosity about what it all meant. For instance with regard to various animals that were appearing in his dreams, he said he thought these might well represent aspects of himself, and that he was particularly interested in a dream in which he was overwhelmed by a gorilla, with whom he then to his surprise found he was able to establish the beginnings of some kind of friendly communication. I suggested that he might be striving to establish some kind of more friendly understanding with the more primitive animal aspects of himself. In another dream he noted that in it he was himself,

but also his father and that somehow these two characters came together in a way that seemed interesting and energising. In yet another dream he was experiencing himself as if he was very much a little boy disguised as an adult, and fearing that other people could see through the adult and perceive the little boy underneath.

When I commented that it seemed as if there was a whole team of people inside himself with different perspectives both in relation to the dreams, and in the dreams themselves, he said that that was a helpful observation. He added that I had figured a great deal both in his dreams and in relation to his thinking about them, and that in thinking about his dreams what he particularly was struggling with was that there was an aspect of himself that felt that he could discover new and even amazing truths in the dream, and another aspect of himself which felt that this was simply being gullible and that there was nothing firm or logical to support the notion of taking dreams seriously. He added that in this conflict with himself what he was beginning to discover was a middle ground linked to his work with me, which was becoming increasingly interesting.

Similarly in his professional role, he is now feeling more optimistic because he is beginning to find ways in which he can develop his new interests without giving up his present profession. He said that he thought what would help him most now was if he could have me in a room in his house so that he could come up and consult me whenever he had a dream that was particularly interesting or felt particularly important. But he also felt that he could continue to cope on his own.

I said that it did seem as if inside himself he did have some kind of representation of me, was also an aspect of himself which would help him to think about and consider the different, and sometimes conflicting anxiety arousing experiences which he had, with a view to taking an interest in them, and perhaps gaining new understanding about them, in a way brought things together. I noted that he seemed to be doing a considerable amount of work with himself, but that he might also perhaps want to come and consult me at some point for additional support in relation to a process which he seemed to be conducting with and for himself. He said he would like to do this, and on his way out commented that he had noticed that he was now being more genuinely helpful to other people because where as previously he used to jump in and advise them what to do, he was now readier to listen and to help them to find their own solution.

At this point I was left not knowing whether we had reached the end of our work together, or whether he might be in touch again. It seemed as if his renewed or strengthened capacities had held for some time, at the same time there were elements, particularly in relation to the more narcissistic,

exhibitionistic aspect of the way in which he was receiving and looking at his dreams, which I thought might present him with some difficulties, and it remained to be seen how he would cope.

In the event he contacted me three months later. The meeting began ostensibly as one to report progress. He told me how people at work had commented on the way he had changed his orientation, and was much more confident and helpful. He also said that there was now a probability that he would have a paid sabbatical year in order to develop his project.

Once I had acknowledged his achievements, he quickly went on to narrate various dreams. I stopped him when he had reached the fourth or fifth dream, in which he noted that he was (in the dream) extremely involved with something that was interesting and fascinating to him, but then happened to walk up stairs and find that his wife was in bed with someone else.

I said I wondered whether he had perhaps become so interested, fascinated, and even excited by the processes in his inner world, that he feared losing contact with his wife and perhaps other people who mattered to him. He looked me straight in the eye and said that that was true.

I said that although he had at one level come to report his progress to me, I was wondering whether that was a total explanation of the reason for his asking for the meeting, and that perhaps what might be more difficult to say, but seemed to be implied, was that he was having difficulty in coping. He seemed relieved. He said it was difficult to say, but that he did feel extremely anxious and felt that he could not cope on his own and really needed help. It was just near the beginning of the summer holiday, and we made arrangements to begin once weekly sessions the following term. He said that he was relieved about the arrangement, and also looking forward to working with me. *He added however, that he did not think that he would have been able to consider the idea of regular psychotherapy when we first met.* It was only now, now that he had some more glimpses of what was going on inside himself and the sense that sense could be made of it, and also the extent to which he was not able to do this for himself, that he could ask for regular help.

Discussion

The particular issue on which I want to focus and expand in relation to this preliminary phase of the work with Mr. Taylor, and starting treatment in general, is that of our timing in relation to offering psychotherapy. With Mr. Taylor, I took time, encouraging adult-to-adult levels of communication in the initial consultations, taking an interest in how he saw his internal situation and external circumstances, and considering with him what he was now wanting or searching for. My decision was influenced by the nature and context of the referral and the way in which I was experiencing him in the counter-transference. I saw my responsibility as observing as much as I

could (including my own reactions), while trying to establish an atmosphere of co-operative communication with the possibility of therapy in view. This may have been too cautious an approach. However there is also the risk of going to the opposite extreme. A recent example appears in David Zigmond's paper Babel or Bible (B. J. Psychotherapy Vol. 12 No. 4) in which he describes a first meeting between Dr. L. and Carol. Dr. L., to whom Carol has been referred for help with her problems, introduces himself in the waiting room. He leads the way to his consulting room, and sits in silence for the next 10 or 15 minutes, then says, rather rhetorically: "I suppose you're rather angry, but don't know how to express it". Carol decided not to continue with Dr. L.

Similarly, in the same number of the Journal, there is an article which includes a commentary by three other therapists, on one therapist's account of a session with his patient. One of the three commentators allows himself with apparent conviction to interpret his colleague's patient's dream. The dream: "I had a dream on the train coming back from London – about witches. They were swirling about. I chiefly remember their long hair, swirling over the faces. They had rather beautiful faces – a bit wistful. I'm not sure about their clothes but they had dark hair, like two folk singers I told you about. They were dancing around". (p.318)

The commentator, who had received the account of the whole session and some background material 'blind', says of the dream: "In it the idealisation of the persecutory breasts (the beautiful witches) into whom he has projected his 'twirling' self and his wistfulness is followed by the experience of feeling 'drawn in' (or being drawn into a feeding situation) in a rather seductive, enticing way". (p. 332) However very little evidence is provided in support of this clearcut 'interpretation'.

These two examples seem to me to both go in the direction of imposing meaning, rather than discovering it, and I am reminded of a Bion's published reply when he was asked about his experience of Melanie Klein's interpretations. Having made clear his respect for, and appreciation of, Melanie Klein's work and discoveries, he says that she "did give a constant stream of interpretations", and continues: "Laterly I would have thought that they were too coloured by a wish to defend the accuracy of her theories so that she lost sight of the fact that what she was supposed to be doing was interpreting the phenomenon with which she was presented". (p.37 Bion in New York and Sao Paulo Clunie Press 1980)

Philip Darley (Students not Clients. Maladjustment and Therapeutic Education Vol. 4 No. 2. 1966) complains about the way people are offered help: "One day they are bone-fide citizens walking around with their head erect, confidently criticising the life style of their neighbours; the next day they have crossed some invisible threshold and been transformed into clients".

We use words such as client, patient or analysand to indicate identifiable differences in our methods. There are also similarities. Ivan Illich focusses on a possible aspect of similarity – a negative aspect – when he proposes that "all" professionals (we may include solicitors, architects, doctors, administrators, ...) who define a person as belonging to a category of someone in need, and then hand that person a prescription as to how that need should be met, are imposing their authority in a way which disables. (Illich et al 1972). In the two examples I have quoted the 'interpretations' seem more like potentially disabling prescriptions.

Clearly Illich and Darley are arguing from a socio-polital perspective. However, the issues can also be well observed in the dyad. Mr. Taylor, about whom I spoke at the beginning of this paper, made the initial phase of the work relatively easy, by being more than ready to take on his share of it. With other people it can be more difficult, especially when there are strong themes of anxiety, panic and dependency. In this connection, I would like to refer to a pilot study by Eric Rayner and myself in which the pre-therapy Projective Test Protocols (Philipsons O.R.T.) of patients who had subsequently done well (in the therapists view) in therapy, were compared with the protocols of those who had done badly. It became clear that in the protocols of those who had reportedly benefitted most from therapy, there were descriptions of people taking responsibility for their thoughts and actions, and entering into various kinds of inter-active relationships. By contrast, those patients who were thought to have benefited little, had often produced stories with themes of helplessness and passivity, where the characters were either 'haves' or 'have-nots', victors or victims, and nothing could be done to change the balance of power and effectiveness, short of violence or magic. Clearly when meeting people who have the latter view of the world, it will be more difficult to explore the possibility of an alliance in which therapeutic work might proceed. Encouragement in working with these issues, comes from Casement in his book On Learning from the Patient in which he gives many examples of how he refers back to his patients communications and reactions to guide him in supervising himself. His examples occur when therapy is already in progress, but his ideas can be usually extended to helping us to consider our initial consultations, the extent to which we are encouraging exploration or pressing for a commitment to treatment which **may** be experienced as our imposing disability.

Shifting the perspective slightly, we can consider ways in which a "client" may exploit the institutionalisation of help in a self-disabling way. Thus Joseph H. Burke in his paper "Shame and Envy" B. J. Psychotherapy Vol. 2. No. 4 1986) tells us of his work with Sue Ann. When he met her she had spent seven years in various hospitals with diagnoses ranging from

psychopathic personality to chronic schizophrenia. She had received medication, electro-shock, insulin shock, group therapy, milieu therapy, individual therapy and been offered a lobotomy. Sue Ann consulted Burke as a last resort, and after meeting her in various combinations alone and with her patients, came to the conclusion that she was a relatively "normal" young woman who had taken up a career as a mental patient in response to various incidents that had occurred at the onset of puberty. He thought that she had developed a self-punishing facade both her family and herself from seeing her as a disappointment. When he put this to her, she hesitatingly and with lowered eye said that she felt terribly ashamed about certain past events which had happened, and had discovered that hospitalisation and treatment were useful ways in which to hide. She now wanted help to give up her career as a patient.

