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BOOK REVIEWS

THOUGHTS ON THE PAIN OF SELF-DISCLOSURE

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Disclosure as Birth

The title raises questions about capacity to 'disclose' ourselves. The word 'disclosure' literally means 'a bringing to light or revealing' and the verb 'to disclose' is used by Shakespeare to mean 'to hatch' whilst the noun 'a disclosure' means 'emergence from an egg' (Chambers Dictionary).

When we think in these terms, of the self as having an innate capacity for living and growing, 'disclosure' takes on a deeper meaning. It can no longer be understood as something brought about by the will of the self in isolation or by the will of another however well-intentioned. It is seen instead as the product of an interaction, similar to the birth process. When seen from this point of view we can appreciate that the pain of self-disclosure, since it is a product of something that happens to the subject as well as within the subject, is felt both by the subject and by the object: as between mother and child, the pain is a shared experience, similar, perhaps, to the 'travail' of birth.

I am now considering the 'self', not as an entity, but as the function of an interaction, which can result in the 'bringing to light' or emergence of 'the self' as such. In psychodynamic terms, a 'psychic subject of experience' exists in the baby long before a specific 'self' differentiates. But the 'self' is always a potentiality in the psychic subject: a potentiality that is realised if the necessary quality of relation can be found with an 'object'. The object of the baby's outreach is, initially, the mother - that is, not really an 'object' at all, but another subject, - with a greater or lesser capacity to relate empathically to the infant psychic subject in a way that fosters the subject's growing potentiality for realisation as 'self'. As D.W. Winnicott (1958) has stated 'there is no such thing as a baby' - because for there to be a baby, there must be a mother. In just the same way, I believe, there can be no true 'self-disclosure' without the empathic attention of another person, who sponsors and fosters that process.

It follows from this that 'selfhood' is a **variable** experience at best: a non-material, receiving, experiencing, organising and expressive centre possessing the capacity to 'own' its experiences and states and to refer to them as '**my** experience' and to identify itself by the proper name of 'I'. The realisation of this capacity depends upon the extent to which this psychic subject is **linked affectively** with others - and, at the very beginning, with **an** other. **The 'self' cannot, therefore, be taken for granted,** nor can it be ruled out as a possibility, even in the most damaged

personalities. Thus, an individual may want ot appear to be a person, like others, but **feel that he has no coherent or viable 'self' to 'disclose'.** For he may not have come by that quality of relationship: that essential **affective link** with another person, which alone can enable him to experience himself as 'satisfactorily in being'. On the other hand, our innate capacity to relate to our human environment means that the 'self' is always a 'latent potentiality in the psyche' (Guntrip 1968), and at the centre of the most disparate and fragmented experience there is enough ego-sense to delcare **'I'** feel this that or the other. To quote Winnicott (1965) again, 'the baby's ego is as strong, or weak, as the mother's ego support is strong - or weak'.

Here I am describing 'self-formation' rather than self-disclosure. The experience of selfhood varies in accordance with the extent to which we are supported and loved for our own sakes. Not only individuals, but whole societies can become depersonalised because the 'selves' they essentially and potentially are,are simply not related to. They are 'administered' by this or that technique, in the shaping of which they have no influence. And this can and does happen in families, in so-called therapeutic 'treatments' and in totalitarian governments. The view here expressed is that for adequate 'self-formation' there is a need, at the very beginning, for the baby to **share in and partake of the ongoing psychic life of another,** whose main satisfaction consists of being at one with the baby. It is that basic link which lays the foundation of self-formation and discovery. When that simple union is experienced adequately and for long enough, the baby comes to develop an individual identity on the basis of shared experience, an identity that is strong because the original foundation was reliable. This is then the birth of characteristic self-feeling out of the primary identification of mother and child. The recognition of this new development, expressed in increasingly complex interaction as the self grows in confidence, is believed to be essential to mental wholeness throughout life.

If this is so, originally the 'disclosure', 'hatching' or 'bringing to light' of such self as we are or have was in the hands of another, parental person. Moreover, whatever capacity we now have for **true** self-disclosure must stem from that first disclosure of our nascent selfhood within the security of a loving relationship. Furthermore, it would be an essential feature of such a relationship that each fresh revelation of selfhood would be in phase with the natural rate of growth, it would be damaging to **impose an idea** of development on to the child (or patient/client). Winnicott (1965) has said that the 'good enough mother', or therapist, recovers self-interest at the rate indicated by the baby's development. In this sense the

disclosure of the infant self (like that of the regressed patient/client) is something which, having at first elicited, we then wait with, recognise and sponsor as it spontaneously evolves. Moreover growth is not an even process; development depends upon the ever present possibility of regression, if under strain, to previous enclosures. It is necessary for the parent or therapist to love the person and not an **idea** of his development.

Closure

I do not think that 'self-disclosure', as distinct from the natural evolution of selfhood, described above, would be a characteristic of a confident person - or of any person when confident. Self-**expression** would be a better term. **'Closure'** - (as distinct from the all important **en**closure from which alone we can emerge into personal life) has rather negative associations. Self-closure implies a threat to the self, and a consequent **withdrawal** into a previous enclosure: as when, in the course of spontaneous self-expression we encounter a lack of interest or an accident, or an attack, causing us to 'close' against the threat (an involuntary wincing away from the danger and from the consciousness of this danger). In practice such threats and consequent closures are inevitable in an uncertain world. If we have indeed progressed in psychotherapy to a point where we aim to reach, protect and support the latent selfhood of an individual, rather than just concentrating upon his symptoms, it is still with the **defended and divided** self that we are confronted initially and for a long time after that. In more severe disturbance, the defended self may be all an individual feels he has, or is. When I sympathised with one person over her difficult circumstances, she looked puzzled and said "But I **am** my circumstances!" Her 'true self' was an unevoked potentiality. Here we encounter paradox - even a **range** of paradoxes. **First,** defences are formed out of **necessity** and not at the will of the individual: so he cannot let them go. On the other hand, since they are distortions, the individual cannot happily accommodate them either, hence the need (despite the pain) of self-disclosure. **Second,** the stronger the defences, the greater the necessity for them, and the weaker the feeling of selfhood within or beneath them; thus the greater the need for self-disclosure the stronger the resistance against it. **Thirdly,** defences are originally formed by **identification** with a stronger person (originally parental figures) upon whom the individual was extremely dependent. They represent the taking-in by that individual of the hostile, dismissive or neglectful attitudes in care-takers, and he unconsciously adopts them in an attempt to become **less dependent,** and more 'adult' than he really feels. They give him a spurious feeling of

power over his own weakness and needs and they also assume the significance of parental objects to him bringing the feeling of a relationship, even though, due ot their frustrating quality, they can never facilitate genuine confidence.

It is therefore a major psychological blunder to encourage 'self-disclosure' from a person thus defended. It can also be a sign of unacknowledged hate of him for, say, his slowness or 'relentless ingratitude' (Winnicott 1958). **His defences are 'enclosures' which he needs, and which he is fully justified in needing, unless and until we can introduce him to a better 'enclosure' rather than a premature disclosure.**

In order to understand this better we need to see how this taking-in (or internalisation) happens from the child's point of view. 'The self is a discovery made in communication' (Milner 1969). The first thing to appreciate is that without relationship of any kind, the infant would most likely die of sheer neglect. Relationship is primary and the need of the psyche for relationship is absolute. No relationship: no self and probably no life. At best psychotic, at worst dead. Thus, the one thing one cannot allow is the loss of relationship however bad. In the earliest stage and to some extent throughout life, loss of relationship means loss of self: no 'self' to 'dislcose'. As mentioned already, in the worst cases the 'self' remains an unevoked potentiality in the psyche, blocked off and dissociated since the beginning of growth, and giving rise in consciousness to feelings of deadness at the centre. But still the struggle for relationship of some kind continues and to the degree that this struggle is lost in the external world, the infant (and the adult when anxious) continues the struggle in an inner world, where with parts of himself, he struggles with the harsh, rejective or remote aspects of the parents whom he could not accept in the external world. According to Fairbairn (1952) and Guntrip (1968), the original unity of the psyche when beset by intolerable separation or impingement becomes fragmented in the following way:

1. On the surface, a relatively devitalised 'self' carries on extracting some sense of approval or at any rate toleration by compliance with the prevailing norms;
2. In the inner world (a) a libidinally excited, angry, hungry part-self continues an all-out struggle with phantasy-figures, which are derived from actual frustrating qualities of the so-needed parents; (b) whilst yet another part-self **identifies** with these ruthless figures in squashing and mutilating the excited, angry and hungry part-selves;
3. In the deepest unconscious, another and **perhaps the most vital,** part-self, the original loving nature, the 'true' (Winnicott 1965) and

'natural' (Fairbairn 1952) self, the 'vital heart' (Guntrip 1968) falls back, exhausted, seeking protection in the deep unconscious as a substitute womb.

The individual dare not 'disclose' this deepest part of his nature. In fact it is not in his power to do so, since, because of his experience, the only 'world' he could feel he was emerging into, is the very world he has retreated from: the inner world of urgent, unmet need and ruthless suppression of that need. In this potentially most personal part of himself, he lies dormant, latent, in 'cold storage' (Winnicott 1965) which is also 'warm storage' (Guntrip 1968) since it feels in his deepest convictions preferable to the external world.

We have to understand that it is terrible for a child to realise clearly that his parents simply do not love him and want him, and he involuntarily splits himself 'every which way' in his attempts (a) to sustain the feeling of attachment and (b) to preserve, in the deepest unconscious, a tiny remnant of his genuine nature, in the slimmest of slim hopes of a 'new beginning' (Balint 1968) in a better environment. This is 'self-closure' with a vengeance, since from this most deeply withdrawn,, repressed part-self come feelings of profound exhaustion, of dying, of claustrophobia, of extreme weakness and fear of the whole external world. Were this part-self to be 'disclosed' we would be faced with wholesale breakthrough of grossly disturbed and debilitated dependence into consciousness. Were the angry passions and urgent hungers and lusts of the 'inner world' to be 'disclosed', we should have (as regrettably we **do** have to some extent) unrestrained murderous rage and lust. If the part self which identifies with the authoritarian and punitive aspects of parental influence were 'disclosed', we should have a 'police state'. **Mere 'self disclosure' in these terms is not only dangerous but anti-therapeutic in any sensible view of therapy.** The causes of psychological disturbance lie in bad relationships and the resolution can only come in the form of good relationships.

Therapy

But what is a 'good' relationship? Certainly not a technique aimed at 'self-disclosure' by, for example 'getting your anger out', as if it were some 'poison in the system', nothing to do with internalised bad personal relations, which needs tapping from time to time. Irrational imperious angers and lusts arise from the inner world where 'libidinised' self-fragments are continually preoccupied in unsatisfying relations with bad frustrating object-fragments: ruthless excitors and suppressors, and people must not be tricked and depersonalised into thinking of themselves

as biological machines with untamed instincts which need to blow off steam in the odd murder or rape. At a certain level feelings of this intensity do indeed present and Freud regarded them as biologically innate instincts. But psychodynamic theory and practice has moved beyond that point in its attempts to understand man, and it is generally now believed that the need of a life-giving relationship is his **primary psychological drive,** and hates and lusts represent frustrated attempts to satisfy that need in unsatisfying 'bad-object situations' - which then become embedded in his personality structure. This insight brings us to a new level of complexity. To bring about a good and therapeutic relationship we need to **contain** these anti-social expressions of a basically social nature, **in order to understand** their concealed origins, so that we may relate to the 'self' who is feeling them: relate to him in such terms that he feels less anxious about himself.

Here, straight away, we encounter resistance. We find the person actually **prefers** to regard himself as bad. In straight terms we are suggesting to him that his 'foul temper, his biting envy, or his excessive sex-drive' might be so troublesome to him and to others, not because he is innately 'bad' but because he is feeling weak and despairing about his value as a person: that they may indicate the lengths to which he was obliged to go in order to get some sense of recognition as having some personal significance. In short, we are doing him no favours! The 'self' thus disclosed is the 'self' he got angry to escape from, the 'self' whose unsatisfied need eventually found some relief, perhaps in exciting masturbatory phantasies or temper outbursts, and though he may at times be able to see that these are grossly over-exploitive of his aggressive and sexual energies, it will be a long time before he can allow his fearful withdrawn personal self to be reached or even acknowledged. Of course, as in all psychological states, our ability to understand them depends on our readiness to acknowledge similar feelings - and origins - in ourselves. In fact it is only through understanding that everyone has at least a token experience of everyone else's disturbance, that we are able to form the affective link which frees a person to grow in his own fashion. **But** in our own search for such 'self-disclosure' we shall encounter the same overriding need for a 'good relationship' and the same resistances to accepting it.

Because of 'resistance', it follows that the 'self' which gets disclosed in self-disclosure is often a reactive 'self', a 'part-self', or at least the part the person can tolerate being, rather than the whole self, which as we have seen can become so radically split, or the 'vital heart', which is so very weak - maybe only a potentiality. Guntrip (1961) has pointed out how

people prefer to be 'bad somebodies rather than weak nobodies' and even if anyone does disclose himself as a 'weak nobody' he can probably manage to feel bad about doing so. People cannot easily risk seeing what enormous needs they are trying to stave off by this 'badness' because it would disclose their **impotence** in the face of an uncaring world: originally the bad aspects of the actual world in infancy and childhood, and later the inner world in which those bad ego-object relations are perpetuated as a continual source of unrest.

Here it is helpful to mark a **distinction** between
(a) good personal relations experience which is **introjected,** digested and used for ego-development, retained in the form of pleasant memories, and
(b) bad personal relations experience which is **internalised,** and since it cannot be digested and used for development due to its unsatisfying nature, it remains 'like a foreign body in the psyche' (Bion 1962) as 'undigested bad experience', continually giving rise to irrational envies, hates and longings, which the ego tries to project on to real figures in the external world, including, of course, the therapist.

In fact, in the proportion that we, as therapists, **prove reliable** in relating to the individual **as a person,** we find such feelings being projected on to **us.** The individual is needing us to **survive** this transference of his bad mother and father on to us, so that, in due course he may discover, in the therapeutic relationship, those vital 'ingredients' of personal development which he originally lacked: an intensified version of the child who 'brings home' from school the discordant attitudes he finds there and directs them at his parents, to see if **they** can survive it.

Perhaps we may say that at this point true self-disclosure has begun. As Lacan (1954) has put it: 'the subject begins the analysis by speaking of himself without speaking directly to you, or by speaking to you without speaking of himself. When he can speak to you of himself, the analysis will be terminated'. I would want to add, however, that the **'analysis'** as such may be terminated, but the **relationship** most certainly must not be 'terminated'. We cannot give people only analytic interpretations when, on the promise of a good relationship, they have disclosed to us their weakness and need. **Our interest in them as persons is vital to them.** As Fairbairn (1952) has pointed out, the basic problem seems to stem from the fact that parents (however caring in other ways) 'fail to get it across to a child that he matters, for his own sake, as person in his own right'. The 'self' which finally gets disclosed in analysis calls not only for rescue from the 'bad-object situations' of the inner world, but also, ultimately, for an 'alongside relationsip' in which he can recuperate from deep

strains, and a supportive belief in his growing capacity to enter into and explore the world. This is real healing and growing and it takes time - sometimes a very long time.

Here is Guntrip's (1958) description of the therapeutic relationship. 'The kind of love the patient needs is the kind of love that he may well feel in due course that the psychotherapist is the first person ever to give to him. It involves taking him seriously as a person in his difficulties, respecting him as an individual in his own right even in his anxieties, treating him as someone with the right to be understood, and not merely blamed, put off, pressed and moulded to suit other people's convience, regarding him as a valuable human being, with a nature of his own that needs a good environment to grown in, showing him genuine human interest, real sympathy, believing in him, so that in courseof time, he can become capable of believing in himself'.

The whole point of 'analysis' and analytic insight is to gain a **clearer view** of a persons's internal predicament in order to help him over his preoccupation with it, so that he can reclaim the vital energies it absorbs, and reinvest them in his own genuine interests. No-one is going to disclose his innermost self to a disinterested technician or to 'group expectation' however 'accurate' they may be. Nor, it must be pointed out, will he be reached by loving which is unenlightened by analytic insights. In fact the nearer one gets to the 'vital heart' or 'true self' the more analytic wisdom is needed to determine the **form of love which will be experienced as loving,** and not, for example, as engulfing or intruding. Winnicott (1958), who combined the disciplines of psycho-analysis and paediatrics, draws a parallel between regressed patients and babies. He states that in communicating with the 'true self' we must abstain from intrusion by interpretation, and allow for 'the period of hesitation' which he noticed in a baby who, after an initial expression of interest in an object (a spatula) would stop, uncertain, either still holding the spatula, or leaving it to bury his face in his mother's blouse. If this period of hesitation is allowed for, however, there is a gradual and spontaneous return of interest in the object, as the baby accepts the reality of his desire for the object. He then becomes confidently possessive of it and plays with it, dropping it as if by mistake. He is pleased when it is restored - but eventually he 'enjoys aggressively getting rid of it' and either gets down on the floor and plays with it or reaches out for other objects. The point here is that forcing either the baby or an adult (client/patient) in the period of hesitation wrecks a very valuable opportunity for them to experience an initiative of their very own, which is not a reaction (to some manipulation of ours) but a

response to a non-threatening interest in them. In the baby, any attempt to force the spatula into his mouth during the period of hesitation causes intense resistance, and where inhibition is extreme, even moving it in his direction can produce 'screaming distress and actual colic' (Winnicott 1958). Winnicott links this reaction in the infant to 'resistance' in adult patients. As Khan (1975) put it, he realised that what many analysts called 'resistance' was a period of hesitation in which the patient was 'groping to find a kind of intimacy in the analytic situation in which he can make his first verbal or gestural contribution'. Thus any attempt to elicit 'self-disclosure' which overrides resistance or a period of hesitation only brings about another reaction. **It cannot facilitate a genuine response.** The nature of the **reaction** varies: in the more confident we may expect anger, the less confident distress. But in the most deeply undermined personalities the result of this kind of clumsiness is only a 'reproduction of the environmental failure situation which stopped the processes of growth' (Winnicott 1958), for such individuals have no 'self' with which to integrate experience, and no confidence that there is anyone with sufficient interest in them to recognise their existence. What they need to tell happened when they had not the necessary ego-capacities to cope with or cognise it. They could only **register** it. Thus **resistance** of any kind is likely to represent the pain of **forced** self-disclosure. In such circumstances the helper must **sense** the need to be reached which lies at the heart of the frozen or automatic personality and **be** the kind of warm and reliable presence the person can accept and use for development. These people are waiting to begin in personal life and are needing a setting whcih they can 'savour' and 'take to' in their own time as just the right medium for growth and self-disclosure - in this case, the disclosure or hatching of a 'self' they know nothing about, since it has not yet begun to be. They need a person who knows how to wait since the 'self' they need to disclose is still only a potentiality. Any focus of attentive feeling on them may feel like painful **exposure,** and that includes 'well meaning' attention like certain forms of therapy. One person, who was singled out by a group as 'secretive' was asked: "Won't you be sorry when this group breaks up and we won't have known you?" "No", she replied, "I shall feel relieved!" She had been troubled for years by a feeling of 'invisibility' as a result of growing up with non-relating parents. Another who actually ran away from an 'Encounter Group' used in sessions with myself to hide behind his hand, and said "I hope you won't feel I'm silly - but I need this hand here for protection". He had paranoid phantasies of being stared at which inhibited him from going out - but deep down he felt fundamentally **un**noticed.

It needs to be said that the reaching of the essential, natural and in that sense 'true' self is not always such a deep and lengthy process, if for example the trouble is of more recent origin - say in adolescence a person's parents divorced or died, and there is a quite recent experience of 'good relations' to reach and evoke. But the earlier in the life of an individual a trauma occurred, the longer and more complex is the therapy - partly because of the extreme vulnerability of the human child, and partly because defences arising from the need to 'be someone' without the necessary resources, tend to become so rigid and congealed over the years. But whether the process of outflanking defences and reaching and restoring the true self, is of long or relatively short duration, its essential **quality** is required to be the same.

In my experience there are always three stages:

1. The winning of the cooperation of the 'caretaker self' (Winnicott 1965), i.e. the coping self, which, however defensive, must always be respected as the valiant though often self-defeating attempt to keep going in the face of underlying weakness.
2. The analysis of the inner world, involving the transference on to the therapist of the bad relationship: i.e. feeling it all for and with the 'wrong' person, who attempts to relate to the other with understanding of the origins of disturbances and bearing in mind lost or unevoked capacities.
3. The reaching and resuscitation of the 'lost heart of the self' (Guntrip 1968) - a potentiality which has always been 'borne in mind' in stages 1 and 2 and which is 'held in the mind' as a latent possibility so as to become a living experience, as the individual emerges from the closure of his inner world into an open relationship of emotional equals with his therapist.

At this point, self-disclosure may have occurred. But the 'self' thus disclosed may not be very strong in the face of the demands of life. Support is needed for this new self as he or she prepares to experience living in the world **outside** the peculiarly intimate therapeutic relationship. Individuals bring back into the therapeutic relationship the challenges they are confronted with in the world outside, and their capacity to achieve and succeed there, without losing touch with, and without becoming false to, their new-found sense of personal reality and cohesion, depends upon their being able to internalise the **availabilty** of the therapist as a person, who must, as Winnicott (1965) put it, 'be available when remembered after being forgotten'.

The growing self in full-expression of its confidence, **forgets** the therapist, in the sense of **taking him for granted,** as someone who **could** be contacted because he **remembers** the 'self'. This remembering of the

'self' is not by an act of will on the part of the therapist, but because of the immense mutual significance of the experience of 'self-disclosure', as, for example, when one witnesses the first genuine, unmanipulated, self-expression of the other - perhaps for the very first time, in the therapeutic relationship.

Such self-disclosure is not essentially **painful,** since it is the spontaneous expression of our social nature. It is, rather, a vivid and meaningful experience co-incidental with our realisation, in relationship, of our personal identity. We can only have and be persons in an environment which relates beneficiently to us **as** persons, and 'self-disclosure' is a product of that interaction -painful perhaps only in the sense that - to the extent that **some** defensiveness is inevitable - any opening in surrender to another entails a feeling of risk.

Finally, there would seem to be two main inhibitors to this essentially personal function: guilt and fear. As far as guilt is concerned, the inevitable feeling of risk is exacerbated by the awareness that painfully intensified love-needs have become, in face of frustration, dangerously destructive hate. The fear arises that this hate may **destroy** the object, so that concern for that person and fear of losing him combine to form a guilty repression of active capacities and powers. Whereas disclosure by confession is decidedly therapeutic ('good for the soul'), experience teaches that the 'acting out' of the hates and lusts that are repressed, is highly dangerous and not in the long-term interests of the individual, however much transitory relief may be gained. The reason is that these repressed emotions are immature. They still retain the infantile intensity of their early origins in tortured relationships with 'bad objects', and are therefore highly **in**appropriate to adult status, in which, combined with adult physique and intelligence, they may, and sometimes do, bring about the very end which the guilt was designed to avert: the destruction of the needed object. It is well to remember that all hate originates in painfully intensified **need.** The opposite of love is not hate, but indifference: not wanting a relationship and having no reason for loving or hating. Thus disclosure of hate, in the transference, must be, not an end in itself, but a vital clue to the enormous disappointment and frustrated need that it represents. In this way the person can gradually move beyond the guilt over hate, to experience a reliable and supportive relationship in which he can discover the right context for the **social** expression of active capacities. In this relatively mature state, one may not experience guilt as such, but a genuine capacity for shame over actual harm inadvertently done to another - an emotion which promotes a desire to make amends, rather than an urgent anxiety-driven need to deny all

active capacities and energies and to turn these against oneself.

Though the therapeutic understanding of guilt problems is far from simple (in extreme cases the damming-up and dampening down of impulses may result in 'depressive paralysis'), the problem of the other inhibitor - fear - is even more formidable. Whereas the guilt-laden, depressed person fears to love lest his hate should destroy, the deeply fearful person cannot love because love itself feels destructive. This problem originates earlier than hate, when relationships and therefore the infant's personhood have not developed to a point where concentrated hate is a possibility. When he cannot get what he wants from the person he needs, the subject instead of getting angry, gets more and more hungry, with an alarmingly intense need to swallow the object - to get it safe inside. And with this fear comes another equally terrifying one: that the other person's love needs are equally strong and engulfing. In the adult this can result in mutually-opposed need for and fear of, personal relations, love, food, anything and anyone which excites need. All that can be 'disclosed' here is sheer fear, and deeper down, an alarmingly intense need which it feels quite imperative to squash. But it will be quite a long time before that much can be allowed to emerge, even in the safest of settings. And it may be mentioned that 'safety' for such a person is not intense human interest, but a 'disinterested love' which holds back without deserting those it seeks to help. Any manifestation of 'closeness' merely intensifies the fear such a person feels over loving or being loved. They cannot stand what Winnicott (1965) has called 'communication seeping through the defences'. Only a 'therapeutic alongside accompaniment' will do. But when that is effective, the 'self' that is born is pristine in its naive simplicity: a momentous 'foundation experience' for both which is never forgotten by either. Often the dream-life expresses this as in one case where a person who had intense fear over starting therapy, due to enormous needs expressed in painful separation anxieties, and compensatory 'bulimia' came at last to produce a dream of scraping aside snow and sand to find small perfectly-formed terracotta figures. She was finding her true self (both in cold and in warm storage, so to speak!) and shortly afterwards was able to finish therapy and begin a new life. It is hard to describe actual cases, because of the enormous emotions they evoke. Certainly, in 'self-disclosure' of this kind, the therapist cannot remain unmoved. And perhaps the tremendous restraint required of him in these kinds of cases constitutes pain - but it is certainly forgotten in the joy that a new person is born into the world.

As Guntrip (1968) has written: 'when the primary natural self containing the individual's true potentialities can be reached, protected

and supported and freed from the internal persecutor, it is capable of rapid development and integration with all that is valuable and realistic' in the self of everyday.

True self-disclosure requires a personal relationship with the subject in which he is gradually **freed from the need to react and freed to fulfil his own genuine nature.** Many so-called self-disclosures are disguised **reactions** to manipulations. True self-disclosure is the result of the innate drive to self-realisation and expression and is only possible in the medium of a true relationship. In practice all relationships are flawed and uneven, but true self-disclosure characterises these relationships in so far as they are experienced as mutually enriching.

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THE THERAPIST'S DEVELOPING IDENTITY AS A THERAPEUTIC FACTOR

Joscelyn Richards

The psychoanalytic psychotherapy situation provides patients with an opportunity to gain or re-gain access to those parts of themselves which have become so locked into a defensive manoeuvre that they are not available to be experienced, observed and thought about. Defences such as denial, splitting and projection may begin as methods of protecting aspects of the self or to preserve part or whole object relationships from real or phantasied internal or external attack. However, if they become too entrenched or too rigidly organised their original purpose of protection can have adverse consequences for the personality as a whole. People often seek psychotherapy because they feel somehow depleted or out of control or trapped in unsatisfying patterns or painfully at odds with themselves or others.

It is very difficult for a person to begin the process, all on his/her own, of mobilising defences or defensive structures in order to examine and understand them. Interaction with another person is nearly always required. Once this interaction has begun the personality and knowledge of the other become crucial as factors which can facilitate or hinder the processe of exploration and understanding that can ultimately lead to insight.

When countertransference, triggered by the publication of Paula Heimann's paper in 1950, began to be recognised as an important tool for understanding the patient's unconscious communications the two-way nature of the analytic relationship also began to be recognised. This recognition opened up the possibility that what had hitherto been conceptualised as resistance in the patient could be due partly or solely to a failure in the analyst's emotional or intellectual understanding of the patient and the patient-therapist relationship. In recent years many analysts and therapists have come to recognise that their own emotional resources and theoretical framework are crucial factors in facilitating or hindering the patient's struggle towards self-understanding (e.g. Klauber, 1968, 1976 and Schumacher Finell, 1985). Herbert Rosenfeld's latest book "Impasse and Interpretation" (published posthumously in 1987) focuses almost entirely on this issue and describes and illustrates a number of ways in which the analyst can contribute to the development

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of an impasse in the treatment. Langs (1975) and Casement (1985) have also written about the consequences of making premature interpretations and misinterpreting as resistance the patient's legitimate protest about the therapist's failure to understand him/her. Sinason has gone a step further and pointed out the adverse consequences for the patient and therapist if the therapist cannot recognise and differentiate the sane and psychotic personality structures in both the patient and the therapist (1988).

Although many people from various backgrounds have contributed to the development of ideas about the inter-actional nature of the patient-therapist relationship a major contribution was made by Bion with his concepts of the container and the contained linked with his conceptualisation of projective identification as a normal mode of communication in infancy, essential to the development of realistic thinking (Bion 1957, 1959). Projective identification was originally conceptualised as a form of defence aimed at getting rid of some bad feeling or part of the self, protecting a good part of the self, controlling another person or attempting to avoid separation and so on. In the person's unconscious fantasy the projected part or feeling is located in the mind or body of the external object. It was in his 1959 paper that Bion particularly developed the "model of projective identification as a communication into a recipient/container capable of modifying the projection so that it can be taken in again by the individual in a less distressing form" (Spillius, 1988). He conceptualised the infant, who is necessarily pre-verbal, communicating with the mother by evoking in her an awareness that the infant is experiencing unbearable, unmanageable or highly distressful sensations and feelings. The good-enough mother receives the projection and through understanding and recognising what the baby is communicating is able to transform the projection so that it is now tolerable to the infant and can be re-introjected as its own manageable experience. This also provides the infant with an opportunity to begin the process of internalising a maternal object who can respond to and make sense of painful experiences. In this way the mother contains the communicated experience but if she cannot bear what is being communicated e.g. panics or turns away in the presence of a crying, distressed or angry baby then there is no containment and therefore there is neither a modified experience nor a containing function for the infant to introject.

Many analysts and therapists seem to have found it useful to use Bion's ideas as a model for conceptualising the therapeutic function of the analyst. Rosenfeld, in particular, has developed the idea of projective identification as a mode of communication in the analytic relationship

and the importance therefore of the analyst's capacity to receive projections however uncomfortable in order to make sense of them. He considers that projective processes, particularly in borderline and psychotic patients, often have at the same time both a defensive or expulsive purpose as well as a communicative one. Even when the primary purpose is to get rid of some frightening feeling or impulse Rosenfeld thought it nevertheless has the potential to be a communication . Thus he writes "The psychotic patient who projects impulses and parts of himself into the analyst is expelling them. But in doing so he makes it possible for the analyst to feel and understand his experiences and to contain them. In that way the unbearable experiences can lose their frightening or unbearable quality and become meaningful. Through the analyst's capacity to use interpretations to put feelings into words, the patient can learn to tolerate his own impulses and obtain access to a more sane self, which can begin to think about experiences that were previously meaningless and frightening" (1987).

Rosenfeld's view that projective identification always has the potential to be transformed into a communication if the recipient can process his responses suggests that the mutative interpretation is one which enables the patient to experience and think about some aspect of himself that he has never been able to experience and think about before. The patient then has the chance to integrate his newly experienced aspect of himself into a more flexible and comprehensive self-image. If the offered interpretation does not open up a dialogue which leads to the patient gaining further insight the interpretation is neither a containing nor a mutative one.

Being able to make a truly containing interpretation involves the therapist in a complex set of operations. To contain does not mean being silent or inactive. It means allowing oneself to be emotionally influenced by the patient and at the same time retain the capacity to recognise and process the meaning of the patient's verbal and non-verbal communications, drawing on one's understanding of theoretical concepts whilst doing so. Having sorted out the significance of one's own countertransference, which is a complex process in itself, the therapist is then in a position to evaluate the patient's state of mind and the extent to which he is governed by paranoid, psychotic or depressive anxieties. At this stage it should then be possible to formulate an interpretation in a language and tone of voice that the sane part of the patient has a chance of hearing and using.

To be able to carry out and integrate these complex emotional and intellectual processes the therapist has to have considerable emotional

resilience and receptivity as well as an adequate conceptual model to aid his/her thinking under internal and external pressure. The development of these emotional and intellectual resources can probably be achieved only through the thorough understanding and working through in one's own analysis of one's own ego splits and psychotic and pathological processes and defences.