Burke's account warns that not only do we risk imposing 'patienthood' or 'clienthood' on people, by too early a commitment to treatment; we are also sometimes in the position of needing to resist collusion with a person's firm wish to be a patient. A less dramatic example relates to someone who came to ask me for further therapy, after she had recently moved to the district where I was practising. She had in fact had completed a period of therapy some time previously and gained considerably from it. She had felt that she no longer needed any therapy, but since she had moved, she had felt unsettled, and spoke to a former tutor who put forward the view that she needed more therapy. At the consultation with me she was matter of fact about going into therapy again, and apparently only comcerned about establishing the practical arrangements for sessions. She did tell me a short dream about a child playing contentedly in a garden, who became anxious when there was a storm, but was soon able to resume her play when the storm died down. Her associations related to her experience of being evacuated during the war, and how this had initially unsettled her, but she had soon come to like the people she was with, and then settled well, although she missed her parents. My impression was that although she was ready to follow her tutor's advice and have more therapy, it was less clear that that was what she was seeking or needing. I suggested that she might give further thought to what she wanted for herself and that we meet again before deciding. She came a fortnight later saying that my question had surprised her, but had also started her thinking. She realised that although their house move and her husband's work change had unsettled her, she felt basically strong and optimistic in herself and did not want more therapy at present. In fact she was already beginning to feel more rooted in their new home and beginning to put out feelers about work. She asked for permission to contact me again if she needed to. In the event, I did not hear from her in the ensuing months and I

cannot be certain whether I helped her to choose what she wanted, or by raising the question in the way I did prevented her from having the additional help she had initially asked for.

What I hope I did was to encourage her to find her own authority and responsibility for her decision, with as little clutter by way of expectation from others, as possible.

Finally I would like to touch on a deeper aspect of our possible vulnerability as therapists which can also have a bearing on the way in which we approach our initial consultation(s). Alice Miller suggests in The Drama of the Gifted Child and the Search for the True Self that all therapists bring with them a narcissistic disturbance.

She notes, drawing on her experience as a training analyst, that those who train for the work are the sensitive children of parents who exploited them emotionally. They had parents with emotional needs which were stronger than their interest in relating to their children as separate people. Because the children were unusually sensitive and aware, they tuned in to these emotional needs in their parents and tried to meet them, as the only way of holding their parents attention. Such children, when they become adults, are in turn likely to project their emotional needs onto their children, and, if they become therapists, onto their patients. The more sensitive and needy the patient, the more likely he or she will register and respond to the therapists needs, so as not in turn to be rejected. Not surprisingly, Miller goes on to stress the importance of the therapists facing and modifying their narcissism in their own therapy. (ref. A. Miller Faber and Faber 1979)

I would like now to refer back to the initial five sessions with Mr. Taylor: Although he told me at the onset about substantial psychological problems with which he had been struggling with increasing difficulty over several years, I made no effort to engage him in regular treatment until the fifth meeting, which was six months after the first. Furthermore, whereas at the first meeting he was clearly expressing a need for help, at the fifth he claimed to be coming only to give me an account of his progress. Paradoxically, it was only at that point, taking the whole situation in context, and listening for the 'music' behind his words, that I decided that the time was right to confront him with his need for therapy. When I did so, he agreed immediatel;y, with relief, and we went ahead and worked on a regular basis for two years.

However I am not proposing that in exploring the motivation of those who come to us for psychotherapy, we should always take time before committing ourselves. To emphasise this point and by way of contrast, a slight acquaintance approached me at about the same time as Mr. Taylor, whom I will call Mr. Jones. He said that he was considering the possibility of

needing therapy in a few months time and wondered whether he might then approach me to recommend a possible therapist – perhaps I might then even consider taking him on myself. It sounded as if he was bending over backwards to say that he wanted therapy not now, but later and not necessarily with me, but with anyone I might recommend. What I felt I heard underneath was an urgent heavily wrapped up request. After some discussion, I put to him that his situation sounded urgent and that he might be wanting to ask me to take him on right away, but to have mixed feelings about it. He relaxed with relief, acknowledged his need, sessions were arranged, and at the first one we clarified that he had feared rejection by me and also feared the pain of facing the problems with me which he knew he needed help with.

Conclusion

In this paper, I have explored aspects of making the decision about when, as psychotherapists, we enter into the commitment to offer regular intensive therapy. I think that there are risks both in starting too soon in a way which may lose the baby with the bath water; and in waiting too long.

The problem of at what point to enter into the commitment seems to me to be one not of the degree of sophistication of the applicant, nor of the degree of dis-ease which is being communicated, but on the extent to which an authentic or emotionally meaningful basis of co-operation seems possible. While this can sometimes be perceived as present or absent very quickly, it may at other times need an extended period of sucking and seeing before the decision can be made.

REFERENCES

Burke, J. Y. "Shame and Envy" **B.J. Psychotherapy** Vol. 2 No. 4 1986

Bion In New York and Sao Paulo Ed. F. Bion Clinic Press 1985

Casement On Learning from the Patient Tavistock 1985

Darley P. Students Not Clients Maladjustment and Therapeutic Education Vol. 4 No. 2 1966

Hahn, H Transference and Counter-transference in Pratice. **B.J. Psychotherapy** Vol. 2 1986

Illich et al Disabling Professions Marion Boyars Pub. 1972

Miller, A The Drama of the Gifted Child and The Search for the True Self Faber & Faber 1979

Rayner, E & Hahn, H "Assessment for Psychotherapy" **B.J. Med. Psychol.** Vol. 37 1964

Zigmond, D. "Babel or Bible" **B. J. Psychotherapy** Vol. 2 No. 4 1986

THE REAL ENDING OF A THERAPY – A PROBLEM OF BOUNDARIES AND SEPARATION

Hazel Danbury

You are not the same people who left that station
Or who will arrive at any terminus

T. S. Eliot, Dry Salvages, I: Four Quartets

In this paper I shall attempt to show how the terminal phase of therapy with a patient was still continuing long after the sessions had finished. This is not a discussion about the psychotherapeutic process indefinitely continuing, but about a specific instance whereby the patient made use of deferred payment, letters and ultimately two further sessions over a two and a half year period after therapy had finished, before she finally felt that she had arrived at the end.

Glover states that, "the main characteristics of the terminal stage are regression, increase in transference-fantasy and fixation, and an exacerbation of the symptom-picture, either in new directions or along the already established lines, all of which lead to an increasing emphasis on secondary gain. This may take the form of increased exploitation of the original symptoms or an intensified transference situation". (Glover, 1974). With this particular patient, it proved to be that these manifestations occurred some two and a half years after the therapy had "finished" rather than during the terminal phase. In working towards finishing, I had taken echoes of original problems to be sufficient indication of the re-activation of original problems and pathology.

I shall call my patient, Jane. Early on in the therapy the word "process" was adopted by her and she continued to use it spasmodically throughout, particularly when she was angry with me. She would then see me as having mystical, omnipotent knowledge of the "process" of psychotherapy, which I was withholding from her; in the transference I was her father, and all the authority figures represented by the Roman Catholic Church who had ever featured in her life. In discussing termination, Greenson comments that, "our deeper knowledge of early childhood development seems to indicate that intense and prolonged hateful reactions towards the analyst should emerge and be analysed before one should think of terminating an analysis". (Greenson, 1974). In the case of Jane, this condition had been amply fulfilled. Greenson's observations endorse those of Klein, who goes further: her short paper, "Termination of Analysis" is pertinent and relevant in its entirety. Her thesis is that termination revives the first mourning experience,

i.e. weaning, and that for a successful ending to take place, early persecutory and depressive anxieties and the mourning experience of weaning must have been worked on in the analysis, as the work of mourning its end is ultimately done by the patient afterwards.

Jane was in therapy with me three times a week for five years, but it was only some two and a half years after the therapy had finished that I was made aware again of some of her problems which had manifested themselves in the beginning; they became re-activated, not, apart from the echoes referred to, in the terminal phase of the therapy, but subsequently. These problems mainly revolved around boundaries, manipulation and separation: (see Casement, 1985). They had appeared to have been largely resolved after the first year of therapy and had mostly ceased to be operative to the point that my counter transference reactions had faded from my consciousness.

The details of the main body of the therapy need not concern us here; suffice it to say that Jane had an extremely disturbed childhood, was frequently in a state of terror, and would drive people away if they came too close to her. She was highly intelligent and by the time the therapy ended she was in a stable relationship and functioning well in all areas.

In the initial stages my overwhelming feeling had been one of having to hold on rigidly to all the boundaries in order to ensure my own survival; I felt as if she were trying to invade me, to control me and to make me do as she wished. I could not afford to risk compromising at any time with any of the "rules" (her word) relating to time, money etc. She hated the "structure", the formality, the strict 50 minutes sessions, having to pay me, but most particularly she hated the lack of physical contact. She never doubted my caring for her and within this, she felt convinced that eventually she would break through all my controls. She could see absolutely no reason why we could not cuddle, sleep together and have the most intimate of physical contact. During this period a great deal of my energy was taken up with dealing with my own feelings of fending off her invasion and defending my personal space. Typical of her behaviour in this phase was the instance when she took on some childminding to augment her income in order to help pay for the therapy and then spent the money on presents for the children concerned. She never directly criticised me for charging her, nor did she complain when this behaviour made no difference to my giving her the monthly bill. However, she argued vociferously at my interpretations.

This sort of pressurising behaviour lasted for about a year, during which time she would sit cross-legged on the floor, leaning against the couch, her body and gaze slightly averted from me. Eventually when she recognised that nothing she could say or do would shift me, and that she had never before had such an experience of containment, she abandoned the attempt with relief, adopted the couch and I never again felt under such intense pressure

from her until the two years after she had finished. In fact, even the echo of it in the terminal phase failed to re-activate my counter transference response.

Jane felt that she had been allowed to usurp her mother's position, that she had controlled and dictated to her mother and siblings all her life and that in very devious ways she had managed to control her violent and dominant father, whom she adored. Mostly, I was this father in the transference. Very successfully, Jane continued this controlling and manipulative behaviour in all aspects of her life, and though she personally might be subject to fits of terror and blind rage, and to feel socially isolated, she had a large network of relationships in which she always managed to be the controller, benevolent dictator, healer, counsellor and helper.