The integration of the therapist's intellectual and emotional self-understanding with his sense of personal identity forms the basis of the therapist's identity as a psychoanalytic psychotherapist. Because this integration takes a long time to achieve a neo-phyte therapist will often be exposed in the patient/therapist encounter to experiences he/she is not yet able to process in a way that facilitates the patient's self-understanding. These indigestible experiences are more likely to occur with psychotic and borderline patients who rely heavily on defences such as denial, splitting and projective identification to deal with unbearable feelings or unwanted introjects or parts of the self and who have a well developed pathological organisation or "bad self" (Spillius, 1988) dedicated to keeping the status quo and undermining therapeutic progress. However, probably all patients have parts of their personality governed by a defensive or pathological organisation determined to prevent the libidinal self from forming good object relations and hence any patient may project an aspect of his/her personality which the therapist has difficulty in turning into a communication.

When the therapist experiences difficulties in processing the patient's material inappropriate interpretations can be made which in themselves disturb the patient's sense of being understood and may well lead to an impasse. At this stage in the therapy it is often tempting for the therapist to blame the patient for being too ill, defensive, resistant or unmotivated. In other words, if the full significance of the patient's resistances are not understood and contained by the therapist this can lead to an impasse. Because there is real resistance in the patient (as well as real longing to change), the therapist may only recognise this aspect and fail to recognise his or her own very real contribution to the impasse. Although this is more likely to happen during the first few years of one's development as a therapist it can happen at later stages as well. If the therapist's problem of containment is primarily due to a deficit in his theoretical and conceptual framework then self-analysis, supervision or discussion with a colleague will probably be sufficient to unblock the impasse but if the impasse persists it probably reflects some area in the therapist that requies further analysis. This is why some analysts and therapists undertake a second or even a third analysis.

Through the refinement and development of his theoretical model and through the emotional and intellectual experiences of understanding himself in his own analysis the therapist may develop the resources to understand and unblock an impasse in his work with a particular patient in a way that had previously been impossible.

CASE ILLUSTRATION

I wish to illustrate these issues with a case of my own. The patient, Mrs N, was my first training case and it was not until the fifth year of her therapy that I was in a position to make an interpretation that shifted an impasse and enabled the patient to understand certain spects of herself and her internal object world that had always been denied and projected. During these five years many developments took place in Mrs N's capacity to think about her inner world and effect positive changes in ways of relating to others, but a very important area of her functioning remained a problem for both of us though in different ways.

I want to present in some detail the session in which a breakthrough occurs but before doing so I will describe the nature of the impasse. For the purpose of this paper it is necessary to give only brief details of Mrs N's background. At the commencement of her therapy she was in her late 30's, divorced and living with her daughter who was 9. She was described by a B.A.P. assessor as having an hysterical personality disorder with features of obsessionality and "belle indifference". The patient herself complained of feeling depressed and suicidal and due to these feelings had a brief period in a psychiatric hospital whilst waiting for a psychotherapy vacancy.

During the first five years of therapy I had frequently observed that Mrs N rarely experienced or expressed her anger directly. She also had a similar difficulty in relation to her dependence needs although not to the same degree. She sometimes experienced a state of feeling that I thought of as anger because of the tone in her voice but whcih she called being "upset". This feeling of "upset" frequently occurred at the end of sessions. She could sometimes acknowledge that she felt angry or even furious with her daughter and she sometimes spoke of being angry with people who were cruel to animals. She quite often referred angrily to a female boss in her recent past whom she thought had treated her very badly at a time in her life when she had felt vulnerable and in need of being understood. Occasionaly there was a brief eruption into consciousness of a very violent and intense anger e.g. images of herself slashing with a razor blade the face of a married man she had felt both loved and rejected by, or remembering a dream of a wild ferocious dog which she actually

thought represented herself and which alarmed her deeply. Nearly all my attempts to interpret her upset as anger at feeling rejected at the end of a session or to link her acknowledged anger towards others with myself were firmly denied. Thus, Mrs N was sometimes aware of an intense anger in herself towards other people but this was never experienced or acknowledged in relation to her therapist.

She herself was sometimes aware that this was a bit odd and needed to be understood. At such times she would tell me that she considered anger was dangerous and best avoided "as people say things when angry which do permanent damage". At other times, however, she expressed admiration for people who could risk getting angry or expressed a longing to have a relationship like some of her friends "who argue and make-up". On one occasion she expressed the thought that people who could be appropriately angry seemed "more real" than she felt herself to be. Interpretations that included the understanding that she was angry with me but feared telling me in case one of us got permanently damaged and making-up would then be impossible were usually dismissed just as firmly as my other attempts at transference interpretaions. Hence, the sort of interpretations that I thought made perfectly good sense were nearly always met with comments such as, "I don't feel anything like that" or "No, why would I be angry with you...you have never done anything to cause me anger...what could you do".

This outstanding feature of Mrs N's therapy i.e. the absence of consciously experienced anger towards or criticism of the therapist was matched, as far as I was concerned, with an equally outstanding feature, namely, that the therapist frequently felt in a state of rage with the patient. I not only felt immensely and irrationally angry with her, sometimes as soon as she spoke, but would become increasingly critical of her inability to make use of my interpretations. I noticed particularly that her most effective way of triggering anger in me was to ask, on arrival, in ever such polite tones if she could open (or close) the window or could I please turn the heater on (or off). I also noticed that her 2nd best method of arousing my rage was to make, again in a polite and genteel way, generalised statements about the selfishness or lack of real caring in the human race and announce her preference for animals, especially her dog, and for her fantasy figures rather than people she actually knew. This announcement would sometimes be followed by a politely expressed statement that she didn't much feel like staying alive. These statements evoked no sympathy in me, only hostility and a feeling that I was being unfairly indicted as uncaring along with the rest of humanity. As on all other occasions, whenever I tried to explore what lay

behind these polite requests or announcements, she would clam up completely or deny any possibility that they reflected some anger or disappointment with me even when there were specific events like holiday breaks that seemed to be the trigger.

She often seemed to me to reject my offerings in a righteous tone of voice and insist that "nice people are always polite and positive". This would make me feel even more angry because I was sure I was right and that somewhere inside her there was an anger with me which was being denied. I would then feel I was up against an implacable authority who would never allow that it was human to be angry and who judged my own feelings of anger as totally unacceptable.

When these communication difficulties occurred, usually heralded by a feeling of intense anger in myself towards Mrs N, there were a range of outcomes but all were unsatisfactory. Sometimes I would try to pursue an exploration but would end up feeling defeated. At other times I was so sure that anything I said would meet with the usual disavowal that I did not even try to formulate an interpretation and held the anger in myself in a painful, passive way. On other occasions I would feel so sleepy I would be quite unable to think and would simply be locked up in a battle to keep awake. Sometimes when I was awake and speaking the patient got sleepy and could not hear me. In some sessions I could not hold my anger in myself and would snap out a pseudo-interpretation in a hostile tone of voice that only made her clam up all the more. It often seemed to me that a battle was going on as to who was going to have the anger and who was going to take on the role of angry accuser and it always seemed that however hard I tried to force her projections back into her I was left with them and it always seemed unfair. She often seemed to be in a care-free state, oblivious of her therapist struggling desperately with feelings of murderous rage. On some occasions I actually had the thought, "If you say another word in that tone of voice I'll kill you".

The fact that I often wanted either to kill Mrs N or fall asleep indicated that something very powerful was happening that I could not process. These sort of sessions increased in severity and frequency in the patient's 5th year of therapy and although I hated them and wished they would miraculously stop I dimly knew that they were an analytic gift from the patient and if I could understand the situation better there was a chance that Mrs N would then be able to understand a central aspect of her pathology.

I am going to present a session in which as soon as Mrs N speaks I begin to feel and think the sort of things that I had thought and felt on so many

other occasions. In this session, however, I am able to think more deeply about what is happening inside us both and finally make an interpretation that enabled Mrs N to acknowledge her anger and go on to explore and recognise the controlling function of an internal paranoid/narcissistic self that had dominated her for years.

Mrs N arrived at this particular session with a heavy cold. She said she didn't want to take her coat off because she was cold. She then got on the couch with her coat on and put the rug over the top of her.

She then described how ill she'd been all day, in fact too ill to go to work. She then explained in some detail how she had felt nauseous before coming to the session and so had decided to ask her daughter to ring me but the daughter couldn't get through or said she couldn't. Mrs N implied she suspected her daughter of pretending to 'phone. As she was talking I noticed how ill Mrs N looked and sounded. She looked to me as if she should be home in bed with a hot water bottle and someone to take care of her. At the same time as noting these observations in myself I also noted that I felt totally unsympathetic to her state and considerably irritated. I wondered if we were about to have one of those unproductive sessions where I would feel angry and she would seem detached.

Mrs N began to talk about not liking people anymore: "I know who my friends are and there aren't many. Most people do not care about others". She went on to insist that this was reality and she didn't like it: she preferred her fantasy world where people were very caring and knew how to respond to her unlike people in the real world. I noted in one part of myself that it was as if she knew I was feeling annoyed with her rather than sympathetic and that in another part of myself I was feeling so piqued by her insistence that people she knows are not as nice as her fantasy figures that I could not use that observation. While I was struggling to sort out the significance of my reactions Mrs N went onto complain about her daughter not paying her much attention when she came home from school but then added that it was unrealistic of her to expect attention from her because all she ever wanted to do was watch television.

She also said something about a teacher who wasn't as understanding about her difficulties with her daughter as she had expected. The daughter does not like studying and this particular teacher had promised to keep an eye on the daughter but had not lived up to her promise. Mrs N was feeing she had been left to deal alone with a situation that was too difficult for her. She spoke about these things in a polite, plaintive sort of way and made a number of statements about people in general not really

caring about any one but themselves. She seemed to be conveying a sense of feeling hardly done-by combined with an attitude of what else can you expect. She had always hoped people could be generous but had known really they were just very selfish.

I thought of pointing out to her that in talking about her hopes and disappointments with all these other people she was trying to tell me about her hopes and disappointments in relation to me. However, I thought of all the times I had tried making such transference interpretations and how firmly they had been rejected. I was also aware of a growing anger in myself towards her which I knew she would hear in my voice and which would therefore confirm her view that she could not hope for much understanding form me. Thus, I decided to think more about my anger and why her way of speaking seemed to be getting right under my skin.

I realised that her sweeping indictments of human beings were irritating me enormously and I wanted to defend the human race. I then recognised that I felt she was judging me and that her moral certainty seemed unfair. At the same time I realised that she seemed to be asking me to be sympathetic to her state of health and the struggle to get here and that as I felt no sympathy she had every right to accuse me of being unfair. In fact, as I thought back to the beginning of the session when I had been observing how ill she looked and had been listening to her catalogue of symptoms I remembered that I had not only felt unsympathetic and unmoved but had actually thought, "if you are that ill why have you come and inflicted yourself on me - I don't want your cold". I remembered that I had also thought something like, "how can you expect me to feel sorry for you when you are complaining about me and everyone for being very selfish". As in so many other sessions I felt mean and guilty for being as self-centered as she had expected me to be. At the same time I felt extremely annoyed with her for complaining indirectly about my unhelpfulness and thereby making it impossible for me to feel concern for her. I realised that it is at this point I usually collapse as a therapist and fail to think through my observations of my patient and myself.

I had recently been reading Rosenfeld's concept of the containing function of the therapist and I suddenly remembered this and the importance of processing unmanageable feelings. This thought seemed to spur me on and strengthen my resolve to not give up.

Awareness of the contrast between Mrs N's misery and my pronounced lack of concern for her health or appreciation of the effort she had made to get to the session led me to review its beginning again. I remembered that she had done a lot of explaining as to why she had come despite feeling so ill and why she had decided she wouldn't try the 'phone herself. On

reflection I realised that she had said these thing defensively as if justifying herself to someone accusing her of coming. I then brought to mind that she had muttered very quickly that it was a Friday session which I had taken to mean, but then forgot again, that she would rather struggle to a session before the week-end break than have to wait until her next session which was not until Tuesday.

Thus, I began to realise that Mrs N had been speaking at the beginning of the session as if in answer to someone who was accusing her of being a nuisance for wanting to come to the session. As the session progressed she had continued to talk in response to a figure whom she felt was, unfairly and cruelly, accusing her of putting first her own need to be here and selfishly ignoring the health of the other. In the patient's mind this other had no interest in the longing of her child self to make contact with a concerned maternal object and her comments about her daughter indicated that she had decided it was unrealistic to expect this.

As soon as I realised that I had actually become this accusing narcissistic mother and had been only concerned with my own health and state of mind thus leaving the patient to manage the child on her own (like the teacher who failed to give Mrs N the support she needed with her daughter) all my anger and irritation dissolved. I immediately felt appreciative of her efforts to get to the session and the underlying hope in her needy self that I might understand her real needs rather than turn into the self-centered angry mother/therapist I had so often turned into under the pressure of her projections and my pathological and narcissistic self.

Having recognised what had happened inside myself I then felt able to formulate an interpretation that Mrs N might have a chance of finding helpful. I said, "I think you arrived at the session quite sure that I would be annoyed with you for coming with a heavy cold in case you passed it onto me. I think you have been feeling very hurt and angry with me because of a conviction that I was much more concerned about my own health and catching your cold than about understanding your need to see me before the week-end and share with me how miserable it is to feel ill and to have to look after yourself today and over the week-end. I think you have been talking to me as if I had actually accused you of being selfish and thus you felt I was like your daughter's teacher who did not understand your difficulties and left you to deal with them by yourself".

There was a pause and I wondered if Mrs N would reject what I had said as usual and deny her anger. Instead she said, "Yes I have been feeling very annoyed with you". After a further pause she went onto say, "I often think like that - that people will be annoyed with me for putting them at risk and I think its unfair of them. I was thinking you must be very

bothered about getting my infection and I was thinking it wasn't fair of you. I could understand you feeling bothered but it seems unfair". I then said, "Because in your mind I had become someone who was only concerned about myself and not capable of understanding your needs or be glad that you could make the effort to come and see me despite your illness. Perhaps that's why you were saying people in general are selfish and not very nice. It was a way of trying to tell me that if I am angry with you for coming to a session with a cold I am certainly not a nice person". Mrs N then said, "I often think like that - I think in advance that the person is going to be annoyed with me and think I'm just a nuisance. I think I do talk to them as if they are really thinking that.....maybe they're not. I suppose I shouldn't jump to conclusions". I then suggested that she might jump to these conclusions especially when she is feeling vulnerable and needs the other person's understanding.

The rest of the session was spent exploring these assumptions and how there is a part of her that always tells her that her needs are a nuisance whenever she becomes aware of needing someone to understand her. I noticed that from the moment I made my first interpretation Mrs N's voice changed. Instead of speaking in a politely complaining tone which irritated me she spoke in a thoughtful lively way which engaged my interest.

Following this session new areas of exploration became possible. Mrs N informed me of times I had angered her, some going right back to the begining of her therapy, e.g. she remembered in the second session that, "when I told you what my problems were you said they were not that, and I was incensed....I nearly wrote you off". She also seemed determined to create situations in sessions which provided her with an opportunty to experience her rage with an authoritarian object in the here-and-now. The intensity of her rage reminded me of the anger I used to feel in the face of what had felt like an implacable judgement of myself as a therapist. She was able to explore the anxiety evoked when she experienced her range and the immediate impulse she felt "to get rid of my anger".

We have been able to use these explorations to map out much more clearly two parts of Mrs N's personality. One she has identified as "the weak me that wants to live" and the other as "the monster" or "wild dog" that "wants to kill me" and used to chase her in a recurring nightmare in her childhood, and which she also refers to as "my judgmental self that has always made me feel I'm a nuisance and shouldn't exist" and expects her and others to be perfect. There are many ways of conceptualising these two different structures in Mrs N's personality but it is not possible

in this clinical paper to examine their merits. I have found it helpful to think of the two parts as indicative of a split in the ego and therefore to conceptualise them as two different ego structures with two different self-representations. Hence, I will refer to them respectively as Mrs N's libidinal or needy self and her distructive/narcissistic or judgmental/perfectionist self.

In exploring the relationship between these two different parts of Mrs N's personality we have been able to recognise that the narcissistic self is always persuading the needy self that communicating her real needs and feelings in a relationship where she feels dependent and vulnerable is dangerous. Hence, she was always being persuaded that her feelings of both need and anger were "totally unacceptable" which made her feel abandoned and mis-understood. Whilst Mrs N was under the sway of the narcissistic self acknowledging her feelings towards me, especially anger and criticism, felt terrifying because, through the processes of projective identification, I was seen to have the same ruthless qualities as her narcissistic self. Thus, my attempts to get her to acknowledge her critical feelings and views only felt like an invitation to be ruthlessly punished. My failure to recognise this and to show her that I understood that she was being influenced by the propaganda from her narcissistic self was a major contribution to the impasse. My failure to sort out her projections from my own narcissism also contributed to the impasse as it is not possible for a projection to be taken back when the therapist is acting it out.