By the time the therapy was finishing, Jane had long since abandoned such behaviour; the echo of it, previously referred to and a hint of what was to come, occurred in one of the final sessions when she observed that, personally, she saw no reason why a therapist could not have a social relationship with a patient after the end of therapy; she was adamant that, if necessary, a therapeutic relationship could be subsequently re-established: it was a non-issue.

We parted with warmth, some inevitable sadness, and a great deal of satisfaction on both sides.

Due to a variety of circumstances, Jane owed me a sum of money at the end. This she paid off in instalments over the next two years, and each instalment was accompanied by a long letter, giving me news of both her internal and external life. One Christmas she sent me a sculpture of a marsupial, with the baby's head and shoulders out of the pouch. I wondered if she would not feel herself to be completely born until she had finished paying me, or perhaps that she would only finish paying me when she felt able to be born: I was curious to know how long it would take her. I merely acknowledged receipt of each communication.

With the payment of the final instalment, Jane felt free to ask to see me again. It was now two years since we had finished. I had been very conscious that she had been using the paying-off as either a means of prolonging the therapy, or to show her inability to end, or maybe both. I was taxed as to how best to help her. After much thought I offered her an appointment, giving her a choice of several times. In my own mind I was quite clear that it would be a fifty minute session, neither more nor less, but I debated long and hard with myself as to whether or not to charge her. In the event, I decided against, but with qualms in case she interpreted this as a relaxing of professional boundaries on my part. I thought that I had to balance this risk against that of colluding with her in not finishing the therapy, as she would then feel free to come whenever she felt like it. Events led me to think at one point that I had

made the wrong decision, but ultimately we both agreed it had been the right one.

Jane arrived promptly. She walked and looked around my new, to her, consulting annexe. She chose to sit on, not the patients' chair, nor the couch, but a rather uncomfortable basket chair, with her back to the window. She said "So this is yours. How interesting. I remember asking you in the old place if you had a hand in the decor, etc., and how shocked you sounded at the very idea". (I recall the incident, and had actually thrown the question back to her; it was she who had been shocked at the thought, but I chose not to comment on this projection). She then studied all the plants, and observed that the books looked old, presumably because they were an overflow from others in the house. Again, though I was alerted to her curiosity about my house and her wish to go in there, I remained silent. She then said that she was looking round the room as she could not look at me, though she wanted to.

Jane told me all of her news and what she was currently doing. She offered to pay me and I refused. Then followed the major part of the session.

"Well", she said, "now that therapy has finished and I have finished paying you, we can become friends". It was then that I felt that I had made a terrible mistake in not charging her. I asked if she really thought we could be friends and she replied, "Yes, of course; no problem". I observed that I thought it neither appropriate not professional, to which she replied, "I do. .....If I need psychotherapy again I'd still come to you. Of course it would be easily manageable. I do a similar thing with other people, mixing my social and professional life". Once again I had the familiar feeling from years before, of being under intense and powerful pressure; it felt like being almost physically battered. This was how she had felt at the hends of her father; this was how she had in the past, made her friends and acquaintances feel: I wondered if she were doing so again, or if it were just here, with me. The old experience of having to summon up a great deal of energy to cope with my feelings was back in a flash. Once again I felt invaded and wanted to distance myself. I concentrated on not being drawn into an argument, but on holding my ground, whilst trying to clear some space to think what she was doing and why, and if she needed to come back into therapy, possibly to do some more work on mourning (see Klein, 1950).

Meanwhile Jane was continuing: nothing could be more natural than to want to be friends with someone she loves, and that as I obviously care as much for her, then I **ought** to want the same. She said that she certainly did not want to come back into therapy. Finally, with a knowing smile, she commented that she would accept that I was adamant at the moment, but that she would **never** give up and would constantly batter at me until I gave in. I then had a very clear clue that she was once again testing me out, as in the first

year of therapy, and she needed me again not to give in: she was checking to see if I were still the person who could not be manipulated by her. I decided not to interpret this but instead to allow her to experience it.

Jane continued: not only was she determined to become friends with me, but she wanted to bring Leslie along next time. She asked what I thought; I returned the question. She replied that she could not see why not, and now the therapy was finished she wanted the two most important people in her life to meet.

I was silent.

"I shall not give up".

I warned her that the time was nearly up, as I had done throughout the latter part of the therapy. (This had started at a time when she found it increasingly difficult to leave at the end of a session, not because of boundary problems, but because of regression. Eventually it was taking her five minutes after the end of the session before she could collect herself enough to go. Until I took it up with her and we explored it, she was unconscious of it. At her request, I warned her five minutes before the end of each session thereafter). Repeating that she would never give up, she smiled secretively and left.

The events in this session reminded me of Winnicott's observation that "it is possible for a good analysis to be incomplete because the end has come without itself being fully analysed". (Winnicott, 1975). In addition, bearing in mind Klein's thesis that successful termination "presupposed analysis of the first experiences of mourning", I wondered if we really had done enough in this area, even though it had been a recurring issue throughout therapy. Jane had almost died because her mother had not enough milk, and astonishingly, she was several weeks old before her father, not her mother or the doctors, realised what was wrong. I knew that this session was not the end.

Soon after, I received a letter from Jane, asking for an appointment for her and Leslie to come and see me before the summer break. I replied, not mentioning Leslie, but indicating that it might be more appropriate to leave it a while longer. She sent me a card from holiday, stating that she accepted what I said in my letter, and that she would wait to hear from me giving her an appointment after the break. Again I felt invaded, manipulated and under pressure. I did nothing.

In the October I received a card with the message, "Looking forward to hearing from you .....J". After a great deal of thought I decided it would be punitive to ignore it, as there was obviously some unfinished business. I wrote deliberately offering her one of only two possible times in mid-November; this was to help her with boundaries. I prepared myself to withstand more battering. However, there proved to be no need.

Jane came in and sat down.

"I still can't look at you. Why can't I? I expect to be able to after two and a half years, but I feel exposed because you know me so well. *(Pause)* The relationship is still there; it's not changed. I used you as a non-real person and I feel uncomfortable looking at a real person. *(Pause)* I may want to shed the therapy .....coming here brings up what is finished business".

I remained mostly silent during this.

"Did you deliberately not contact me after the summer break?"

"Yes".

"I waited for every post for your letter and then I suddenly thought, she's waiting for me to contact her, and it felt alright".

I asked her why she wanted to come. She did not really know, except to keep in touch with someone she loves. She suddenly said that she was worried that I might feel hurt and rejected if she no longer needed or wanted to come; she came to keep me happy.

I asked if it were she who had felt hurt and rejected by my actions; she laughed and said, "Oh no, not by you; I never could, but I was trying to work out what you were doing and why. I'm very tenacious. Don't all people have this problem? Therapy is addictive". She made the latter observation three times during the session. I commented that it was alright to shed something that was finished and no longer needed. She said she felt relieved and freer.

She said that throughout the therapy she had felt like a baby: "the last time I saw you I was a child; now I am a grown up". I was reminded of the Christmas present.

She was silent for a while, then, "The problem has been in **my** boundaries, not yours, and in separating. The process is continuing and your leaving this meeting to my initiative has helped. I may still try to push and manipulate you though".

I reminded her of her pressure on me at the last meeting, and I wondered how much this was still a problem for her. I also explained my dilemna over charging her. She understood instantly and said that it had helped her to separate and to grow up. Knowing I would not charge her helped her not to come whenever she wanted to. Not charging her meant that I considered the therapy ended, and my withstanding her pressure meant that she was free to leave me. She felt very free, knowing that she had been unable to shift my boundaries. I felt that her mourning work had mainly been done.

Money, she went on to say, was always an issue with her, though we had scarcely talked about it. "I don't like money but I need it. I do lots and lots of jobs that could be done for money and I love them. Once I'm paid for them they assume a different feel and I get bored and don't like doing them anymore ..... I really do have a lot to think about".

Suddenly she said, "Do you feel exploited?" I asked if she thought I did. She replied that if she thought I did, we should have to discuss it. She considered, then said, "No, but I think I could easily try to". Another silence followed, then, "It's useful to come back and check out the real you, as the-you-in-my-head had no boundaries. That's as it should be of course, but then I have to check it out with the real you which does have boundaries".

I warned her when there were eight minutes left and again when there were three. She smiled. I wondered aloud what she would feel like on leaving.

"Excited. I have a lot to think about. I feel quite different from last time. Then I felt as if cushions were all around me and I had cotton wool in my head. Now it feels clear and grown up and I am a lot more separate. ..... Is it still alright to write to you?"

"What do you think?"

"Yes, of course it is, so I will". *(She has not).*

I asked if she were ready to go.

"Oh yes", but even so she spent two minutes gazing around and collecting herself.

"I still can't hug you yet. Perhaps one day I shall be able to. I hope I do see you again sometime".

She said goodbye and left, smiling.

Not once had she referred to our becoming friends, nor to bringing Leslie along to meet me; the only references had been made by me, about the pressure she exerted the previous time. In accepting that therapy was no longer necessary, Jane could accept its limits and boundaries and be free to go her own way. At Christmas Jane sent me a large bowl of pot plants; she did not send a letter.

"The business of the analysis is to secure the best possible psychological conditions for the functions of the ego; with that it has discharged its task". (Freud, 1981).

REFERENCES

Casement P. (1985) **On Learning from the Patient.** p.207-209. Tavistock Publications

Freud, S. (1937) "Analysis Terminable and Interminable". **Standard Edition 23.** London, Hogarth Press (1981)

Glover, E. (1974) **The Technique of Psychoanalysis.** Ch. 4.5.9. New York International Universities Press Inc.

Greenson, R. (1974) **The Technique and Practice of Psychoanalysis.** Vol. I, p. 235. London, Hogarth Press.

Klein, M. (1950) "Termination of Analysis": **Envy and Gratitude and other Works,** 1946-1963. London, Hogarth Press (1975).

Winnicott, D.W. (1975) **Through Paediatrics to Psychoanalysis.** p. 143. London, Hogarth Press.

OBITUARY: ALISON LYONS

Joan Reggiori

Alison Lyons joined the B.A.P. Jungian Training Committee in 1979 and became quite central to its training. She was to commit herself to much hard work for the B.A.P. for the following seven years until illness curtailed her physical strengh for the last months of her life. Even so she remained interested in and welcomed discussion of important B.A.P. issues to the very end. Although a senior analyst of the Society of Analytical Psychologists, and elected as their Chairman from 1981 to 1983, she was never slow to offer practical help of a quite basic kind when it was needed. Her death on August 22nd 1986 diminished us.

One of her major contributions was the bridgebuilding she effected between the B.A.P. and the S.A.P. when she expanded and affirmed creative links between the two Jungian bodies and from which we benefited enormously. She demonstrated a steadfast belief in the B.A.P. and what it stood for, and in the quality of its training and its growing potential. When times were hard or difficult, as they inevitably are in a progressive and dynamic training, her insight and encouragement warmed and supported us. As well as serving on the Training Committee she was also a Council member, elected first in 1980, where her quiet reflective comments and her wise counsel contributed much to important decision making.

I first met Alison in the 1950s in a very Jungian setting. She was a Committee member of the Analytical Psychology Club when I joined it as Hon. Secretary. Her husband was Treasurer. Lifts home in their car were offered to many after late Committee meetings. I dare not think what this did to the springs as we all piled in, blissfully ignorant of the effect of our combined weight. It seems that Alison has been giving lifts to people on their psychological journeys ever since. And the long hours she worked made me wonder if, like her car, she did not sometimes overload herself. Yet only during one period did I ever hear her complain of feeling overtired.

She had several careers before training as an analyst; these included working as a secretary, then probation officer, and later psychiatric social worker before training with the S.A.P. She became very involved with the Institute of Marital Studies and always remained associated with them. Marriage and marriage in its many senses always remained a major source of interest to her and she wrote several papers on the subject, illustrating her understanding of the complexities of relationships.

Alison's capacity for bringing together in a relationship two people or two organisations had a special quality. The S.A.P. had emerged from within

the Analytical Psychology Club around 1945 when several Club members together formed the first professional Jungian training in London. When the A.P.C. celebrated its 60th anniversary in 1982 Alison returned, then as Chairman of the S.A.P., to partake of the event, thus contributing to a meeting of two separate organisations with a common origin, a typical position in which to find Alison. Another example of her ability to span boundaries was her abiding interest in the Jung Freud discussion group of which she was an active member for very many years.

She was one of the most popular and sought after persons I have known. She gave generously from what seemed an endless inner bounty and one wondered what she was able to reserve for herself. It was said by some that she had a regal presence, but there was also a youthfulness and a responsiveness which, combined with a childlike enjoyment of benign gossip, made her into a very human person. In the latter part of her illness the phone was alive with calls offering help and expressions of concern. She had made everyone feel special – and to her they were. There was an attractive immediacy to her contact with people. She was generous in her belief in the potential of others, a generosity matched only by the munificence of her table and her warm hospitality.

There are tragic life experiences which we all dread, such as major bereavement and a drawn out terminal illness. Alison was to demonstrate that both can be lived with. Sam, her husband, died in July 1978. This was a devastating loss for her, throwing her back heavily on her inner resources. Some time afterwards she and I talked together of the importance of demonstrating that this particular pain can be borne. As she put it then "It is survivable". She was to show later on, that a long terminal illness, borne with immense courage, can also be survived in that her spirit continues to be alive in all who knew her.

If she is to be remembered for any two qualities, for me these are her multi-faceted generosity and her special gift for facilitating relationships between groups and between individuals.

She was loved and she is missed.

BOOK REVIEWS

Holding and Interpretation: Fragment of an Analysis

By D. W. Winnicott. Introduction by M. Masud R. Khan. London: The Hogarth Press and The Institute of Psych-Analysis. 1986. Pp 202. £15.00.

How does one review a new text by someone of Winnicott's stature? Certainly not by making judgments about whether it is worth reading. One might attempt a full scale essay relating it in detail to the rest of Winnicott's work. That would be fascinating, but a paper in its own right rather than a book review. Probably the most useful thing is simply to try and give prospective readers some idea of what is in store for them.

The book is in three parts: an introduction, written by Masud Khan; the text, which is the "Fragment of an Analysis" of the title; and an appendix. Chronologically the appendix comes first. It is a reprinting of the paper "Withdrawal and Regression" which appears in *Through Paediatrics to Psychoanalysis.* This is a clinical paper dating from 1954 in which Winnicott describes certain episodes in an analysis. These were moments of withdrawal by the patient, and Winnicott writes about the difference between the patient's simply distancing himself from the analyst and his being able to enter a state of regression in which he is held by the analyst. The "Fragment" which forms the bulk of the book consists of session by session notes from a later period of treatment with the same patient. Winnicott made notes during the sessions or soon after, and we have the record of six months of three times weekly treatment. It is fascinating, as one might expect, but it is pretty demanding reading if one is to do more than skim it. Even skimming it, though, would bring its returns. We notice immediately how ready Winnicott was to admit to the patient that for the moment he did not understand him. We catch particular turns of phrase, such as (after a period of the patient's not really bringing himself to the session): "So it seems that you have turned up and you have an inside and an outside" (p.134). Above all we sense how completely Winnicott's analytic stance had become part of himself, so that he makes the most unexpected, spontaneous remarks without our ever thinking he departs from it. To dig beneath this surface, however, will demand some work from the reader. We have 165 pages of Patient/Analyst dialogue, mostly in direct speech, without accompanying description or commentary. Nothing very dramatic happens during the six months; if there is a central motif it might be the shift in the patient from having, or showing, certain features like excitement, without really being aware of them, to

experiencing them as something belonging to himself. The more one immerses oneself in the detail, the more one is bound to learn from seeing what Winnicott is doing, and the book can provide different reading experiences according to how far one does that. It is here that Khan's introduction is extremely helpful. He summarizes the patient's history, which allows us to understand otherwise obscure references in the sessions; and most importantly he relates the case record to some of Winnicott's central theoretical ideas. Accompanying the session notes themselves there are also occasional footnotes indicating papers of Winnicott's which are germane to the current material.

It will be clear that this is not a book for the casual reader. One needs to cultivate a leisurely, but eventually profound acquaintance with it. It is not a difficult book to read, though, and even the beginnings of that acquaintanceship will make a difference to how we sit with our own patients.

MICHAEL PARSONS

Autistic Barriers in Neurotic Patients

By Frances Tustin. London: H. Karnac (Books) Ltd. 1986. Pp. 326. Cloth Edition £19.95. Paper Edition £9.95.

This book is an exciting and readable addition to the literature on both psychogenetic autism and the understanding of and treatment of neurotic patients.

The book is a collection of papers written in "an attempt to get in touch with idiosynchratic preverbal states, to try to bring them within the orbit of human communication". With the eloquent use of imagery and drawing freely on poetry to illustrate her comments, Mrs. Tustin succeeds in this aim.

The book is divided into two sections, the first dealing with childhood autism; the second with autistic barriers in adult neurotic patients.

Because it is a collection of papers, this book inevitably suffers from a certain amount of repetition. However the author is aware of this and warns the reader in advance. The positive effect of this repetition is to reinforce for the reader, some new ideas and to enable them to be the better assimilated.

Part one of the book traces the genesis and development of autism. Previous, simplistic and cruel theories relating to bad mothering are discussed and put into their rightful context, whilst bringing into focus the part the child might play in becoming autistic. The point is cogently made that it is important not to talk in global terms of unresponsive mothers and babies, but to seek to understand how the minds of autistic patients work. Autism is

seen as an immobilising response to the imposed recognition by the child of separateness from the mother at a time when the child is not ready to cope with it; for a number of reasons, the child's cognitive and emotional development becomes frozen, as he envelopes himself in a protective, hard shell: the mother is frequently found to have been depressed, but there may be a variety of other external reasons.

The child resorts to the use of autistic objects and shapes to protect and comfort himself, and becomes unable to make use of human relationships. The concepts of autistic objects and shapes are discussed fully in a series of papers with many clinical examples as illustration.

By the end of this part of the book, the reader has very vivid glimpses into the world of the autistic child, and a greater understanding of his inner world.

Part two focusses on areas of encapsulated autism in otherwise neurotic patients. When these are recognised in therapy, then there is a possibility of movement in otherwise intractable spheres of resistance. This is illustrated by a number of examples, but the one which I found to be particularly useful is the detailed account of an anorexic patient: I was encountering problems in my own work with one such patient, and found the concept of encapsulated autism illuminating and fruitful, as her rigid controls and obsessive behaviour appear to be manifestations of autistic objects. She was also using terminology which Mrs. Tustin sees as significant, for example a terror of falling apart, dissolving; "I feel as if I am hatching out of my shell but I want to clutch a piece of the shell to stick back on my head in case I need protecting from falling apart". The use of the words "shell" and "stick" are particularly significant in indicating the presence of autistic barriers, according to Mrs. Tustin. In the following session her use of the anorexic rigid eating control as an autistic object was even clearer, "it is my magic mantle, my shining armour containing the mess inside my skin".

The book is written in such a way as to be meaningful whatever one's theoretical orientation. It brings hope into work with autism, and brings autism into the realms of psychological understanding: autistic elements may be far more ubiquitous than previously thought. The use of poetry lends credence to this idea, as poets have obviously recognised the existence of autism throughout history.

This book is an important addition to the literature. Neurotic, borderline, narcissistic and psychotic states have previously been isolated: to these we must now add the earliest one of all which may occur, that is, psychogenic autism.

HAZEL DANBURY

Difficulties in the Analytic Encounter

By John Klauber. London: Free Associaition Books and Maresfield Library. Reprint 1986. Pp. 272. £9.95.

Klauber sets out to question difficulties inherent in the therapeutic situation, technique, and person of the analyst, and to give his personal solutions. As a book it can, therefore, be anxiety provoking, frustrating, fascinating and occasionally reassuring in a kind of "well, yes, I knew that all the time" way.