I have tried to illustrate that when I was eventually able to recognise what was happening and pass onto Mrs N my understanding of her inner world and its projection into me she was immediately able to accept the interpretation and to realise that her image of me as an implacable narcissistic object actually represented an aspect of her own personality which had always dominated her. Over the next 12 months she became very interested in identifying the many arguments that this part of her employs to persuade her to keep her libidinal self hidden and to turn instead to animals and fantasy figures for gratification. The main argument is that at the very moment when she is most trusting the need-fulfilling object will sadistically reject her. She finally came to the conclusion that the ultimate purpose of the constant persuasion to turn away from real objects is "to get me so despairing about trusting real people that I will kill myself" and then she added that, "it might want to kill you too".

Thus, the therapist no longer has thoughts of killing Mrs N and she, in turn, no longer perceives the therapist as the agent who wishes to destroy her. Instead Mrs N has been able to own to the murderous rage of her narcissistic self. I do not think this point would have been reached if I, as therapist, had not finally found a way to process the projections into myself of Mrs N's two selves.

DISCUSSION

In retrospect I think there were basically 3 reasons why I took so long to process my intimate knowledge of Mrs N's internal world and transform it into a communication that she could take back and use to understand herself better.

(1) As already indicated I was on the receiving end of powerful projections from both parts of her personality. At one moment I was being made to be the narcissistic and psychotic maternal object who is only interested in her own needs and is infuriated at the slightest hint of any imperfection in her maternal capacities and has no interest in understanding the effect these attitudes have on the child and prefers eliminating the dependent, protesting object either by killing it or going to sleep. At the next moment I was being made to be the needy child feeling appropriately annihilated, outraged and frustrated by the narcissistic mother's refusal to recognise her own contribution to the child's distress and by her disregard of the child's need to have her point of view listened to and understood. Possibly sleep feels to be the only option for the child in the face of unbearable feelings of frustration. I think these different aspects of Mrs N's personality were being expelled so forcefully because there was no internal container to help either side negotiate and modify the intense feelings. I was being forced to bear the unbearable and became as paralysed as the patient.

(2) Mrs N's criticisms, implied indirectly through her tone of voice and comments about others or requests to alter the temperature of the consulting room and so on, mobilised my own narcissistic self with its omnipotent belief in my perfect capacities as an understanding therapist and maternal provider and its own hatred of criticism and insight.

It was only when I began to recognise and explore my own pathological narcissism in my own analysis that I developed the capacity to recognise the complex inter-action between Mrs N's narcissistic structures and mine. Exploring these structures in my own personal analysis necessarily involved exploring that aspect of myself that held a conviction about my analyst's wounded narcissism if his capacities as an analyst were questioned. Thus, I began to internalise a patient-therapist couple in

which the therapist could not only tolerate but welcome an exploration of the validity of the patient's criticisms of his/her functioning. This not only enabled me to locate precisely in whom the narcissistic object belonged but to be interested in understanding my patient's need to criticise, by implication, my capacity to understand her and to differentiate between those criticisms that came from her child self and were justifiable and those that came from her destructive/narcissistic self and were unjustifiable and to recognise the destructive operations of my narcissistic self in reaction to these criticisms.

(3) The third reason is to do with inadequacies in my conceptual thinking. I did not have a clear understanding of containment as an active process on the part of the therapist or of a splitting in the ego creating two different personality structures both of which could be projected into the therapist. Thus, I did not have a clear idea of what to do with the feelings in myself that I identified as belonging to the patient. I did not really have a concept of having to transform and modify them so the patient could recognise and integrate them. Nor did I recognise clearly the split between my own and the patient's libidinal and narcissistic egos and the ways in which the latter were dominating the former in both patient and therapist.

SUMMARY

At various stages in the therapist's emotional and intellectual development he or she may be exposed to certain sorts of communications from the patient that are too difficult to process. This is most likely to occur in the early phases of development when the therapist may have an inadequate conceptual model to aid his/her thinking and is very likely to have areas of his/her personality not yet analysed. Difficulties in processing are likely to lead to an impasse which at first sight can appear to be due to resistance on the part of the patient only but on closer examination turns out to reflect some deficit in the therapist's emotional resources or conceptual framework.

I have described an impasse in an important area of work with my first training patient. Because she was very dominated by defences of denial, splitting and projection it was tempting to blame the impasse on her and accuse her of being a resistant, uninsightful patient who preferred to get rid of unbearable feelings rather than think about them. However, I have tried to illustrate that the impasse was also due to inadequacies in both my self-understanding and my conceptual tools and that it would not have shifted without refinements in my own thinking about the containing function of the therapist and splitting of the ego and explorations in my

analysis of my own pathological narcissism and what I thought was my analyst's. Once developments took place in my identity as a therapist I was in a position to make use of the intimate knowledge I had of the patient's internal world through her projections and to transform her apparent resistance into a communication which enabled her to understand herself better.

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DEFENSIVE PATTERNS IN A PRE-PUBERTAL BOY

Miranda Davies

I should like to describe my clinical work with a boy of 10 in the light of his defensive patterns, particularly of his defences of the self. So far in the development of a working model of analysis, we have, broadly speaking, two main categories of defence: ego defences and primitive, infantile defences against pain and anxiety. The ego defences were delineated by Freud and further elaborated by Anna Freud in *The Ego and Mechanisms of Defence* (A. Freud, 1937). Then Klein distinguished a more primitive group of defence mechanisms used against early infantile anxieties. These are splitting/projective identification, and idealization, defences against bad objects, and it is these primitive defences that Fordham explores in his paper 'Defences of the Self'. He writes that, 'in the case of part objects there is no unconsciousness, but rather more or less violent attempts to attack and do away with the bad object - they can reach a level at which one must speak in terms of annihilation. It is in this area that total defences are mobilized' (Fordham 1974/1985, p. 153). Fordham has called these total defences 'defences of the self'. The difference between Klein's primitive, infantile defences and Fordham's defences of the self is quantitative: defences of the self are more extreme, they are total. A definition by Kenneth Lambert is helpful here.

Although the distinction is by no means absolute, it is still possible to distinguish between a kind of half-blind defence against annihilation of the personality as such and defences that are involved in protecting the ego-consciousness from the experience of pain of all sorts.

(Lambert, 1981, p. 211)

I think what shows in the description that follows, is that Peter's defensive patterns were predominantly coloured by defences of the self, and for this reason, the gains that could be made in analysis were limited. Other considerations were the limited time during which we worked and my personal limitations as a child analyst. My lack of experience at the time will come through clearly, and I take comfort from these observations by Donald Meltzer:

There is a function of interpretation related to the analyst's struggles to preserve the analytic attitude rather than to the accuracy with

which he is able to comprehend the unconscious meaning of the material. In a sense the outcome may be said to depend primarily, for its success, on how **hard** *the analyst works, rather than on his talent or experience.*

(Meltzer, 1967, p. 84)

I do claim to have worked hard at Peter's analysis, and it may be observed, in my long description of the material of Peter's analysis, that I and my analytic attitude were identified by him at first as alien, as 'not-me' phenomena. As time went on, he became increasingly able to co-operate, although I never felt he really enjoyed his analysis. Quite a lot of this paper is the result of thinking several years after the analysis was finished, and I am particularly indebted to Elizabeth Urban for clarifying some of the theoretical ideas, particularly those relating to the archetypal contents of the self and its earliest 'deintegrations'. In thinking about defences of the self, it would be helpful if I were to say what concept of the self I am referring to.

THE SELF IN JUNGIAN CHILD ANALYSIS

In a paper published in this journal in 1987, Carvalho distinguished clearly between ideas of the 'self' in Freud and Jung's writings.

Pychoanalysts 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.

(Carvalho, 1987)

As a result of his work on infancy and childhood, Fordham postulated an original state of the self which he called the primary self, that exists from the onset of life (Fordham, 1976). The primary self contains all the potentiality of the individual, what might be called the blueprint of the

individual's future development, and this "blueprint" consists of 'archetypal predispositions or potentiality, a potential for the emergence of bits of ego-consciousness, and certain potentialities connected with self-realization' (Lambert, 1981. p. 193). The primary or original self is an integrate, but in order that psychic structure may come into existence, it "unpacks", to use Lambert's word, and moves outward towards the environment (as a baby does in looking, touching and feeding). Fordham called this capacity "deintegration" to describe how the integrate loosens and unfolds itself and to distinguish the process from disintegration. The deintegrate (the baby's looking, for example) meets the environment, (the mother's eyes and all that is expressed through them) and the new experience is "reintegrated" to become part of the self in steady, quiet states and in sleep. This is a theory of process, often referred to as 'primary self, deintegration and reintegration', and the example most frequently given to illustrate the process is the baby's deintegration in breastfeeding and reinegration in sleep. 'After this matching has reliably taken place over a sufficient period of time, the self will be able to reintegrate something rather different from the original deintegrate. The infant now has the basis for a true internal object' (Samuels, 1985). More complex processes and the importance of the mother's containing capacity are beautifully illustrated in Mara Sidoli's paper, 'Deintegration and Reintegration in the First Two Weeks of Life' (Sidoli, 1983).

Fordham's paper, 'Defences of the Self' describes the "total defence" exhibited by patients who are in a transference psychosis, 'where everything the analyst says is apparently done away with either by silence, ritualization of the interviews or by explicit verbal and other attacks directed to nullifying the analytic procedure' (Fordham 1974/1985). My young patient, Peter, was not in a transference psychosis, and so his attacks on the analysis were not so extreme or complex as those described by Fordham, but his analysis did have some features that accord with this description, including silence, ritualization and activities directed towards nullifying the analytic procedure.

REFERRAL

Peter was referred because of his extreme timorousness, and what he called his "habits". Sometimes his head nodded in a convulsive way and he put his hand on his forehead to stop it. When preoccupied with drawing or writing, he spontaneously lifted his collar to his mouth with his left hand and chewed the material. He also had minor speech difficulties, so that sometimes the letters b and d were transposed and occasionally other lettes were confused. His mother was concerned

because, at the age of ten, he was still frightened of crossing the street and of using a public telephone even when she was nearby, and she was afraid that he would not be able to get himself to secondary school the following year. While watching television he got terribly worked up during competetive sports and horseracing and sometimes bent over his knees, twisting his hands together in a movement that his parents found disturbing. He obsessively studied football scores, cricket scores going back for years, and the index of the hymn book every Sunday.

In order to help him cope with the everyday world, his mother insisted that he learn to swim, ride a bicycle and cross the road by himself. Sometimes he clung to her hand so fearfully that she felt she was being cruel, but she persevered with firm kindness and eventual success. His school performance was average over all, but he was good at English, particularly at making up stories. With his pale skin, light hair and slight build, Peter stood apart from his siblings in appearance, as well as in temperament.

GAINS IN THE ANALYSIS

I worked with Peter four times a week for just over two years and in that time he passed the entrance examination to his brother's highly regarded school, found his feet there and gradually improved his marks. He also enjoyed some modest success as a cross-country runner and was able to negotiate the ride on three buses to get him home after school. His mother reported that he was more affectionate with his parents, his head-nodding had disappeared and his collar chewing had lessened, although he still occasionally bent over and twisted his hands when he got excited while watching television.

THEMES IN THE ANALYTIC MATERIAL

Castration Fears

Peter was inhibited at first but soon started drawing prolifically, as well as using the room and the time in ways that I often felt were just a means of filling a gap, repetitive activities designed to block the analytic process. One of his early drawings depicted a man standing rigidly propped up by one crutch, his left leg amputated; the round face was boy-like. It gave a vivid sense both of his rigidity and of his sense of being castrated, poorly propped up, with no ground near his feet. The drawing made me think of Erikson's description of 'the stage of fear for life and limb, of the "castration complex" - the intensified fear of losing..the male genital as punishment for secret fantasies and deeds'. (Erikson, 1968, p. 119)

Heroism and Defiance of Death

At first he brought comic books and copied many pictures of the football players, making his own comic book. While pointing out his identification with the good, heroic, phallic characters, (his drawings of himself had enormous feet and fingers), I particularly focussed on a short, fat boy who ate a lot, because I wanted to put Peter in touch with his own infantile, oral longings, so evident from his collar chewing and from the big mouths in his drawings. But most important to him was a story call *Death Wish* in which the hero stretched a wire across Grand Canyon and crossed it on his motorcycle. This, of course, was a world record, world records being a constant motif in Peter's inner world and representing some security of accomplishment. His dream was to get his name in the record book. I linked the story of *Death Wish* with his fear of crossing the road, his fear of death and his sense that his own life was hanging on a thread.

The Race Against Time

From this emerged play that depicted a race against time: he put a piece of paper on his knees and hastily folded it, concertina-fashion, bunched one end in his hand and fanned his face. This was done repeatedly over weeks, each time trying to beat a record of an increasingly small number of seconds. Then he told me something crucial: "Once when I was a baby, there was a crisis and I couldn't breathe and in ten seconds I would have died". He always made the fan in considerably under ten seconds, and I tried to help him make a link between past and present, by talking to him about how making the fan represented the race against time in his babyhood, his anxiety and his determination to survive.

The Rescues

The theme of survival was acted out in a series of rescues. For example, he dropped a pencil or rubber under his chair, pulled his feet up as if he were floating on a raft, and bent his body in all kinds of contortions in order to rescue the pencil by lifting it onto the table by means of two felt pens. This was enormously difficult for him and experienced as perilous; the pencil often dropped off the table just as he thought that the rescue had succeeded, and he had to start all over again.

The Obstacle Race

The rescues were followed by an obstacle race that was also a vital race against time, and I had to time him accurately by counting out the seconds. In its finally evolved form the obstacle race went like this:

1. Throw up lid of plastic box, let it hit head as it descends, catch it.
2. Walk, throwing and catching the lid with two hands.
3. Throw lid up under left leg, walk with left foot in waste bin while throwing and catching the lid.
4. Walk with right foot in bin while balancing lid on head.
5. Balance tissue box and then animal box on head.
6. Run with the big roll of sellotape balanced on head.
7. Empty animal box onto table, pile animals into deep lid of animal box, close box.
8. Pour animals onto floor, put them back into box, reach in, eyes closed, and choose the cow.
9. Balance tissue box and animal box on head and return them to table. Sit.

He planned to run this race in competition with his brother in order to win his mother's love, and I saw it, at one level, as aimed towards winning a genital union with mother (foot in the bin), while on the pre-genital level, as aimed at finding the breast. Picking out the cow unerringly with his eyes closed was like an infant blindly rooting for the nipple. Throwing things up and balancing them on his head seemed to me to represent an attempt to keep himself from being depressed: he must keep these bits of memory, sensation, fear and pain "high"; they must not fall and make him feel low. At the same time, if he could keep them above his head and in concrete form, they did not get into his head and get thought about. Peter was not skilful or dexterous, and his success in this race was fragile. He was never satisfied with the score and subjected it to the kind of perfectionism that Lambert describes in his glossary of defences.

> *The alarming plight of the perfectionist is that he embraces unreal absolutes. If things are not good then they are impossibly awful. Anyway, perfection is hardly ever possible. If, however, it is approached, the perfectionist is not defeated. He can set up a* **sliding scale of perfection.** *Every time an ideal seems reachable, or something satisfactory or good enough is realized, the scale of measurement is advanced further so that the present achievement is felt as worse than useless.*
>
> *(Lambert, 1981, p. 215)*

Peter set a time within which the race had to be completed. When, after repeated attempts, he achieved this time, his pleasure lasted a few seconds, and then he reduced the time within which he had to run it. In this way he ensured that he never won the race, his achievement always

slid away from him and he was never secure. In a letter to me about this material, Dr. Fordham was interested in the way Peter organised the obstacle race so that he almost always lost it, in spite of the fact that he knew that he had survived the ten seconds. He saw this as an expression of Peter's pessimism, a defence against depression expressed as: "However great my efforts to overcome my deficiencies, I cannot succeed, so there is nothing to be depressed about". The same pessimism can be seen pervading the play with the fan and rescues.

A colleague has pointed out another view of this material that links it with Peter's early picture of the one-legged man. She sees the race as showing his fear of being handicapped and his continual practising of skills as a compensation, something like the experience of a handicapped person spending three hours getting up, feeling triumphant, and then instantly let down by the thought, "All I've succeeded in doing after all is getting dressed". Certainly, my experience of these races always contained let-down: so much effort expended for so little result.

PETER'S UNREACHABLE QUALITY

Peter was often unresponsive and silent in a way that made me feel that I was talking into thin air. I found it hard work to make interpretations to him, but I worked diligently at it, talking about his natural preoccupation with phallic prowess, shown by the comic book heroes and the enormous fingers and feet of all the figures he drew. I interpreted his head-nodding as a displacement upwards of masturbatory wishes, and after six months this symptom had virtually disappeared; I interpreted his two-year-old rage at his mother's pregnancy and the birth of a sibling when he drew a fat-bellied Mickey Mouse and cut the belly into tiny fragments, while working his jaws; I interpreted his infant rage with the inaccessible breast as he cut and picked at the large roll of sellotape and worked his jaws, while saliva dripped from his lower lip. The striking thing was that he rarely succeeded in unrolling a strip of sellotape that could be used; the tape-breast almost always frustrated him. By this time, we had been working for six months, and in spite of all my interpretations I was painfully aware of counter-transference feelings of bleakness and emptiness. In my notes of the time I wrote that I felt helpless and useless, occasionally verging on panic that I would never say anything tht would help relieve his problems. Perhaps it was here that my inexperience was most evident, for I was unable to gather these counter-transference experiences into interpreations that could be useful to him. It was only later that I gained a better understanding of my experiences of helplessness and panic as projective identification and linked it with his

early history. Most of my interpretations, I realised at the time, were by-passing Peter and making very little difference.

He made me feel controlled and shut out, while eliciting a concentrated and specific kind of attention. He used to tap out the rhythm of a nursery rhyme with his feet or with his pencil on the table top, and I was to guess which rhyme it was. Later he conveyed a message in code at the beginning of every session by holding up his fingers to indicate the number of the designated letter in the alphabet. I was required to record the numbers, convert them into letters and write the message. For example, 6 fingers - F, 15 - 0, 21 - U, 16 - R, and so on, until I had the message, "Four more days until exams". Frequently the messages were far more banal than this, and my sense of let-down after sustained effort was great. Here we can see another link with the idea that he had an underlying phantasy of being handicapped. Often when he was tapping a rhythm he sealed his mouth with sellotape. I felt that he needed me to decode his rhythms and messages at a pre-verbal level, as a mother understands her baby, that he was eliciting a specific kind of maternal preoccupation from me in a very controlling way. I interpreted it like this, but the tapping, and particularly the messages remained a feature of his analysis throughout. I was to allow my mind to be filled with what he directed into it, but he would not often take in what I said. He talked through my talk, or ignored it, or changed the subject, or dramatized what I said. If, for example, I made a link between his preoccupation with life-threatening dangers and his need to get air in ten seconds, he hurriedly and dramatically folded another fan. It looked like confirmation of my interpretation, but it did not feel like it; it felt to me like simply another of his flights into bodily activity, a dramatization "on stage" or "up front", so that we would not get to the deep-seated fear behind it. Its effect was to nullify the analytic procedure. Although his drawing became more flexible and free, he continued to feed me endless drawings until, in desperation, I reduced the amount of drawing paper I gave him to one sheet. The never ending supply of drawings made me feel that I was being fobbed off, while he was being a good little patient producing pictures to please his old analyst! This kind of resistance characterized his whole analysis.

The Battles

Nine months after we started work, the battles began with the injury of Otta, a large, otter-like mammal. I interpreted this picture as his fantasy of a dangerous parental intercourse in which father stuck his knife-penis into mother's insides and injured her. This injury started a long and

catastrophic war, developing from the first attempts of the Grizzly Bear Family to avenge Otta, to a full-scale battle between the Jankos and the Humans. The invasion of the Jankomen from Mars was led by Thin Neck, while the Human defence was led by Super-Peter. At first I interpreted it as a conflict between his genital impulses and his super-ego, but as the battle wore on with enormous casualties, I saw that it was a more fundamental struggle for survival, an elaboration of the earlier themes of Death Wish, the rescues and the fan: a terrible battle against the invasion of alien forces as experienced by Peter at a very early stage of life, which he could only represent by projecting it into outer space. He only referred to this crisis once, on the occasion when he told me that, as a baby he could not breathe, and would have died in ten seconds. The outcome of the conflict was dangerously close: by the end of the war, the number of Jankos dead totalled 15,238, while the Humans won by a hairsbreadth with a total of 15,119 dead. The gravestone in the last picture of the series indicated the end of the battle; it came to an end two days after Peter heard that he had been accepted at his brother's school. But the war continued to rumble on in the background for another nine months as Peter picked his ear from time to time to get news from outer space.

The Space Game

Meanwhile, Peter started drawing a space game, the battle of the Squares and the Curleys. It looked like a computer game in which the participants blew each other up, and it suggested a battle of part-objects to me. The game went on for weeks, interspersed with an endurance test in which Peter had to run, do press ups and various physical feats, again in a race against the clock. He might begin such a session by coming into the room in a floppy manner. My interpretations of his need to build up strength to ensure survival, and at one stage, of his negotiating a difficult passage down the birth canal, did not alleviate the desperate, anxious pressure to beat the clock, but just had the effect of pressing him back into repeating the endurance test. He blocked all my attempts to interpret the battle of the Square and the Curleys, but did agree that he prefers to keep his conflicts projected into space. Confirmation of the theme of survival appeared in his drawings as a "spiral of life". When a figure had a spiral of life drawn near him, he would not die. The images in this battle, in which one space-satellite object blew up another, were the most telling depiction that Peter produced of his fear of annihilation, evoking Fordham's description of more or less violent attempts to do away with the bad part object that I quoted at the beginning of this paper.

The Characters

Peter started to draw figures while he had his eyes closed, so that the various parts of the body - head, torso, arms, legs - did not join. By now, I had spent a long time trying to help him see how he protected his vulnerable, floppy, sensitive baby part by exaggerated dramatization, and how he used his vivid imagination to depict himself as enormously strong (manic defence). It seemed to me that he was now, in the drawings, able to reveal a little more of this floppiness and his sense of not being all-of-a-piece. From this loosening up of his body image, there emerged four characters whom he drew and acted for months. They were Rich Man, who was superior and elegant, a composer and conductor who lived in a mansion; Champion of the World, who held the world record for everything, even eating breakfast; Yobbo who was like a tramp, picked his nose, did not wash or brush his teeth and just lay about; and Hitler. Peter often conducted an orchestra or a large choir (omnipotent defence) in the character of each of these in turn: Rich Man high-nosed, thin and elegant, with graceful gestures, Champion forthright and robust, Yobbo floppy and all over the place, and Hitler relentlessly four-square, beating his baton mercilessly. The baton, of course, was his ruler.

It was through these four characters, evolved during our second year of work, that he was most willing to co-operate in analysis, because it was far less persecutory for him when we looked at his 11-year old self than when I interpreted his baby feelings. Rich Man was the part of him that wooed me and wished to be my husband, responding as he did to my love of music - I think he picked this up from the accuracy of my response to his nursery rhyme tapping - and his perception of my clothes as elegant. It was through Rich Man that we could get closest to his oedipal rivalry with his father. At the same time, Champion of the World was an idealized version of his father, who actually did play sports well, while Peter felt defeated in his attempts to emulate both his father and his siblings. Champion's feats were prodigious: he could build a mansion in one day, and wallpaper it in .09 seconds, and, of course, he held the world record in all sports. As months went by, this defensive idealization lessened slightly and Champion began to lose records and be challenged by Champion Junior.

In the meantime, Peter was settling well into his new school, enjoying extra cricket after school and finding a niche as one of the fastest runners in his class. Yobbo, however, was naturally not to show his face at Peter's smart school, and had to be banned to outer space. His place was taken by Funny Man, who juggled and did pratfalls to entertain people (another aspect of manic defence). This was a side of Peter that his

mother knew well, his tendency to take centre stage, bow self-mockingly and send himself up. She felt that it could become a distortion in his personality. Through Funny Man, we were able to look at how Peter got people to laugh at him so that they would not discern how much he feared that he was wierd, that he was a Mindbloggs, brother of Sid Bloggs, with wierd and shameful sensations in his penis that he was afraid would show on his face, the way they did in his drawings. He wanted to become a brain surgeon in order to operate and straighten out his own mind. (His analyst obviously was not going about it the right way, not giving him any medicine). His speech impediment intervened here and he said "drain surgeon", betraying how quickly his hope of being cured went down the drain. In time, interpretation of his masturbatory wishes brought relief, and Funny Man caught influenza and died. This did not mean that interpreatation had penetrated to his more profound sense of being weird in his mouth, disabled by impulses that got enacted in relation to his mouth and made him feel caught unawares.

Hilter did the goose step and beat his enemies into the ground. He obviously could not show his face at school and soon died, but another character called Fred Hurtman took his place. Fred Hurtman beat and hurt people and then felt so guilty that he pulled his own hair out. The characters battled in Peter's mind and he received news in his earphones that Fred Hurtman was beating Sid Bloggs. At last the battle in outer space was coming down to earth and becoming humanized. I tried to show Peter how the exaggeration of the characters, particularly of Champion, illustrated how very much he needed to control and defend himself against his baby feelings of weakness and helplessness. It emerged that Champion's name was Smith and that he had the same first name as Peter's father. He started to lose world records and was succeeded by his son, Simon Smith, who was about 10 years old. Not long after this, Peter heard in his earphones that the Janko-Human war had ceased for good.

THE LAST PHASE

By now I was pointing out to him how he kept my words out because they hurt him inside: he seemed to experience my words as invasions, like an attack of the Squares, or the stab of a Janko knife. He said that he thought it would be great to have a computer brain, and he begun to respond to my interpretations by crunching together his "robot jaws", stretching his arms straight out sideways and bringing them together in front of him, while making the noise of the devouring rubbish truck that used to stop outside our window.

Now, at last, the encounter was between Peter and myself, and I was experienced as an enemy whose rubbishy, attacking interpretations had to be crunched up and annihilated; Peter had come quite a long way in bringing the projection back from outer space. He was now able to show a little more of his depression when his parents went away, and he sometimes responded more openly to my interpreations. He made a figure with the 'Playdoh', broke it up and put it together again, which I felt expressed the breaking up of some of his defences. The figure was boken up again and the dough softened with water to make other objects, as he acquired an improved sense of being able to make and accomplish things. His mother reported that his school marks had improved greatly, he was more affectionate, and many people had remarked, independently of each other, that he had come out of himself.

Near the end of treatment (which was ended at his mother's instigation), Peter reviewed his Characters and then conducted a "scientific experiment" with the Playdoh. Working on an experiment meant, he told me, that he did not want to be spoon-fed by me. With this improved ability to relate directly to me, he was able diffidently to admit that he did not want me to "butt in" with interpretations when, for example, he was having a daydream of a perfect car that contained everything he could want, including orange drinks and banana milkshakes on tap. He reiterated that he would really love to live in a robot world, and showed no sadness or regret at leaving me. The only sign he gave of any attachment occured on the second last day, when he wore a T-shirt that indicated, indirectly, that he knew I came from a city a long way from London. So I understood that I was still only safe for him if I stayed a long way off, while he created in imagination his own perfect breast-car. My mind was not to be taken into himself and experienced as the breast. It was only safe when he himself controlled a representation of the breast, as when he drew a bottomless glass of coca-cola by his bedside, or imagined that the building was filled with fudge and had chocolate doors and icecream radiators. Here is how Lambert describes this defence:

Idealization comes in as a defence mechanism as a way of dealing with the pain of lack of food, mother, validation, love, etc. It consists in building up in phantasy an ideally perfect peson to aid one or a perfect situation. Thus the fairy godmother, the perfect meal, the perfect attainment, the perfect environment are the creation of idealization in phantasy..... Idealizations falsify life by phantasizing that it could be better than it could possibly be. The defence is expensive: when it fails, despair and disillusion set in and any help

available seems worse than useless and cannot be accepted.
(Lambert, 1981, p.215)

Again, my colleague's observation is interesting here, that the room is experienced in an archetypal mode in that it is pre-personal. Aspects of the building are experienced as delicious, and he may miss the building, but not his analyst (Urban, 1989).

DEFENCE PATTERNS

It was not only when he was imagining oral delights that Peter's mouth dripped saliva. It happened when his attention was elsewhere and he was concentrating on the game of the Squares and the Curleys, or drawing a picture. The same was true of chewing his collar. As he concentrated on drawing with his right hand, his left gently lifted his collar to his mouth and he chewed it, making it wet with a flow of saliva as copious as that of a baby mouthing his teething ring. Sometimes it dripped down onto his shirt and he awoke from his state of absorption and wiped it shamefacedly. This was where his deepest feeling of wierdness lay: when his conscious attention wandered away from the control of his mouth, the mouth took over with an life of its own. He often taped over his mouth with sellotape in an attempt to stop the flow. Throughout our work together I talked about the longing of his mouth for the nipple and breast, and how he supplied his own collar-breast substitute. But whereas interpretation of genital impulses and phallic goals did help, very little change showed in his collar-chewing. It occurred less frequently, that was all. He also loved to lean back in his chair and tap thythms on the floor with his feet, or kick and toss his feet into the air. I saw the kicking as also stemming from this early, oral, baby stage, the sheer exhuberance, rhythm and aggression of baby kicking, which later, with added anal components, became his Hitler stamping, and a stamping out of my interpretations.

DEFENCES OF THE SELF

In the Preface to *The Self and Autism,* Fordham puts forward 'the concept of the self as a defence system designed to establish and maintain a child's individuality.....' (Fordham 1976, p. xiv), a concept that resulted from his investigations into infantile autism. The idea of the self as a defence system is congruent with a primary self that does not deintegrate: there can be a defence against deintegration, for example when the environment to be met is deemed to be too threatening or non-existent. Peter's sense of his individual self was so fragile, so vulnerable, that it had to be protected in a total way, by a defence system that was

self-contained and, to some extent, inaccessible. I thought that his fragile self was represented in one of his last drawings by an embryo-like shape. I interpreted the meaning of his dripping saliva and collar chewing as his recreation of his own collar-breast, and at one stage, I took the deliberate step of adding some specific reconstructions from his history as given to me by his mother, but little changed in this area; it remained an experience in a few muscles, nerves and glands, in what Bion calls beta-elements. I think that at the anal and genital level Peter was capable of more symbolization, and there we can see distinct and meaningful defences of ego-consciousness. But at the very early, oral level, elements of the self stayed fixed and could not loosen and open out or deintegrate.

In his chapter on Archetype and Complex, Samuels discusses a parallel with Bion that I found particularly helpful in this context.

According to Bion, thoughts precede a thinking capacity. Thoughts in a small infant are indistinguishable from sensory data or unorganised emotion. Bion uses the term proto-thoughts for these early phenomena. Because of their connection to sensory data, proto-thoughts are concrete and self-contained (thoughts-in-themselves), not yet capable of symbolic representations or object relations. That is, they are not yet transformed into specific visual or any other sort of imagery. These **thoughts that precede a thinker** *cannot fail to influence what the thinker will think as he develops. The thoughts then function as* **preconceptions** *- predisposing psychosomatic entities similar to archetypes.*

(Samuels, 1985, P. 41)

I thought that Peter's saliva dripping and collar chewing were like thoughts-in-themselves at the sensory level, before they acquire symbolic representation, let alone an object relation; we never came to a stage in the analysis when my mind, or my words, could represent the breast his mouth sought, and he showed little attachment to me or sadness at leaving me. My attempts to help him make these proto-thoughts symbolic were a failure, and, as Dr Fordham said to me, it is characteristic of defences of the self that they have an inaccessible quality.

Samuels links preconceptions to archetypes through Money-Kyrle, who states that archetypes are probably much the same as preconceptions in theory. The breast created by Peter out of his collar can be understood as being very close to the early self, imbued with mana qualities and heavily idealized. He makes his own breast and nipple from the collar

and milk from the flow of saliva, as a defence against having to take in persecutory not-self (depicted as attacks of the Jankomen or the Squares or perceived as penetrating qualities in my words). Intrinsic in the archtype is a pair of opposites: when idealization is turned inside out, there is, in Peter's case, an opposite experience of something out there that is mechanical and inhuman, trying to attack. The baby has not had enough experience, through deintegration and reintegration, of meeting the flesh-and-blood breast; he has not internalized a good object, and so there is no internalized good breast to be projected onto me. Instead the deintegrate has been arrested by trauma and has remained in a position very close to the self; it is thus imbued with the extreme opposites of an ideally available beast and an inhuman attack that threatens annihilation. The dramatization of Peter's robot jaws crunching up my interpretations is a beautiful depiction of Kelin's "primitive annihilation of bad objects". It may be understood that, while some aspects of the analysis were experienced as alien, attacks from not-self elements and later as "butting in" interpretations that had to be defended against, good aspects of the analysis were experienced as part of the breast that had been created out of the self through idealization, that is, as aspects of the collar/breast. It remains an open question whether the process of symbolization of the beast, which was begun with the car full of sweet drinks and the bottomless glass of coca-cola, could have provided the avenue to further deintegration, reintegration, internalization of the breast, projection, symbolization and reintrojection in the analytic process, given more time.