The book is clear and well presented; the reader knows where he is all the time. The clinical examples illustrate what Klauber is trying to communicate, and whether the reader agrees with the interpretation or not, he is given space to differ. Possibly this is the book's strength because one can differ in interpretation or the way of presenting it, and still feel there is room for both points of view.

Klauber first postulates his belief that a love of truth is what draws a trainee analyst to psychoanalysis, and furthermore, that it is truth that is ".....the great corrective by which, with the analyst's help, the patients heal themselves". In case any reader finds such statements too esoteric, it is reassuring when the author describes his own responses to being a patient: fear of the couch and free association; the disconcerting eruption of emotions: the wonder of a good interpretation. An important comment is that analysis works towards development, not cure, and that therapy aims to start a process in motion which the patient continues after analysis has been terminated.

In the first section, Klauber deals with difficulties in the therapeutic situation itself, such as what dreams are really communicating in his experience, why they are reported sometimes and not always, the need of the analyst to "hold onto" a dream and allow the interpretation over several sessions, how in his view it can be related almost always to a particular session, and how it is ".....a private work of art.....a fiction that brings us nearer reality". He reviews the different schools of thought in relation to the transference/countertransference and its producing of tension between patient and analyst, ranging from the view that it was always a resistance, through to the Balints' recognition that analysts analyse within the bounds of their own personality, and Winnicott's feeling that a patient needs to reality test his analyst's emotional response. Countertransference gradually evolved into being more than unresolved transference and resistence, until now, when analysts attempt to separate transference and "real" relationship, which must be part of all therapists' self-questioning.

The author describes movingly the beinning of practice for the newly-qualified analyst, the feelings of "therapeutic inadequacy (which) might be called the depressive position....." in a situation where he may not satisfy an instinctive desire for object relations, at the same time as feeling a great sense of object loss of his own training analyst. This is compared with the trauma of beginning analysis for the patient, "an experience of helplessness on the part of the ego in the face of accumulation of excitation whether of external or internal origin" (Freud 1926). The patient must allow a relaxation of his control on reality just as he feels he needs most to be in control. He must rely upon a stranger to share and help resolve past traumatic problems; he will experience being "let down" by lack of understanding or perhaps by a mis-timed interpretation often emphasising aggression rather than the anxiety behind it, yet he must learn to understand that he is looking for the first analyst of childhood – "the mother who understood the thoughts he could not verbalise".

Difficulties in technique cover the structure of the session, in which Klauber suggests locating first the patient's anxiety and then its manifestation in the transference, and finally the impulse at the root of the anxiety. He goes on to state his independent view while acknowledging his debt to Kleinian theory of the depressive position, in relation to the analysis of depression, and the infant's projection of split objects, re-enacted in the transference. He notes the feelings of isolation in depressed patients dating from early childhood and attempted defence using early mechanisms such as denial. Object relations are difficult, characterised by fear of loving (fear of disappointment) anger at early disappointing objects (relived in the transference) and self doubt (based on feelings that they were not loved because of being unlovable) leading to idealisation of love objects and then inevitable disappointment. This is recognisable to all therapists who have severely depressed patients in their practice. The patient must gradually be given opportunities to emerge from his isolation and integrate his degraded object with his love object. But Klauber emphasises the need for building bridges, facilitating rather than confronting a patient's awareness with an interpretation of deeply-buried unconscious material which can result in splitting and traumatic feelings of powerlessness.

The author feels that the psychoanalyst's personality and its effect upon his method of working has been underestimated and not studied enough; "To be a psychoanalyst is no longer so much to accomplish a certain task as to offer a new method of relationship" (Widlocher). How can a relationship exist at all without the personality of each person being available? Tribute is paid to contributions on the personal response of the psychoanalyst to his patient, including Balint, Winnicott, Heimann, Gitelson

and Little. Klauber concludes with Winnicott that the patient must feel the analyst is capable of emotional response, negative as well as positive, and that this must be separated from the countertransference responses.

Klauber's papers range over possible and potential difficulties within the psychoanalytic situation. His views are clear, honest and invariably thought-provoking, and as always, it is a priviledge to be invited to share the space of the consulting room.

The Work of Hanna Segal. A Kleinian Approach to Clinical Practice. Delusion and Artistic Creativity and Other Psycho-analytic Essays.

By Hanna Segal. London: Free Association Books and Maresfield Library. Reprint 1986. Pp. 256. £9.95.

After reading these essays, one is left with an overwhelming impression of an articulate, sensitive and intuitive psychoanalyst working within a clear framework of Kleinian theory. Dr. Segal uses the first two essays to summarize Kleinian technique with adults and children, which then serves as the link between her own clinical practice and other related subjects.

Klein's analysis of children led her to formulate her theories of the paranoid schizoid position with its splitting, denial and projective defences, leading on to the depressive position where the infant perceives the mother as a whole object, and in relation to whom he feels ambivalence. This leads to new anxieties and new defences; the infant fears his own destructive aggression towards the object and his defences are manic, often also regressing to the earlier ones in an attempt to protect the ego from depression. Working through the depressive position depends upon a capacity for restoring the good internal object, the basis, in the Kleinian view, of creativity. (This point is expanded later in the book in the chapter of the book's title). In the depressive position, the infant experiences loss and recovery of his object, which is also a re-creation of it, where he can withdraw projections and allow the object a separate existence; ".....a successful working through of the depressive position is fudamental to mental health. In the process of working through, the ego becomes integrated, capable of reality testing and sublimination, and it is enriched from the introjection and assimilation of good objects".

Emphasis is given to analysing envy, more primitive than jealousy, relating to part objects and sometimes interfering with early schizoid splitting mechanisms into ideal and bad object, as it is the ideal object which is envied.

The introjection of the ideal object is disturbed and ego development hindered. Devaluation and contempt lead to persecution anxiety and an envious superego, something recognisable to all therapists where a patient negates anything good in therapy.

Within this framework of Kleinian theory, Dr. Segal argues clearly and cogently her case for the treatment of borderline and psychotic patients, giving detailed and interesting case histories on the analysis of schizophrenics and schizoid mechanisms underlying phobia formation where she relates the symptoms of her patient to paranoid schizoid mechanisms of projective identification and ego disintegration. In her theory of analysis of psychotic patients, the author points out some fundamental differences with Searles, Jacobson and Freida Fromm Reichman, who felt that the negative transference should not be interpreted; Dr. Segal powerfully argues from her standpoint that until it is interpreted, the splits and projections will be prolonged and the relation to a whole object in the depressive position not achieved. This is related back to Klein's work with children where the primitive defences give way to ego strengthening integration, introjection and identification with the good object.

In the chapter on delusion and artistic creativity, the author investigates, through the material of the book, William Golding's *The Spire,* what the calls "the shadowy area in which originates both the psychotic delusion and the artistic creation". She illustrates brilliantly the similarities and differences between the artist and the psychotic, how close they are in their feeling of the destruction and chaos of their inner world and their overwhelming need to create a new world. For the artist, the act of creation is symbolic restoration, lessening the guilt of destructiveness. In delusion formation, the guilt is perpetuated by repetition. The artist moves on after each reparative act; the creator of delusions repeats and does not make true reparation. In allowing his objects to be separate, the artist, who has reached the depressive position, can reality test. He is never completely identified with his work and does not become confused. His work symbolises parts of his internal world. To the creator of delusions, symbols are concrete and he *is* the subject of his delusion.

This book merits careful reading, and reading again. It stimulates though and enquiry, as Hanna Segal always does, and provokes a standing-back and reassessment of one's own clinical work.

Transference Neurosis and Tranference Psychosis Towards Basis Unity

By Margaret Little. London: Free Association Books and Maresfield Library. Reprint 1986. Pp. 352. £9.95.

"Iam postulating that a universal idea exists, as normal and essential as is the oedipal complex.....an idea of absolute identity with the mother upon which survival depends". It seems to me that this is the idea that is central to the book and which unifies all the work demonstrated in this collection of Margaret Little's papers. Her concept, which she calls "basic unity" belongs to the earliest stage of development, preambivalent, pre-symbiotic, as symbiosis already supposes the presence of two bodies.

The book is a personal exposition of analytic ideas and her very particular way of using them in her clinical practice. She feels that it is not a "tidy" book; perhaps that is what gives it such a unique quality. It is a total response to patients, based on her own learning process and personal development from "false self" to intergration. Throughout, one is aware of the person of the analyst not in an intrusive way but because she so intensely believes that psychoanalysis is a relationship where ego, id and superego of both people are used to the full; where transference and countertransference are both acknowledged and used to further understanding. Little feels that analysts were (are?) phobic about countertransference. She speaks of it with great candour, demonstrates how she is able to use it, and finally states that patients often unconsciously understand the analyst's countertransference before the analyst, and can help the analyst retrieve a bad interpretation.

She reminds us that psychotic anxiety is based on fear of annihlation, while neurotic anxiety is fear of separation and abandonment, and relates this to her great interest in her borderline and psychotic patients. For these patients, survival can never be taken for granted; they totally identify with the analyst and verbal interpretations often have no meaning. They *are* the analyst and the analyst *is* them. Little gives an example of a patient who did not tell her analyst about an important contemporary experience because she felt that the analyst knew already; they were one.

In trying to define countertransference, the author suggests, rightly in my opinion, that it has various meanings, and that analysts feel it to be known and recognised but unnecessary and dangerous to interpret it. She wonders why it seems so undefined, feels herself that it means "repressed elements in the analyst himself which attach to the patient in the same way as the patient "transfers" to the analyst affects etc. belonging to his parents or to the objects of his childhood.....," and shows in clinical examples of her patients

how she uses it, not intensively or burdensomely, but as a positive help in the growth of the patient's psyche. Her sensitive responses which may include touching in quite specific situations when she deems it necessary, can allow a patient who has regressed to the stage of primary unity with the analyst, to understand that the analyst is in reality, a separate person who can touch; this in turn leads to him understanding that he is a separate person. Little does not underestimate the difficulties inherent in this mode of working with borderline or psychotic patients, and emphasises that such countertransference responses are not needed with neurotic patients who do not regress to the primary state of basic unity. She feels that not only does the patient fear such regression to a point that seems chaotic, but that the analyst finds enormous difficulty in being simultaneously "at one with", and yet separate from, a deeply regressed patient. Yet she feels that without the analyst's capacity to respond totally to the patient, either in expressing her own feelings, or sometimes physical contact, growth will not take place and the patient and the patient's ego will not be accessible.