In outlining Fordham's defences of the self, Andrew Samuels writes,

It is not simply trauma or disappointed expectation that destroys the capacity to symbolize. There are also defence systems which can react to insensitively presented not-self as if it were a vicious enemy which must be neutralized by any means.

(Samuels, 1985, p.121)

I found Samuels' way of putting it suggestive when looking at the battle of the Squares and the Curleys, which represents the neutralization of a vicious enemy, particularly when I thought of it as a depiction of a biological defence system such as white corpuscles destroying invading germs. When, in illness, the body fights to throw off infection, the biological defence system recognises what is not-self, attacks and neutralizes it. In his paper, 'Introducing Not-Self', Stein puts forward the action of the immune system as an analogy to illustrate the actions of the self when it feels itself to be threatened with annihilation by elements that

are not-self (Stein, 1967). I did, in fact, interpret this battle, as well as that of the Jankos and the Humans, as a depiction of an early trauma which I shall describe in the next section, and there was some modification as a result. That is, Peter eventually dramatized himself as a single Robot Jaws crunching up and annihilating a single Miss Davies, and I was seen to survive.

HISTORY OF PETER'S INFANCY

It may be that the material presented here and the defences described will be illuminated in a slightly unusual way by giving the history last, rather than at the beginning of the paper, as is usually the case. Peter's mother felt that he had had an unfortunate start in life, compared with his siblings. It was a long and difficult labour and he was born with a heavy bruise in a band around his head and across his forehead, as if his head had been caught in a severe contraction. This description is striking in the light of Fordham's speculations about when the first deintegration of the primary self occurs. He writes,

In view of increasing knowledge about intrauterine life, we may think it happens before birth. The flood of stimuli provided by birth itself produces anxiety, the release of breathing, and crying activities that must certainly suggest an early deintegrative state. It is assumed that the infant reintegrates again before he starts his first feed, in which further instinctual release (deintegration) occurs.

(Fordham, 1985, p.108)

This opens an area for speculation about the nature of the deintegrative experience before birth, and its influence on the mother's body response to the deintegrate that initiates the birth process. At the same time, we cannot know how Peter would have reintegrated this traumatic birth through repeated cycles of deintegration at the breast and reintegration in sleep, because it was succeeded by two life-threatening experiences.

Breastfeeding did become well established, but at three weeks Peter's oesophagus collapsed and he stopped breathing. He went blue and his rib cage protruded in a V-shape in front. His mother rushed him to hospital in an ambulance, the collapsed cartilage was opened again, a feeding tube put down his nose and he was put in an oxygen tent. He was taken home and a less severe collapse occurred again a few weeks later and was more easily dealt with. The condition was not operable and in time the cartilage strengthened naturally. At home he was kept in a sitting position in a little chair to aid his breathing. When he was in the pram in the garden or in bed at night, his mother listened to his rattling breathing through an intercom for babies, and the instant it was not audible she rushed to him. Within a few months, his parents noticed a way he had of

opening his mouth wide and stretching his eyes open in an almost clown-like expression that made them laugh in spite of themselves. He did not like to be cuddled and his mother felt that he kept her at a distance, but she accepted this as "just his nature" and did not force herself upon him. As an older child he did not like tickling or rough and tumble, and was particularly frightened when the duvet was thrown over him. He continued to fend off his mother's caresses and she felt guilty about having to make an effort to provide them, especially as it was so easy to show affection to the other children.

BETA ELEMENTS

It seemed likely to me that the feeding tube had been put down Peter's left nostril, because this was the one he constantly rubbed and worried while sneezing and blowing during his many colds and allergy attacks. He often sneezed straight out and mucus dripped on his clothes or splashed on the floor. These symptoms can be understood as proto-thoughts of the feeding tube, as facts that have not been digested by alpha-function. These beta-elements are defined by Bion as suited for use in projective identification and influential in producing acting out; they are objects that can be evacuated or manipulated in a way that is a substitute for words or ideas (Bion, 1962, p.6). In the absence of alpha-function they are, like the suddenly unavailable breast, unavailable for conversion into thinkable form.

CONCLUSION

A considerable amount of material from the analysis of a pre-pubertal boy has been described and discussed in the light of his defensive patterns, with particular emphasis on his use of defences of the self. These defences are seen as a total response, difficult to modify in analysis, and having the purpose of defending the whole personality from the experience of annihilation. Whereas ego-defences are available to a child who has obtained unit status at around the age of two, an infant does not have the capacity to symbolize, and when he is traumatized, 'very intensive defences spring spontaneously into being to cope with the miseries involved'. This involves a defence of the self that Lambert calls a 'half-blind defence against annihilation of the personality as such' (Lambert, 1981). In Peter's case the overwhelming pain of terror, loss, rage, and hate continued to be expressed by what Bion calls proto-thoughts or beta elements, that is, physical symptoms with an affective content such as saliva dripping, collar chewing, nose rubbing and mucus dripping. These were hardly accessible during the short analysis

available to him, and therefore, although a considerable amount was accomplished in other areas, little could be done to bring the psychosomatic symptoms into alpha function, that is, into the area of phantasy, dream and myth, from where they could be symbolized and brought into the analytic relationship.

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NOTE:

I should like to acknowledge my indebtedness ot Elizabeth Urban for thinking about this paper and clarifying and illuminating some of the theoretical concepts for me.

TUMMY TALK

Martin Freeman

This is a paper about non-verbal communication. There is nothing particularly remarkable about that - we notice such communication regularly with our patients - but "non-verbal" normally means "silent". Here the communications are primitive, expressive - and inescapably audible.

Most of the material refers to "Tommy", a youngish man, brought up in the industrial North, who managed to disentangle himself from a large, close-knit family and make something of a life for himself in the South. He is the youngest of the family, within which his sensitivity was battered and oppressed. His older brothers and sisters were each fighting for individual survival on their own part of the family battleground. If one of the others, usually little Tommy, was receiving the brunt of the current campaign of parental harassment then they could enjoy temporary respite. As a sacrifical animal he was useful to them.

The scapegoat is a familiar object. In the past, societies have acted out the ritual, choosing an animal, tree or even human to bear symbolically the community's sins which would be expiated by sacrifice. According to Brewer's Dictionary of Phrase and Fable the allusion is to Jewish custom. Two goats were brought to the high priest on the Day of Attonement. He would cast lots; one would be for the Lord, the other for Azazel (Satan). The first was sacrificed at the altar, the other was the scapegoat. "The high priest having, by confession, transferred his own sins and the sins of the people to it, the goat was taken to the wilderness and suffered to escape". Today such ritualised, conscious activity does not occur - we are of course much too civilised for such superstitious behaviour - but the unconscious process is alive and well. It happens in any contemporary group quite as much as in primitive communities, but with a polished veneer of twentieth century sophistication.

The more valuable the sacrifice, the greater the future rewards. But human nature being what it is, one might suspet that the goat chosen to be led into the wilderness to starve or be devoured by wild beasts, whilst not being emaciated and disease ridden, might not always have been the prize of the herd. Little Tommy was such a goat - but he had just about survived the wilderness and the beasts. Over the years he had developed an adequate persona, perhaps even a false self, and it was with this psychological equipment that he started therapy once a week. After about six months he was coming twice a week and now, after two similar

intervals, attends Monday to Thursday. Indeed, given the opportunity, he would probably come five or even seven times per week, but a work committment makes this impossible. I am not entirely convinced that this is the real reason, but on balance I feel it to be legitimate at this point in time. As the therapy progressed, the need for the socially adapted, defensive persona declined. Signs of a move towards regression began to appear: any break, the over-long weekends as well as holidays, became threatening and provoked anxiety; he lay under the blanket on the couch; he would become fixated upon some small detail in my consulting room; changes, either in the position of furniture and ornaments or in entry and exit procedures, would disturb him - and he began to talk less. The sessions turned into silences interspersed with brief comments.

My reaction to this varied. Often I would feel that he needed to be silent, to be held securely and unconditionally, but sometimes I found myself feeling irritated and short tempered. This was a countertransference reaction to an experience of Tommy's which occurred several times in his childhood. The family would always spend holidays in the South West of England and they travelled by car, all crammed in together, assorted children bickering and arguing. Father, a self-made man and proud of it, always drove and was always in charge. Tommy dreaded these journeys. He survived them by retreating into a protectively insulated world of introversion and silence. "Why doesn't he talk?", his father's hard Northern voice would ask of his mother, rhetorically and dismissively. These were just the words which echoed within my mind.

Sometimes Tommy would feel insecure and unsafe in our silences, but only occasionally could he talk about his discomfort. At other times he was evidently peaceful and contented as he lay. "I like the sound of the radiators", he once said as the warm water slurped its way through the central heating system. What was the source of the apparant comfort in this sound? Was it an unconscious memory of maternal sounds heard while still in the womb? That may have been the only time he had felt genuinely safe and protected - his mother had said on several different occasions that, before he was born, she had never wanted yet another child. Whether the sound of the radiators was a memory of foetal security or provided the consulting room with a measure of inner comfort is not especially relevant - but it was around this time that I started noticing the sounds made by his stomach.

In Tommy's case my own anxieties and mixed feelings at his silences were a factor. Certainly I felt on occasions that it was an encouraging sign that he was able to *not* talk. His superego, in the guise of father's voice, expected him to "get on with the therapy" and would criticise him

for being "stupid" or "thick" and certain remarks would be preceded by advance censure, such as a perjorative "silly". Or perhaps other remarks would have been so denounced internally that they would never be uttered at all. Later, when Tommy was able to become slowly more aware of needs and wants that were not being met, these comments would come to be described as "demanding"and "it's pointless". I felt "hungry" and "needy" were not available words in his internal vocabulary, only "greedy" and "demanding". But there have also been many silences when I have wondered if it was *my* fault, my failing that I was not facilitating the flow of words. It seemed to be obvious that, consciously, Tommy desperately wanted to talk, but so often the barriers, the fears, the mistrust (all of which he hated himself for having) would prevent him. "There is so much I want to say, I could burst - but I just can't talk", he once said. But more often those words would be replaced with silent tears - and, I began to realise, by noises from his stomach. As I listened with increasing awareness, the irritations and anxieties which I had been experiencing receded. I heard that these noises varied and that they had a communicative expressiveness all of their own. But was my focus of interest merely grasping at something tangible in the silence? An indication of communication where there was otherwise none - a relief for my anxiety or irritation? It was a dilemma; but after thinking about it I felt that it seemed legitimate intervention to move tentatively towards verbal responses. "I do understand how difficult it is for you to talk, but at least your tummy has a lot to say", might have been a comment. Or: "Your tummy seems to be saying that this is a comfortable silence" or, after a particularly complex rumble: "Hmmm! That was quite a comment! I wish I spoke tummy language better". In the old folk tales and myths it often happens that the wish that is unwittingly spoken is unexpectedly granted. In my case it was granted obliquely and in a way I am sure I did not mean had I really been meaning to wish. My own tummy started communicating in response. And this enabled me to introduce more actual words into our silences and into our one-sided or burbled conversations. I also noticed that many patients' tummies make audible noises; that the timing was usually significant and that I could make a response which in most cases appeared to have positive results.

Many people find it difficult to allow space for play in their lives. Where patients are concerned the psychotherapist may all too easily forget the importance of playfulness in the process of their therapy. Enforced play is not play, but without some encouragement the child within may never dare to come out of hiding. It is not easy to spot a camouflaged, tentative

invitation to be playful; it is a delicate matter to find the middle path between, on the one hand, imposing something lighthearted on the patient and, on the other, waiting with analytic correctness for certainty and confirmation before responding with a touch of levity. A rumble from the stomach can be an entry to that middle path and a playful tone of voice legitimate in the comment - particularly if the therapist's tummy has responded already.

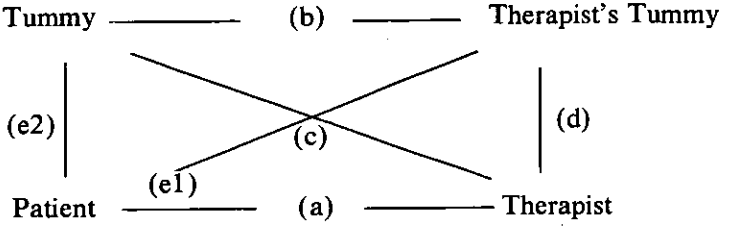
Medically these stomach rumblings are known as borborygmi and (in spite of the name) are perfectly normal. Indeed there is a generally unnoticeable level of continuous muttering in the healthy intestine as fluids and semi-solids are gently pushed on their journey, nutrition absorbed, waste matter moved along. It is when too much or too little food is ingested that the intestinal contractions become more audible, or when tension or anxiety are present - needs or greeds perhaps - that the body may start communicating in its primitively simple and yet so subtly sophisticated way. Borborygmi may be looked upon as audible psychosomatic statements.

Tommy's brothers and sisters were generally given preferential treatment at home. As a result, Tommy has, on one level, a smouldering dislike of his siblings. He cannot entertain this feeling consciously, because holding the tension between hate and affection in the depressive position is, as yet, too painful. But the feelings are able to be explored in the transference and in relation to the analytic siblings. On one occasion, a session when Tommy has to lie down on a warm couch and under a warm cover, he asked: "Have you ever thought of having two blankets?" In the context, I felt this to mean that he would prefer me to alternate two blankets. Now, in retrospect, I feel he was saying that I should have one blanket for him and another for everyone else. At the time I responded: "I think you're telling me how much you dislike feeling the warm presence of the previous patient". There was a silence, followed by a barely audible: "Mmmm". I paused and waited, but he was not going to say any more. "I feel there are a lot of much stronger feelings behind that mmmmm", I ventured. And quick as a flash came the response - from Tommy's tummy: "Rumble, grumble; squergle gurgle squeech". Later in the session I was able to make an interpretation of this intestinal response and suggest, in words, what he may really have been feeling.

At one somewhat depressed and despairing time Tommy commented with a sigh: "I have nothing to say". Tummy thought otherwise - and said so, quietly and without protest. "That was a mournful little noise", I commented. "You seemed to be saying: I wish you'd appreciate my worthless words, if only I could speak them". Another occasion was at

the end of a session, a moment which Tommy finds difficult and which he seems to make into a clean-cut ritual of separation. It had been a more verbally interactive session. As I was about to open the door, tummy made quite a definite and expressive statement - uninhibited protest at the fifty minute boundary. Another patient, after saying something which seemed to hide more than it revealed, was betrayed by her stomach. My reaction commenting on this produced a wry chuckle and a confession that she had indeed been thinking of something rather different - a somewhat uncomplimentary thought about me.

Sometimes a diagram can clarify and simplify where extra words would only obscure. A useful one was employed by Jung in his difficult but profound paper, *The Psychology of the Transference.* (In CW. 16). There he discusses the archetypal levels of the transference process, using alchemical symbolism and the illustrations to the *"Rosarium Philosophorum".* He refers to the hermaphrodite as the goal of the *opus,* to adepts and to the *soror mystica.* The diagram shows the cross-complexities of the transference relationship. It was used eloquently in the 1988 Jungian half day conference on "Supervision". Here I use it to illustrate the non-verbal communication discussed in this paper.



The diagram shows the lines of communication that are possible; from direct, verbal patient/therapist interaction (a) to the incomprehensible, perhaps even unnoticed intermurmurings of the two tummies (b). It includes the psychotherapist's inner questioning of what the patient's tummy is saying (c) and why his own might be responding (d); and it allows for the patient's similar curiosity (e1) and (e2).