Margaret Little says of her book that it "represents something of my own "total response" to life". It is a moving and courageous testament to her own psychological growth from illness to health, how she has been able to use her experiences to help develop her own theory and practice with patients. She does not omit her doubts and her failures. She includes personal writings, comment and poetry and a paper on post-therapeutic self-analysis where she sagely reminds us that "our sane selves have "the lunatic, the lover, and the poet" inside them trying to get out .....", that we too can suffer psychotic anxiety even fleetingly, and need to acknowledge and understand it.

A book to be read and slowly absorbed, not always comfortable, but of intrinsic interest for all therapists.

HELEN ALFILLÉ

Psychoanalytic Psychotherapy, volume 1, number 1. Edited by Michael Sinason

(Journal of the Association for Psychoanalytic Psychotherapy in the National Health Service). 1985. Pp. 116. £15.00 per annum.

Bertram P. Karon and Gary R. VandenBos, authors of a brilliant textbook on the psychotherapeutic treatment of schizophrenia (1981) have lamented that the best trained mental health professionals (i.e. psycho-analysts) tend to treat the *least* severe cases (such as neuroses); whereas those clinicians who lack psychodynamic sophistication and ability (i.e. orthodox biopsychiatrists or behaviourist psychologists) tend to treat those clients afflicted with the *most* severe difficulties (such as psychoses).

There is much truth in this observation. A depressed housewife can always find a very competent psycho-analyst in Hampstead, but a hallucinating adolescent boy may not be as fortunate — in all likelihood, he will be hospitalised, and "treated" with neuroleptics. Psycho-analytical therapists have of course made great contributions to the *theoretical* understanding of psychotic mechanisms, but very few have ventured to practise their art in the asylum. Happily, the inefficacy of psychotropic medication has become increasingly apparent; and many mental health workers have begun to recognise the value of psycho-analytical treatment in hospitals; and in May of 1981, a group of bold clinicians established The Association for Psychoanalytic Pscyhotherapy in the National Health Service. The organisation has flourished, and it now boasts a journal, *Psychoanalytic Psychotherapy,* edited by Dr. Michael Sinason.

The first issue of this new periodical is very encouraging indeed. Many of the psychodynamic clinicians employed by the N.H.S. often try to keep a low profile in hospital, hiding behind the medicine men, and praying that they will not offend the Maudsley-trained Professor. In this new era of the dexamethasone suppression test and the viral theory of schizophrenia, many psycho-analytically-orientated professionals fear for their jobs. Fortunately, the contributors to *Psychoanalytic Psychotherapy* all display a cheerful confidence in their work, and many speak out against the insensitivities perpetrated by their non-psycho-analytical colleagues. Jon Sklar presents a very interesting case report of a Senior Registrar who endorses electroconvulsive therapy as a treatment for depression. Inspired by the writings of Michael Balint, Dr. Sklar skilfully instructed the registrar in the basic tenets of psychodynamics, and then applied these to the case at hand, demonstrating that one need not resort to organic psychiatric theory to understand the genesis and meaning of symptoms, and that one ought not to rely on somatic treatments as a means of alleviating suffering.

In a similar vein, Thomas Freeman, a veteran in the application of psycho-analytical insights to the study of psychosis, bemoans the increasing separation between the disciplines of psycho-analysis and psychiatry. Freeman notes that the creation of the post of Consultant Psychotherapist has in fact distanced psychotherapy from general psychiatry, because such consultants tend to work in isolation, and most Consultant Psychotherapists have no direct responsibility for the management of actual hospital wards. The papers by Sklar and Freeman will certainly generate much necessary discussion about how we can best improve the impact of psychotherapy in hospital.

Michael Conran has contributed a stunning paper on "The Patient in Hospital", in which he impresses on us the overwhelming importance of careful listening and empathising, especially when treating cases of psychosis.

He criticises that destructive myth which claims that "schizophrenics" do not form transferences and hence cannot be treated. Conran parries this notion with the observation that, "Psychotic patients make immediate transferences and they make them all over the place" (p.42). His ability to reach a particular young man is very moving. Richard Lucas, a Kleinian analyst, also provides an essay on the psycho-analytical treatment of psychosis, though he reports rather pessimistically about his work: "From my own clinical experience, attempting analysis with schizophrenics is much harder than one is led to believe from the literature". (p.12). He also comments that it is "extremely difficult to get them into a working analytic relationship" (p.13). Dr. Lucas's confessions reveal to us that even psycho-analytical psychiatrists do not possess enough experience or confidence in the psychotherapeutic treatment of psychosis, and that we must somehow improve our training programmes in order to render our therapists more effective. Certainly not everybody can treat cases of schizophrenia, but one wonders whether the teachers of psycho-analysis might devise ways of changing this situation. The pioneering work of Dr. Geoffrey Pullen at Littlemore Hospital in Oxford suggests that even non-psycho-analytical psychiatrists can become effective psychotherapists. Still, we lack a solid theory for the therapy of psychosis, and, as Lucas reminds us, this should be our highest priority.

The only truly disappointing paper in this pilot issue is Nina Coltart's account of a three year treatment of a transvestite.

In summarising the case, Coltart writes, ""I suppose one might say that from a withdrawn, impotent, fantasy-ridden transvestite, B. has changed into an aggressive, potent, alcoholic sex-maniac"." (p.78). This is hardly the sort of outcome that most psycho-analysts would desire. Clearly, the vast majority of therapists never work with transvestism, and so, Dr. Coltart's clinical results should be evaluated with this in mind; but I did wish that she had attempted to explain why the treatment had not been more successful.

In general, the collection of papers should provide much stimulation, though I hope that future issues will contain more articles by nurses, social workers, and psychologists--this issue is dominated by psychiatrists. I must also applaud William Gillespie for his very excellent and balanced book review of Jeffrey Moussaieff Masson's infamous polemical tome *The Assault on Truth: Freud's Suppression of the Seduction Theory* (1984). Masson has written an important (if misguided) book, yet all previous reviewers have treated Masson in a *very* unfair manner. Gillespie, in contrast, recognises that though Masson misunderstands certain tenets of psycho-analysis, his important documentary evidence on the pervasive incidence of child abuse should not be ignored.

Dr. Sinason and his colleagues should be congratulated for their efforts. This journal can only have a beneficial effect on the position of psycho-analytical therapy within the confines of the N.H.S. In a recent essay, Dr. Robert Hinshelwood (1985), editor of the *British Journal of Psychotherapy,* reported that only one percent of the British population actually receives psychotherapeutic treatment. We all know of *potential* analysands who never enter therapy because they claim that the fee is too high. Of course, this can serve as an *excuse* for not wanting to face the emotionally trying process of therapy, but, our worries about the fee can be a *reality* as well. Private therapy is often prohibitively expensive. The N.H.S. problem-ridden though it may be, still offers the primary means of therapeutic support for those who cannot afford private treatment. Of course, we all know the horror stories about some of the dreadful trainee psychotherapists in the N.H.S., but I know of many fine N.H.S. thereapists as well. Let us hope that *Psychoanalytic Psychotherapy* can provide the educational forum that we so desperately need to revitalise our services and ourselves.

REFERENCES

Hinshelwood, Robert D. (1985). Questions of Training. **Free Associations, 2,** 7-18.

Karon, Bertram P. and VandenBos, Gary R. (1981) **Psychotherapy of Schizophrenia: The Treatment of Choice.** New York: Jason Aronson.

Masson, Jeffrey Moussaieff (1984). **The Assault on Truth: Freud's Suppression of the Seduction Theory.** New York: Farrar, Straus and Giroux.

BRETT KAHR

Melanie Klein.

By Phyllis Grosskurth. London: Hodder and Stoughton. 1986. Pp 516. £19.95.

Absorbing a biography is a complicated process of building a relationship and, of course, a twofold one, with the subject and the author. As with all relationships that are to prove meaningful there will be exhilaration, despondency and pain; outrage and remorse; relief as well as disappointment, as we adjust and readjust any pre-existing image, or seek to maintain it at all costs, complete with every prejudice. Such a gamut of feelings is inevitably due to every contact which we value sufficiently to undergo the upheaval of making it an enduring part of us.

As I embark on this review, with new snow in my garden, I realaise that nine months have passed since I first read the book, soon followed by a second

reading and the struggle with a first review. That I return to the fray in the following year doubtless speaks for itself.

Initially, I felt distress of a quite relentless kind: were 'the parents' really then as outrageous, quarrelsome, often childish – even disturbed – as is evident from this fair-square testimony? For unlike Ernest Jones, several decades before, Phyllis Grosskurth has produced a more realistic picture, very much less idealised, and in that respect more valuable. "In the telling of her story Phyllis Grosskurth has chosen not to beat about the bush. She has reminded us again that genius and the persona are sometimes curious bedfellows."[1] Having focused previously on her concepts and ideas, what strikes me most at this third reading is the Job-like weight of tragedy which Klein endured in her life in the virtual holocaust of its outer events, mirrored by inner convulsions which she managed to convert to grist for her creative mills, pulling back from the brink, or at times from beyond, from near psychotic episodes, and with such a minimum of psychoanalytic help disrupted as it was in as malevolent an era as any lifespan can encompass.

Herself the youngest of four children born to uneven circumstances, her much loved sister, Sidonie, died when Melanie was 4: the first agonising loss in an endless succession which would offer no respite. Her father, Moriz, was to die, when she was only 18, her brother Emanuel, two years later, her mother Libussa, a few months after the birth of her third child, Erich, her youngest son. Her second analyst, Karl Abraham, died in the second year of her analysis at the moment of her final separation from her husband, Arthur. Her lover C.Z. Kloetzel ended their relationship by returning to his wife and settling in Palestine. Her son Hans died while mountaineering, possibly a suicide. Her only daughter, Melitta, was to turn against her mother in a most painful manner. They remained estranged, although Klein always kept her daughter's photo at her bedside. Her last remaining sibling Emilie, died in 1940. Finally, the only family she had was her son Erich, who changed his name to Eric Clyne, with all its painful implications, his wife Judy and their two children Michael and Diana Clyne to whom she was very close.

With such a savage history the inner struggle between the life and death instincts, as she would conceptualise it as her very cornerstone through four decades of work, was most fatefully joined. If we think along these starkest lines, as Grosskurth documents them for us, without shrinking – and unlike Jones she was not there as history was being made, but had to habilitate this monumental past from scratch with its mountainous controversies – we reflect on a case history where the healthy and the threatened parts of the personalty were so closely matched in life's ring as can take one's breath away.

Klein did not study medicine as she maintains she had wanted to, not,

as she claims, because she married. That drawn-out engagement, threadbare as its fabric was, hardly served as a true detraction. But more feasibly because for the first 32 years of her life she was clearly in the grip of a depressive neurosis with hypochondriacal features, which at times almost threatened to extinguish her for good. Libussa evidently derived a certain sense of satisfaction from her daughter's malaise, since it left her in command of her son-in-law and three grandchildren while Melanie sought relief in continuous absences. "It was no surprise that I went down like that, when I had to witness your intense suffering and could not help you",[2] she wrote to her travelling daughter with a certain hint of perverse enthusiasm; every letter of hers mentions Arthur's "nerves", insomnia, stomach complaints and other symptoms. Clearly the interactions between the adults on the scene must have proved a heavy burden for the children in this case. And we could say that Klein's life – one deserving of that name – only, in fact, began in 1914.

In that year several events swam into a constellation under whose more hopeful aegis an inner rescue operation clearly got under way. After a decade of loveless marriage it would seem that she embarked on a passionate love affair, to judge by poetry she wrote. The all-powerful Libussa died. Her husband, Arthur, was conscripted into the Hungarian army. She read Freud's Paper on Dreams and, it would appear, began an analysis with Ferenczi, although it was shortly interrupted when he joined the Hungarian Medical Corps.

This is not the place to argue why the relationship to her mother and her husband no doubt compounded her regression, and it would take twelve further years until she finally broke free with the decision to divorce and to make the move to England, via a sojourn in Berlin, analysis with Abraham, and her early work with children with the latter's encouragement.

The five years in Berlin would prove a 'Sturm und Drang Periode' such as we would normally associate with adolescence. "She was most elaborately got up as a kind of Cleopatra – terrifically décolté – and covered in bangles and rouge ..... she was frightfully excited and determined to have a thousand adventures....."[3] Alexis Strachey who was also in analysis with Abraham, was obsessed by 'Die Klein'. And there is little doubt that this intelligent woman intuited genius beneath the troubling facade with its streak of sheer flamboyance sustained by manic tendencies. These tendencies Klein would painfully confront in later self-analysis, when, some nine years on she had the news that her son Hans died in ambiguous circumstances; a tragedy which bore new harvest to enrich her conceptual world through new insights into herself.[4] For it was then that she discovered a "modified and transitory manic-depressive state" as[5] a part of normal mourning; a "phase of

triumph" which Freud had failed, himself, to understand. Reading Alexis Strachey's letters it is hard to remind ourselves that she is, in fact, portraying a woman in her early forties, a mother of three children who was finally facing a divorce, who had, after the war, been made a member of the Budapest Psychoanalytical Society and read her first paper there; who had, in 1922 became an Associate Member of the Berlin Society, full Member in the following year, and started on her work with children, encouraged by Abraham, which was to come to the attention of Ernest Jones around that time. Beyond this her exuberance enrolled her in a dancing class where she would meet C. Z. Kloetzel and begin a love affair of uneven involvement which would bring her further pain.

It is, perhaps, not surprising that such a hurricane life of making up for lost time would also draw disapproval on purely personal grounds. Anna Freud who remained Daddy's 'good girl' throughout her life, never ceased to see her rival, somewhat enviously, no doubt, as something of a "low woman". Alexis, who was always loyal when Melanie was attacked wrote angrily to her husband: "Someone ought to speak to her about her general sniffiness, don't you think?"[6] – a touch of pure Bloomsbury in the heart of the sombre Freudian world. Whatever the antagonism Klein's complex being often drew, as distinct from that engendered by her startling ideas, her powerful instinct for survival always helped her to scramble to the right place at the right time, regardless of stupendous odds, as when she somehow got her husband, as early as 1909, to agree to move to Budapest after years in stagnant places like Rosenberg then Krappitz and finally Hermanetz, the most hopeless of locations for her dreaming alter-ego which we assume was then still split off. Next, in 1921, she determined to exchange, with the most tenuous of resources, the anti-semitism which was rampant in that city, for a temporary respite in the German Capital which offered her the stimulation and new learning situations which she needed at the time. But with the death of Abraham, when her work and the whirl-wind of ideas it was generating, the 'vurk' she came to see as her most important offspring mobilising maternal instincts, fiercer and more obstinate than any elicited by her natural progeny – were rejected with much scorn she turned her sights on London. With the help of Ernest Jones she shook the dust of the soil of a hostile continent finally off for good in 1926. The warm reception which her lectures to the British Society had received the previous summer, despite her language difficulties, had clearly reassured Klein that here was a domicile which would offer her ideas the best possible chance for survival and for growth, for a hospitable foothold from where to conquer the world, as she determined that they would. Psychoanalysis, which had come to her rescue, had become identified, in the intervening years with her own contribution, as her person, in her mind. So

powerful was this conviction with its delusional undercurrents that she actually told Jones in 1938 that he had done "much harm to Psychoanalysis" by letting the Freuds come to England. Why could the Viennese not go to America?[7] Genius, we must not forget, as Klein's life illustrates, often parents its contributions most painfully at the expense of its nearest and dearest, a fact which they are all too often quite unable to forgive, as in the case of Klein's daughter Melitta Schmideberg. Both sides of this predicament may be comprehensible, which however does little to assuage the human pain. And where the culprit is a mother, then the consequences may prove to be devastatingly disturbing for all who are involved. It is a conflict which may be literally so soul-destroying that for a woman to consent to be inhabited by her genius calls for greater fortitude even than for a man, as the figures testify.

The Biography emphasises Klein's inadequacies in the first three decades of her life. But "nothing comes from nothing, nothing ever could, somewhere in my youth or childhood there must have been something good", as the Austrian Maria sings in the much loved Sound of Music. "I have found that I was usually much less capable of condeming the more I matured .....Therefore it is no punishment when I say that "good" and "evil" (and not only in theory) do not exist for me because I am getting to know in myself and through observation how inextricable and undefinable these two concepts are..... My shattered sense of security manifests itself in my striving for the "tout comprenez".[8] These sentences were written by Melanie Reizes to Emanuel in the summer of 1902, when she was 20 years of age! Here is surely food for thought.

Reading the book for the third time I find myself marvelling at the inner and outer odds against which this extraordinary woman, born in Tiefengraben[9] in Vienna, transformed herself into Klein, and kept going on, and going, and returning to the fray to secure a future for the mindchildren which have brought relief from suffering where there was no relief before, but beyond that cleared the way to a new metaphysics whose far-reaching application only few have so far truly grapsed.

As I lay the book aside I find myself pondering an interlude in Klein's life which Grosskurth has not deeply questioned, namely the Pitlochry stay in the first phase of the war. True, the parents of Dick sent her young patient there for safety and invited her to go. True, as Sylvia Payne confirmed, there was little work in London at the time of the Blitz, and Klein's childhood may have left her in great dread of poverty. True, her house in Clifton Hill sustained direct bomb damage, "a gap in the roof and most of the windows broken".[10] ....."the sky was red with fires in the City – a gruesome and impressive sight",[11] Klein wrote to Clifford Scott on her return to Pitlochry from a Christmas holiday to see her grandchildren and patients, if only for a

week. Earlier she had written him: "We are told that in the next two months we may expect attempts for invasion or whole sale bombing etc....."[12]

This is all very true in terms of the outer world, but in those of the inner one leaves certain questions unanswered for it was not like Klein to desert that crucial battlefield, which raged around her ideas at the heart of the Society, when Anna Freud had remained in London with her wartime nurseries.

Klein, as we are told, left London, in the first place for Cambridge, where she planned to stay in quite sufficient safety, the day the Germans invaded Poland: why then flee 500 miles further North? Something else was happening nearer home at the time which was, of course, that Freud lay dying.[13] Although she later wrote to Jones: "I also am very glad to think that Freud had a happy year in England in spite of the difficulties to which Anna's presence here gave rise",[14] his death may well have mobilised paranoid fears of retaliation, for surely her images of London under siege carry cataclysmic overtones.

But looked at from another angle, with the death of this great Patriarch, this Moses of the wandering tribes, Klein had doubtless also lost a powerful protecting father she had craved throughout her life, disappointed in her own. True, he had ignored this daughter to an agonizing extent. Much as her own father, Moriz, had preferred Emilie, so Freud had sided with Anna, in his great dependency.

But by Jewish tradition, after 7 days of mourning, usually the eldest son, by time honoured ritual, goes into the wilderness for a certain length of time to discharge protracted mourning, to come to terms with the loss, and slowly prepare himself to take that heavy mantle on to his own shoulders for the future.[15]

We are clearly straying here into a realm of pure poetics and hoary mythology. But are we are entitled to when we reflect quietly on these two giants, on the parents of Psychoanalysis as we live it in our day.

(1) Nini Ettlinger: British Journal of Psychotherapy, December 1986
(2) Page 49
(3) Page 133
(4) A Contribution To The Psychogenesis of Manic-Depressive States. 1935.
(5) Page 251
(6) Page 140
(7) Page 253
(8) Page 32
(9) Translated means 'deep ditch'.