It may be helpful to look at this phenomenon in terms of projective indentification. When a patient says he feels that the therapist is angry, we observe a projection which normally can be discussed or analysed. When a patient believes the therapist to be consumed with wrath, indeed *knowing* this to be true, and when the therapist experiences an extra-ordinary, unexplainable anger welling up inside him, then projective identification is occurring. Hopefully a little bell rings somewhere in his

psyche; he becomes aware of the dynamic which is occuring and realises that this projective mechanism needs delicate and more careful handling. Referring back to the diagram, when the patient's tummy rumbles and the therapist's tummy responds - interaction (b) - there is a mutually primitive or unconscious communication occurring. In some respects this is an example of the benevolent aspect of projective identification, what Jung described as *participation mystique.* It can be seductive and dangerously comfortable. But if the therapist uses interaction (d) to examine what his own tummy rumble (or mysterious feeling of anger) is about, then he can use interaction (c) to consider the patient's tummy rumble (or wrathful outburst). This will enable him to make an interpretion to the patient - interaction (a).

However, as I obliquely hinted earlier, it is not impossible that, in Tommy's case at least, this paper is actually about *non-communication.* The fact that he is "unable" to come five times a week (which I feel would be desirable), does suggest resistance. The intestinal noises do not offer definitively understandable sense and they may be revealing Tommy's desire to destroy or evacuate any words which might interfere with a potentially blissful silence. The alternate extremities of an apparantly eloquent intestine are quite capable of uttering either vomit or faeces. There are times when Tommy - or at least one part of him - is entirely comfortable in the silences. He feels safe, contained and nurtured; we are in a merged oneness. Words, leading the way to analysis, threaten this. It is almost as if words are like siblings, who get between me and him, between mother and child. Is Tommy wanting to communicate? Or is he trying unconsciously to destroy communication? It is a dilemma, not only mine but also his, for it is evident that he feels some sort of conflict between the two. My feeling (my gut reaction perhaps?) is that the balance points more towards communication than not. Certainly with all other patients where I have reacted to stomach noises there has seemed to be a desire for communication, but an inability to use words.

Of course one can say that we are merely examining yet one more form of unconscious communication. For "tummy rumble" substitute "body language" - a squirm in the chair, eczema, habitual gesture - or parapraxes or any of a host of phenomena we meet daily in our work. It is not my intention to suggest that a patient's intestinal gurgle is in reality the voice of the *soror mystica,* merely to hope that something ordinary and unsensational is not overlooked. And if one agrees that it is good practice to try to use words that the patient uses rather than one's own normally preferred alternative, perhaps there is an argument for responding to, or even with, somatised communicative rumblings.

Sometimes a tummy can in no way be overlooked. One particular patient, having waited for the incumbent analytic sibling to leave, came in and lay on the couch. It was only a short silence which preceded borborygmi of behemothian proportions - totally unexpected. There was a mighty burbling and a liquidly rumbling tattoo which rose to a crescendo before cutting off with a squelch. "I wonder if your tummy is saying you are not happy about something" - I made the interpretative understatement of the month. With hardly a pause, she almost shouted: "I can *smell* the last patient" - she was close to tears. Her anger had come near to the surface; our interchange helped subsequent gradual acceptance and expression of it over following months.

Tummies do not always register protest or create camouflage. After an interchange of actual words, which evidently created some security and trust, Tommy was able to recount a dream. He had dreamed it several weeks previously, but something in our discussion had enabled him to remember. It did indeed fit with what we had been talking about and I felt I was able to make some helpful interpretative comments. Tommy was silent, but tummy said: "Glip-glop". It felt like a friendly remark and I translated it silently to myself as: "O-kay" or "That's right".

This paper focuses on primitive, non-verbal communication and much of the material considers only one patient. Intestinal noises can be seen as a particularly interesting form of body language which seems to have more potential for interpretation than do mere bodily getures. In one case it exists in the middle ground of the conflict between, on the one hand, the desire to communicate and, on the other, a need to feel held and nutured in the comfort of silence. There may well be also some form of projective identification being enacted. An attempt or invitation to be playful seems to be being offered - or at any rate there is an opportunity to offer playfulness in return. However, we must not disregard the possiblity that the phenomenon could actually be an anti-communication, a destructive evacuation. Whether the latter is true or not, the tummy is certainly making some sort of statement, using its own idiosyncratic linguistics. But without the unwritten "Analytic Dictionary of Stomach-English: English-Stomach", it is left to the psychotherapist - hopefully with help from the patient - to become the official interpreter of this particular language.

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EMERGING FROM THE NARCISSISTIC SHELL

Noel Hess

This paper describes two and a half years psychotherapy with a young man, whom I shall call Mr C. The purpose of the paper is to describe the complex interplay of narcissism, sexuality and phobic states in this patient which locked together to form an organisation of the self directed towards pseudointegration and pseudocohesion, and the avoidance of pain and discomfort. I will describe the course of his therapy to date in detail, in order to demonstrate how this complex organization became unveiled, how it shaped the course of the work, and how it has led to a tentative investigation of underlying anxieties of a more primitive kind.

THE PATIENT

Mr C. a single man in his late 20's was referred by his GP to a Psychoanalyst and thence to the BAP as a training patient. His presenting complaint was a severe and incapacitiating phobia of crowded places: he became panic-ridden when travelling by tube and when entering busy shops. These symptoms had been present for a few months, though he had a similar episode three years before, which lasted for a few weeks and then abated.

My initial consultation with Mr. C. was prophetic of things to come: he did not turn up. He phoned me, apologising profusely for 'oversleeping', and a second interview was arranged. Mr. C. conducted himself throughout the interview with an air of masterful control. He spoke in an aloof, apparently thoughtful but clearly well rehearsed manner, telling me about his recent panic attacks, though nowhere was the crippling reality of this experience present. He is the younger of two sons from a Northern working-class family, his brother being four years older and married. Mr. C. had come to London to go to college, and now worked in the City. He also informed me that he had been hospitalized for surgery to correct a squint at the age of 18 months, and again at 3 years of age. He had had a relationship with a woman, Jane, for a couple of years when he first came to London, but always believed he was homosexual, and had been living with his boyfriend for the past few years. His 'gayness' was mentioned as if as a barely interesting or relevant aside. His mother had been depressed when he was born; father was described as a rather grey

This is a amended version of a qualifying paper for Associate Membership of the British Association of Psychotherapist.

and withdrawn figure, mostly emotionally absent from the family. Although he spoke about is parents at some length, his words allowed me only the vaguest outline of them as people, and implied that these figures from the past had been largely disowned. My atempts at interpreting his underlying and unspoken anxieties about engaging in psychotherapy - evident from the previous missed session - were politely listened to but treated as a minor interruption to his carefully thought-out exposition of himself.

Mr. C's. appearance impressed me in a way that his words did not: he was a short, slightly built, sandyhaired young man, dressed in a drab grey suit that appeared too big for him. Though in his late 20's, he had the air of an anxious and uncertain schoolboy, struggling to don the mantle of masculinity and maturity and which, like his clothes, was rather ill-fitting. He spoke in a formal, precise, superior and rather artificial way, with not a trace of what I assumed to be the accent of his parents.

Although my patient presented himself with what appeared to be straightforward neurotic distress, I was aware of a number of other things from our first encounter: that I would be required to fit in with his need to be in charge; that I would be under great deal of pressure not to disrupt or unsettle him; and that somewhere not far beneath the facade of aloofness and superiority there lurked a feeling of sadness, drabness, even anonymity, that could not be spoken out.

THE TREATMENT

'Therapy' duly began, and often in our first year this had what I now see as a rather two-dimensional quality: Mr. C. dutifully attended sessions, spoke in the required manner, and I made the required interpretations, and with little sense of a real emotional contact. Much of the time my presence and my comments were idealized, which served to keep me at a safe distance and protected from his frustration and hostility. Occasionally, more genuine feeling emerged: he was initially very disturbed by lying on the couch, which reactivated memories of his time in hospital as a child, with his eyes blindfolded. "The nurses told me my mother was just outside, and when I realised they'd tricked me, I was furious. It was supposed to be a 'charitable' place", he snarled, with barely-concealed rage at being abandoned on the couch in such a helpless and humiliated state.

I soon realised that such an outburst of true feeling was felt by Mr. C. to be a toxic and dangerous event, and was quickly dealt with: his narcissism came to the rescue, and my consulting room was taken over: the furniture in the room was assumed to have been chosen specially for

him, he was my only patient, and he and I were united together in a magical and idealized bond.

Excitement was a feature of the therapy, as well as anxiety, and he often seemed somewhat excited by the analytic situation. This also functioned to cure him of inner despair, loneliness and abandonment. Shortly before the first Christmas break, during a weekend, he went to a public toilet and picked up a man to have sex with in a nearby park. He reported this to me rather blandly, though I was aware that my reaction was being quietly but excitedly monitored. As well as this, my countertransference feeling were mostly consumed with a sense of the risk and danger implicit in what he was telling me. As long as this sense of dangerousness could be split off and evacuated into me, it would leave his excitement uncontaminated by worry. I understood him to be telling me that if I did not continue to function as his exciting toilet mother over the holidays then another man would be found to do so, regardless of the risk. This was the first of a long and complex sequence of acting-out that became a crucial and integral component of this man's treatment.

His phobic symptoms disappeared after a few months; that this was a transference cure and linked with his anxiety about separation became apparent when he had a panic attack on the tube the day after I announced the dates of the first break. He also told me around this time of a recurring nightmare of being smothered while alone in bed. This, coupled with his panic attack gradually alerted me to the bipolar nature of his anxieties about space: a claustrophobic anxiety of being smothered by an invasive degree of closeness, and an agoraphobic anxiety of being alone and abandoned in a vast, empty, boundaryless space.

Around this time Mr. C. reported seeing the film 'Dance with a Stranger', in which a glamorous and seductive but unstable woman leaves her dependable but dull husband for a feckless young racing driver, who initially excites her but whose promiscuity finally provokes her into shooting him. In reporting this, he described how vividly involved he felt with this story, and how he felt a complete identification with this woman and found her violent solution to her dilemma perfectly reasonable. I interpreted that he feels his whole therapy to be a dance with a stranger, and that when this stranger has an identifiable shape it is of a promiscuous and untrustworthy man who excites and frustrates him, picking him up one minute and dropping him the next, and that this gives rise to violent and desperate feelings.

I also suspected privately that this anecdote allowed us a glimpse of his own Oedipal scenario: of a seductive but disorganized mother who turns away from her grey and withdrawn husband in favour of her young son,

for excitement. And that this son's private sexual activity is meant to have, at least in phantasy, a very provocative effect on mother. In one sense, the notion of 'Oedipal anxieties' for this patient seemed wrong, as there seemed to be no Oedipal situation to negotiate or struggle with: mother, it seemed, was always available to be possessed, in fact hungry for her son's attention, and father had been easily pushed out and triumphed over. He told me how his father had always been a poor reader, and Mr. C. as a boy had worked hard at developing his language skills and reading ability to a high level. The impression was that he could then parade about the home displaying his verbal potency and exciting father's envy. It is still very difficult to know if a father exists in his mind who has capacities that are desired or envied by his son.

I was subjected to the same triumph and contempt during this period of the therapy. It was most apparant in his response to my interpretations, often taking the form of a condescending but distantly encouraging pat on the head ("Um..not sure if that's right..but you're on the right track") and also evident in his awareness of me as a student being educated by my patient. Occasionally, his aggressive superiority was more overt: "Not all that Freud stuff again", he'd say in a tone of weary dismay. He would regularly get drunk at weekends, and on one weekend when drunk, told himself triumphantly "I'm never going to see Mr. Hess again". The conscious affect accompanying this was enormous relief, and any attempt I made to interpret it as perhaps also the scream of terror from an abandoned, blinded child, alone and in the dark, fell on deaf ears.

I want now to present detailed clinical material from a session towards the end of the first year, to illustrate this patient's narcississtic object-relating, its defensive functions and how this was enacted in the transference. In the Monday sessions of this week, Mr. C's aloofness from me had been unusually vivid and overt, and had resulted in his sleeping on the couch for 10 minutes near the end of the session. I felt, but did not interpret, that I was being made to feel and tolerate being excluded from his mind, and that he was seeking refuge in another state of consciousness that was calmer and safer than having to think. I also felt, at the end of the session, that he was rather shaken by so obvious a loss of control. He phoned late that evening to cancel the next session. He arrived for the third session of the week early (unusually), and began straightaway by speaking in his usual voluble, pressured way, filling up the time and space of the first half of the session with his unstoppable flow of words. He began by apologising for cancelling the previous session, saying that when he phoned me it was late and he was "a bit drunk" and he didn't think he'd be able to get up in time for his session the next

morning. In fact, he did wake up in time, "so it was a bit shortsighted of me". He went on to say that it was probably inconvenient for me to have the session cancelled at such short notice, but it was also embarrassing for him "and kind of self-destructive". Maybe it had something to do with the Monday session when he was "half-asleep" and couldn't listen to me properly. In fact, after that session he couldn't face going to work, and returned home to sleep.

A short silence followed, the function of which I felt to be to act as my cue and nudge me into action. When I remained silent, he continued talking saying that he was probably so tired on the Monday because his parents had stayed with him that weekend and it was all a bit hectic. Actually, he added tentatively, on the weekend he had gone to a gay nightclub with friends and taken acid and the next day had fallen into 'a really deep sleep - like being unconscious'. He wondered if I would interpret his drugtaking as a way of getting back at his parents, but really it was a sign that he felt more confident and independent.

Given this flood of words, I was in a familiar state of mind of not knowing what to interpret. I was angry and alarmed to hear of his drugtaking, and aware of the lack of anxiety in my patient about this, but most of all aware that my reaction to his illicit nocturnal activities was of some interest to him. I therefore chose to say that it seemed he was quite worried about what effect his activities had on other people, and that this was true for both his sleeping on the couch on Monday and for taking drugs under his parents nose, as it were. These activities were clearly exciting, but afterwards he seems to be afraid of how other people were effected - both his parents and me -and this could not be faced, so sessions were cancelled. He agreed with this, saying that he did recall actually going to sleep on Monday, and that it was the first time he'd felt really out of control in a session. "And something about the session felt sort of unreal - like I was here but not here". He went on to tell me that his parents seemed older and frailer, and this alarmed him, and his mother had become partially deaf so tht he was forced to shout at her to make himself heard. After a short silence, he went on to say that often when I spoke, its as though I'm talking about someone "who is like me but not me". Though I well recognised this phenomenon, I wondered privately how, or if, it was possible to gather this "other person" into the consulting room. I also felt that my patient was drifting away from me, becoming encased in a shell of apparent deafness. I said that I was forced to shout to be heard as it seemed that he needed to be deaf to is own anxieties about himself and to something quite self destructive. He replied that he felt like that on Monday too - out of contact, not just with me but with himself.

And that he also felt "terribly unhappy". I was reminded of his earlier comment about being shortsighted, and interpreted that he was telling me how terrified he was of being left alone, especially when it meant being alone with something out of control and self-destructive inside him like a tiny child in hospital with no one to see or hear his worries for him. He seemed surprised and affected by this, and said quietly but genuinely that that was how he felt, and that after the Monday session when he went home, he felt frightened and was terribly relieved that a friend was in the flat. "Just to know that he was there felt better".

I think this session illustrates a number of mechanisms this patient uses to deal with psychic pain: the first half of the session is taken over, such that the patient is in possession of the session and of the therapist (sometimes this is a calm and absolute possession, sometimes a frantic and desperate possession), and the therapist is made to stand being subjected to this. This is an apparently benign but actually quite subtle and insidious kind of aggressive turning away from help and understanding and from his own needs that is more overtly demonstrated in his falling asleep on the Monday and in other forms of acting out. This in turn gives rise to anxiety and guilt that the source of help has been damaged by this neglectful and aggressive activity, which is manifested in the telephone calls to see if I am alive and in pressure on me to speak in the session. It illustrates how reality - both internal and external - is twisted and perverted by the use of drugs, alcohol and sexual excitement so that the reality of his own needs and of his parents age do not have to be faced. Mr. C's. identification within the session with a damaged mother who is remote and inaccesible is also vivid here, so that the therapist is made to feel like a small boy who has something important to say but cannot be heard. This unwelcome and troublesome part of the patient is evacuated into the therapist. The psychic cost of this relative security achieved through encasement and inaccessibility is isolation, loneliness and terrible unhappiness; in fact, being left alone in a kind of sleep of death.