(10) Page 258
(11) Ditto
(12) Page 254
(13) Died 23.9.39.
(14) Page 256
(15) I am indebted to Mrs. Levana Marshall for these ideas and reflections which are shared.

NINI ETTLINGER HERMAN

PUBLICATIONS RECEIVED

Argyle, M. *The Psychology of Happiness.* London: Methuen. 1986. Pp. 256. £7.95

Ashbach, C. & Schermer, V.L. *Object Relations, the Self, and the Group. A Conceptual Paradigm.* London: Routledge & Kegan Paul. 1987. Pp. 313. £25.00

Bion, W.R. *The London Week-end. 1897 - 1919. Part of a Life.* London: Free Association Books. 1986. Pp. 287. £6.95

Clegg, H.G. *The Reparative Motif in Child and Adult Therapy.* New York: Aronson. 1984. Pp. 226. $25.00

Corob, A. *Working with Depressed Women.* London: Gower. 1987. Pp. 160. £5.95

Ellis, A. T. & Pitt-Aikens, T. *Secrets of Strangers.* London: Duckworth. 1986. Pp. 216. £12.95

Ernst, S. & Maguire, M. (eds) *Living with the Sphinx. Papers from the Women's Therapy Centre.* London: The Women's Press. 1987. Pp. 265. £5.95

French B. *Coping with Bulimia. The Binge/Purge Syndrome.* Northants: Thorsons. 1987. Pp. 160. £4.99

Freud, S. (Selected and Introduced by Anna Freud) *The Essentials of Psycho-Analysis.* London: Hogarth Press and The Institute of Psycho-analysis. 1986. Pp. 597. £20.00

Havens, L. *Making Contact. Uses of Language in Psychotherapy.* Cambridge, Mass: Harvard University Press. 1986. Pp. 201. £15.75

Kennedy, R., Heymans, A. and Tischler, L. (eds) *The Family as In-Patient. Families and Adolescents at the Cassel Hospital.* London: Free Association Books. 1987. Pp. 377. £22.50 (Cloth). £8.95 (Paper).

Klauber, J. *Difficulties in the Analytic Encounter.* London: Free Association Books and Maresfield Library. 1986. Pp. 272. £9.95

Lindner, R. *The Fifty – Minute Hour. A Collection of True Psychoanalytic Tales.* London: Free Association Books. 1987. Pp. 293. £7.95

Little, M. I. *Transference Neurosis and Transference Psychosis: Toward Basic Unity.* London: Free Association Books and Maresfield Library. 1986. P. 352. £9.95

Masson, J. M. (trans. and ed.) *The Complete Letters of Sigmund Freud to Wilhelm Flies 1887 - 1904.* Cambridge, Mass.: Harvard University Press. 1986. Pp. 505. £7.50

McAll, K. *Healing the Family Tree.* London: SPCK. 1986. Pp. 138. £3.95

McDougall, J. *Theatres of the Mind. Illusion and Truth on the Psychoanalytic Stage.* London: Free Association Books. 1986. Pp. 301. £25.00 (Hardback), £9.95 (Paper).

McKeon, P. *Coping with Depression and Elation.* London: SPCK. 1986. Pp. 99. £3.95

Mitchell, J. (ed). *The Selected Melanie Klein.* London: Penguin. 1986. Pp. 256. £4.95

Natale, S.M. (ed). *Psychotherapy and the Lonely Patient.* New York: The Haworth Press. 1986. Pp. 120. $19.95

Rodman, F.R. *Keeping Hope Alive. On Becoming a Psychotherapist.* New York: Harper & Row. 1986. Pp. 213. $15.95

Samuels, A., Shorter, B. and Plaut, F. *A Critical Dictionary of Jungian Analysis.* London: Routledge & Kegan Paul. 1986. Pp. 171. £6.95

Segal, H. *The Work of Hanna Segal: A Kleinian Approach to Clinical Practice.* London: Free Association Books and Maresfield Library. 1986. Pp. 256. £9.95

Symington, N. *The Analytic Experience. Lectures from the Tavistock.* London: Free Association Books. 1986. Pp. 347. £8.95

Travers, J. A. (ed). *Psychotherapy and the Interminable Patient.* New York: The Haworth Press. 1986. Pp. 144. $19.95

Tustin F. *Autistic Barriers in Neurotic Patients.* London: Karnac Books. 1986. Pp. 326. £19.95 (Cloth). £9.95 (Paper).

Tyrer, P. *How to Stop Taking Tranquillisers.* London: SPCK. 1986. Pp. 96. £2.50

NOTES ON CONTRIBUTORS

Helen ALFILLÉ — Full Member BAP. Psychotherapist in private practice.

Elizabeth BOSTOCK — Associate Member BAP in part-time private practice. Team Leader, Social Work Department, St. Bernard's (Psychiatric) Hospital.

Richard CARVALHO — Professional Member of Society of Analytical Psychology in private analytic practice and Consultant Psychotherapist, St. Mary's Hospital, London.

Hazel DANBURY — Deputy Director of the MSc Course in Social Work, Royal Holloway and Bedford New College, University of London.

Arna DAVIS — Full Member BAP Jungian section. Member of Council. Has had considerable experience in the mental health field and family work with local authorities. Now psychotherapist in private practice.

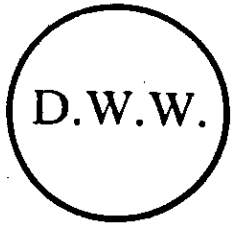
Nini ETTLINGER HERMAN — After two decades as a Family Doctor Nini Herman embarked on the training to become a Psychotherapist. As described in her book *My Kleinian Home,* the bedrock of this 'return to school' was a Kleinian analysis. Her time is now divided between her private practice and writing. Her second book *Why Psychotherapy* (Free Association) came out in the spring and she is working on: 'Reality and Phantasy. Ten thousand years of mother-daughter'. She is married to the artist, Josef Herman.

Barbara GAFFNEY — Child Psychotherapist, St. George's Hospital Child Psychiatry Department and Kilburn Child Guidance Clinic.

Herbert HAHN — Full Member and former Vice-Chairman BAP. Founder Member and current Chairman of The Severnside Institute for Psychotherapy. He works part-time in private practice and part-time in the N.H.S.

Brett KAHR — Psychologist and currently works as Deputy Director of the International Campaign for the Freud Museum. He is former Research Officer at Littlemore Hospital in Oxford, and the former Director of the Oxford Psycho-Analytical Forum. Since 1985 he has been the Host of *Fifty Minutes,* the award winning American television programme on psycho-analysis.

Masud KHAN	He comes from a feudal family of Pakistan. He has been educated at Oxford and London and got his analytic training at the London Institute of Psycho-Analysis. He has been Editor of the International Psycho-Analytic Library and has been published widely in six languages. The three books of his collected papers in English are: *The Privacy of the Self* (1974), *Alienation in Perversions* (1979), *Hidden Selves* (1983). His fourth book *Transgression* has just gone to press. Masud Khan lives in London and carries on with his private practice, supervisions and editorial work.
Michael PARSONS	Associate Member of the British Psychoanalytical Society.
Joan REGGIORI	Full Member BAP and Training Therapist. Chairman Jungian Training Committee. Private practice. Leverhulme Teaching Fellowship in Psychotherapy and Supervisor, St. Bartholomew's Hospital D.P.M. Formerly PSW. Member Group Analytic Society. Analytical Psychology Club Chairman 1980-83.
Jill WALKER	Social Worker to Department of Psychological Medicine, King's College Hospital, London. Associate Member BAP. Psychotherapist in private practice.



WINNICOTT STUDIES

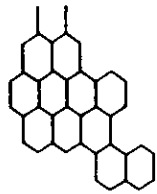
The Journal of the Squiggle Foundation

Number 2 1986

This issue includes original papers by
Peter Fuller, Victoria Hamilton, Dr. Kenneth Lambert,
Dr. Jonathan Miller, Frances Tustin.

For further details please contact:

The Secretary
The Squiggle Foundation
19 Chalcot Road
Primrose Hill
London NW1 8LL



GAPS

Group for the Advancement of Psychodynamics and Psychotherapy in Social Work.

GAPS is a voluntary Social Work Organisation for workers in all agencies and settings. Psychodynamic principles are fundamental to understanding behaviour in individuals, families, organisations and communities; and are therefore essential to the practice, teaching and management of social work.

GAPS publishes the **JOURNAL OF SOCIAL WORK PRACTICE** twice yearly in May and November. The issue in May 1987 is a Special Edition containing the papers of the Anglo-American Conference held in York, England, in 1986.

GAPS sponsors the **CLARE WINNICOTT ANNUAL ESSAY PRIZE** for Student Social Workers. For further details contact Journal Administrator, Barbara Ogden.

GAPS MEMBERSHIP: Annual Subscription £18
(students & unwaged £ 9)

Subscription includes Journal of Social Work Practice

Further information from: Elizabeth Smith,
Membership Secretary, 45 Heath View, London N2 0QD.

JOURNAL OF SOCIAL WORK PRACTICE:
Annual Subscription £14, Overseas £16.
Students reduced rate.

Further information from: Barbara Ogden,
Journal Administrator, 98 Leigh Hill, Leigh-on-Sea,
Essex SS9 1AR.

NOTES FOR CONTRIBUTORS

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

Manuscripts should be typed in double spacing, on one side of the paper only and be submitted in duplicate. The maximum length of any one contribution is normally 7,000 words. The Editor reserves the right to edit all contributions. Authors must ensure that publication does not involve any infringement of copyright.

CONFIDENTIALITY: authors should take responsibility for ensuring that their contribution does not involve any breach of confidentiality or professional ethics.

REFERENCES

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

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

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

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

References for books should include the author's name and initials, year of publication in brackets, title of book, place of publication and name of publisher, e.g.

Winnicott, D.W. (1971) *Playing and Reality*, London, Tavistock.

AN IMPORTANT RESPONSIBILITY OF THE AUTHOR IS THE PREPARATION OF A CORRECT REFERENCE LIST.

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

Acorn Press, 15 Goldhurst Terrace, London NW6

ISSN 0268-6643