Up until this time, I had gained no real understanding of my patient's sexual self. He kept this firmly apart from the sessions, behaving often like a pseudocompliant schoolboy eager to appease a difficult teacher. When the issue of his homosexuality did come up, it was regarded by Mr. C. with an attitude of pseudo certainty as though it was beyond question and beyond investigation. It seemed to exist in some terrain beyond psychotherapy. I think this pseudo certainty was a necessary facade to prevent something vulnerable being probed, interfered with or taken away. My response to this was to be equally wary. Despite this, his homosexuality did come into focus during the second year, partly as a

result of a change that I suggested in our times, from morning to evening. Although this was a change that he had repeatedly requested, he was very alarmed when I suggested it, as it meant that instead of the sober-suited serious-minded young man, I might catch a glimpse of his nocturnal self, a self associated with alcohol and drug abuse and sexual excitement. As this emerged, his pseudo certainty about his sexuality began to visibly crumble; beneath it lay a sense of considerable confusion and fragility about himself, which his adoption of the identity of "homosexual" in adolescence was meant to cure him of. It also had many other defensive functions in his object relations: it protected him against the anxiety of penetration (his preferred sexual activity being mutual masturbation) and kept a safe distance between himself and his objects of desire, without the risk of intimacy or deep involvement. He told me on one occasion about his only sustained heterosexual relationship, with Jane, with whom he was clearly deeply involved and with whom he found intercourse deeply satisfying, but while with her he had pursued his homosexual involvements, as a means of modulating his dependence on her and to keep something exciting for himself that he could control. When she finally left him for another man, he found to his horror that his protective shield of homosexuality failed to ward off the pain of abandonment. It was at this time that Mr. C. experienced his first panic attack, which he described as "like a fit" - he collapsed in the street with blurred vision, the link with the earlier trauma of hospitalization was clear, though at this stage it could only spoken about as a past event. The other aspect of his relationship with Jane of importance is that in one session he told me how wary they both were of penetration, but that after a period of cautious experimentation they both felt at east with the intimacy of intercourse, and then Jane was able to move onto another man, whom she married. This was a major injury for him, not only in terms of the jealousy it evoked, but because he felt he had been "used like a dildo" - that this woman had taken over his penis, appropriated it, used it for her own gratification, until it could be discarded. This, I think, illuminates the compulsive nature of his homosexuality - as a means of frantically reassuring himself that his penis is his own and he'll do what he likes with it.

His fear of being possessively taken over by me soon emerged in the transference. On one occasion I referred to him in an interpretation as "my patient"; he became quietly enraged and missed the next week's sessions. I discovered when he returned that he had heard these words as meaning that he was now a part of me - my dildo -presumably to make me feel complete. Missing sessions thus became a crucial way fo reasserting his separateness and independence.

This struggle, which dominated most of the second year, is also reflected in a dream he brought at this time: he had been given a gun, he did not know what to do with it, and he was excited by it but frightened of it. His only association was to grudgingly suggest that he "supposed" the gun was something to do with a penis. As this dream was brought at a time when he was missing sessions and expressing serious threats to leave treatment, I interpreted that a gun was being aggressively pointed at me and at his therapy and could well go off if I did not fit in. In response to this, he told me of an occasion just before the recent onset of his panic attacks when he had been having sex with his boyfriend and was alarmed to discover after ejaculation that his penis was bleeding. The gun, it seemed, had gone off and someone was in a damaged state. The dream and his associations also conveyed his fear of being damaged if he allows himself to become closely involved with me.

As I have described, missing sessions became an established means of ruthlessly dealing with his dependence and of shaking my complacent belief that 'my patient' would always be there.

This struggle emerged in the transference, partially catalyzed by external factors. I was forced to move my consulting room for three months to a different location, and as this was a room in a private flat, Mr. C. assumed it was where I lived. He felt seduced and tantalized by being invited into my private territory. He felt invaded, complaining that "no neutral space exists anymore" and that he could not now keep "a proper distance". He made it clear that he could only tolerate my presence if I was "just a vague outline" or "sort of a phenomenon - not a person", and the fact that this newly personalised setting added unwanted details to that vague outline resulted in me being experienced as tantalizing and intrusive. This was partly a projection of his own wish to be intrusive, and partly also a result of his curiosity about me being excited and frustrated. Any attempt I made to interpret his fear of his own intrusive curiosity met with a flat denial.

The anger and fear of what he felt exposed to drove him to gross acting out: sessions were repeatedly missed and a campaign was begun to force me to agree to reduce his sessions. When he did attend, our work had a stale and sterile quality, with little room for any creative contact between us. This was linked with the sterility of the homosexual couple, a sterility he often complained of, but was also a source of some comfort to him. He often compared the closeness and aliveness that he perceived in his heterosexual friends with the distant, companionable but stale quality of his own homosexual relationship. On occasions he could acknowledge how consciously envious he was of this creativity and intimacy that was

denied to him, though it was usually hidden beneath an attitude of contempt for ordinary heterosexual life. He often spoke of "Normal Norman - a wife, 2 kids and a mortgage" - a figure equated with the therapist who is openly despised and mocked. Similarly, his parents sexuality was dismissed as "mindless reproduction", and he claimed it to be a "mystery" why having two children could have been felt to be fulfilling to them.

However, this defensive contempt grew increasingly shallow, and did not entirely protect him from feeling that something was missing in his sexual life, nor from the envious attack on me and on our joint work when we were occasionally able to form a creative couple and do some useful work. A pattern began to emerge whereby if some new ground was covered, the next session was missed. When I detected this Negative Therapeutic Reaction I interpreted that a good experience gave rise soon after to a violent hatred in which a voice exists inside his mind that asks why he has allowed himself to be put in such a helpless and humiliating position and that it results in a need to sever any creative link between us. To need help and to relish it and to value the provision of it is to put oneself in a position of infantile helplessness. To my surprise, he seemed to know what I was talking about: it made sense to him and became a discovery that he often returns to. As he said "I know that I hate it when you talk about creativity, especially here. I thought it was something I didn't need....I guess its an awful shock to find out I do".

The acting out however, continued. The campaign to reduce his sessions to once a week became more tyrannical, such that when I did not agree, he only attended once a week. I felt angry, helpless and hopeless, all of which I believe I was meant to feel, while at the same time I was aware of being carefully monitored to see how I dealt with this state of mind. I believe that I was required to feel and stand these projections without being paralyzed by them - that is, to think about it rather than collapse into a depressed state, as mother had done.

Interpretation of what I felt to be happening did not resolve it; words were no substitute for the gratification of discharge and enactment. The campaign was accelerated and he missed a month's therapy without contacting me. I felt subjected to a sadistic omnipotence in which all need and dependence was evacuated into me - if there was no patient for a month, it was assumed to be only a problem for me - and I was made to feel like a helpless and tormented child, alone and in the dark. Finally, he returned after I had written to him, spelling out firm limits. He appeared blandly unconcerned about the missed month, though I felt it was a relief to him to discover that I could stand this cruel attack on my work. This

was very much a time in which **standing** took the place of understanding.

Any attempts I made to interpret his guilt at something that was needed being so neglected and damaged met with little response. I slowly became aware of how skillfully he would invite me to attack him for his destructive acting out, thereby easing his guilt by converting it into a masochistic excitement and drawing me into a cruel interchange with him. When I understood this, and recovered some neutrality, it became possible for Mr. C. to himself discover the guilt he does at times feel at subjecting his objects to a cruel knife-edge of uncertainty and neglect which causes them to collapse.

He told me how his evening language class had "folded up due to poor attendance", and now he missed it, and that he believed that his mother had become depressed as he was "too difficult to handle" as a baby. This depressive anxiety was also expressed in terms of an awareness that something drab and dreary exists inside him, and that if everything is kept lively and exciting and uncertain then the drabness is kept at bay. This is also associated with a dread of sameness: when he spoke about being able to go shopping without his phobic symptoms, it was with a sense of profound disapointment: his self idealization had temporarily dissolved, and it left him just the same as everyone else.

The panic attacks returned during the summer holidays at the beginning of the third year, and Mr. C. seemed quite relieved at the commencement of therapy. This relief was because therapy was now seen and used as a sanctuary away from his phobic terrors. The conditions that determined this experience of therapy as 'a safe place' were as follows: that his frightened and confused self could be projected into me and disowned; that he could retreat into a narcissistic relating so that therapy became "just talking aloud, working things out for myself"; and that he felt under no pressure to think. If I dared to challenge these stringent conditions, then sessions were missed and the ongoing existence of therapy threatened. Despite his attitude of bland disinterest, it was apparent that he was quite incapacitated by his panic attacks. Travelling on the tube was a daily source of overwhelming anxiety. Though he spoke about his anxiety, it seemed to exist somewhere in the middle distance. As I began to interpret how he was using the therapy to create a safe shell around himself, he began to have panic attacks on the way to sessions, and the phobic transference came a little closer to the consulting room.

He then began to describe a sense of impending crisis and catastrophe: "I feel something is going on" or "something is going to happen - something horrible". I became aware from his behaviour in sessions that I was felt to be the phobic object: he would rush into my room in an

anxious state, too afraid to look at me, establish himself on the couch, talk in a way that often excluded the possibility of any real relating and then rush out of the room at the end, again too afraid to look at me, as though fleeing from something awful. He conveyed to me that all was well as long as I only echoed back his own words and only functioned as his shadow - as long as I did not think for myself and did not have a separate existence. This was felt to be catastrophic.

The link between his phobic state and his homosexuality emerged when he had a panic attack one evening with a female friend who invited him back to her flat: he felt trapped by her and under pressure to be sexually involved with her. Her flat assumed the dimensions of the inside of her body which trapped him, like being underground in a tube train. My consulting room assumed the same significance, such that on one occasion when a rare and detailed exploration of his sexual anxieties took place, resulting in him missing the next two sessions. I had become a suffocating sexualized mother who trapped his penis rather than containing it. His explanation of the missed session was "I just didn't want to go through all that fucking mess again".

It was my impression that any close engagement is felt by Mr. C. to be literally a fucking mess, in which he becomes trapped inside a sexualized mother and in which part of himself is taken over and lost. It was then possible to interpret his fear of being trapped inside such a maternal space, alongside his rage at this maternal space daring to have a separate existence from him. As this could be interpreted and understood, and not without considerable resistance, his narcissistic relating did diminish in intensity and urgency. He also came to the discovery himself that he experienced genuine difficulty in **using** his therapy. He said "I know that I want to be here, even that its vital for me, but I dont know how to use it when I'm here".

As can be seen, he is now more aware of and at ease with his own dependency needs, and also more aware of the existence of a therapist, with the seeds of concern that such a therapist might feel somewhat neglected or abused by his way of conducting himself in sessions. There is also a growing and painful awareness of a need for a mother who might be able to break through his defensive armour to understand his anxieties. A dream from this phase of treatment illustrates this. The context of the dream was that he had to go to Oxford for a week for his work, thus missing that week's sessions. When he returned, he told me the following dream: He was in Oxford in an 'olde worlde' pub, drinking with a group of men, when his mother came in, accompanied by his Aunt, and said to Mr. C.: 'come away from here because you're ill. He initially

found this to be an interference, but he knew what she said was true. His associations were that while in Oxford he had drunk heavily, and that his Aunt was someone who had always been ill with various chronic physical complaints. I interpreted the dream as representing his trip to Oxford as a flight from therapy and from the maternal relationship into a defensive world of alcohol and homosexuality which represent archaic ('olde worlde') ways of functioning, and that he relies on a mother/therapist to break through this defensive structure to alert him to the fact that something is wrong, with a reminder of chronic illness that is left unaddressed. The fact that mother could be perceived as **both** interfering and helpful reflects, I think, an important change, in that previously these dual perceptions would have needed to be split off from each other to avoid the danger of ambivalence. Although his phobic symptoms are still present, they exert less of a grip on his life. He has been able to achieve promotion at work and gain more satisfaction from his work. He has also began to cautiously mourn his lost objects, though as yet this is limited to Jane: she is now spoken of as someone who understood him and contained him to some degree, and whom he misses. He has also began to see his homosexuality as a desperate quest for a strong and present father, whose potency could have helped him to disentangle himself from mother.

DISCUSSION

(i) The Narcissistic Organization

Rosenfeld (1964) has described in detail how in narcisistic states, defences against separateness play a predominate part. This organization of the self also defends against dependence, as an awareness of the object as separate brings with it an awareness of ones dependence on it. For Mr. C. dependence was equated with being left in a screaming, blinded and humiliated state, a kind of psychic death which must be warded off at all costs. The narcissistic organization also operates to negate frustration, for just as separateness implies dependence, it also implies frustration. As long as the infant omnipotently possesses the breast, it cannot frustrate him. In this way Mr. C's. narcissistic takeover of the session and of me cured him of the problem of not being able to see me, having to wait for me to speak, not knowing what was in my mind, of holiday breaks and weekends - in other words, all of the normal frustrations of the analytic set up.

I was required to function as part of an idealized bond or as no more than the patient's shadow, i.e. a vague outline that mirrors him and follows wherever he goes. It was not until he came to a realization of the cost of

this form of relating that it could change - that is, that it did not allow for a meaningful use of the object in the form of help or understanding. Winnicott (1969), in differentiating object relating and object usage, describes how an object cannot be used until it is felt to be real and not just a bundle of projections - until it can be seen as separate and independent.

Akin to this is the function of narcissism to defend against the envy aroused by an awareness of the object as having qualities that are intrinsically valued and desired. Joseph (1971) describes a patient whose attitude of aloofness and hollow politeness conveyed a belief that he would depend on no-one, and that the analytic work was kept sterile and stale to protect him from the dependency and envy aroused by real emotional contact leading to understanding. This was most evidence in Mr. C's therapy on those occasions when we were able to form a therapeutic couple, whose activity was not mindless reproduction or a fucking mess, but joint creative work. It is this awareness of a wish for and a capacity for creative work within himself and when patient and therapist are operating together that evoked the envious attack demonstrated by Mr. C's Negative Therapeutic Reaction. As Limentani (1981) has shown, this is also often a response to a painful awareness of the separateness of the object. Rosenfeld (1971) has also shown in narcissistic states where the libidinal aspects of the personality predominate over the aggressive aspects the patient feels humiliated by contact with an object who is felt to be valued, and envy is consciously experienced.

It is worth commenting how external changes introduced by me, such as alterations to the time and place of treatment, provoked intense anxiety and anger in this patient, because they were evidence of my independence from him that he could not be blind to, and because these changes made him aware of his own dependence on a secure and containing environment. It is of interest to add that these changes also helped to uncover crucial aspects of the transference that had perviously remained hidden.

(ii) The Homosexual 'Solution'

As has been noticed by many writers (Rosenfeld, 1964; Stoller 1974; Glasser 1986), a close connection exists between narcissism and homosexual object relations: both operate to cure the self of dependence on the primary object, and of any awareness of separateness and difference, for fear of the humiliation, envy and hostility that this awareness evokes. For Mr. C., as long as mother was kept idealized, she was safe from his hostility, while his homosexual activities enacted his triumph over her and lack of need of women. It also protected him from a

relationship of sustained intimacy with women, which he feared because mother was felt to be intrusively possessive and robbing him of his uniqueness and his sexuality. It also represents an eternal quest for a father and a father's penis which is potent enough to act as a barrier between a vulnerable child and a narcissistic mother, thus aiding a disidentification with her (Greenson, 1968). It is the eternal nature of this quest that gives this version of sexuality its compulsive quality (McDougall, 1972).

Homosexuality was for Mr. C., only a partial solution to this nexus of entangled object relationships. It worked, but at a price : the price being that it left him without the opportunity for a creative and alive contact that he so longed for, and that he had experienced with Jane. His abandonment by her had been a major injury, leaving him terrified and alone, and he thrust himself into the homosexual milieu to make himself invulnerable and to exact his revenge on these seductive and treacherous women who lead one on an erotic dance, awakening desire and need, only to frustrate it.

(iii) Anxieties underlying the phobic state

Mr. C. presented with 'neurotic' anxieties of a claustrophobic and agoraphobic nature: no kind of space existed that could be experienced as containing or enhancing of growth. Close contact with an object was felt to be engulfing and lack of contact was an abandonment. Object relations therefore had to be maintained at a fixed, safe distance. Beneath these anxieties it was possible to uncover unconscious anxieties of a more primitive nature relating to the disorganization and loss of the self. The identity of 'homosexual' was aimed at organizing his sense of himself into a pseudointegral until, so he would not be faced with the confusion of not knowing who he ws. His own discovery of this was an important turning point in the therapy.

This fear of his own disorganization is also reflected in his phobic anxieties. Segal (1981) describes a patient with a phobic avoidance of crowds, for whom the crowd represented a meancing conglomeration of the projected and unwanted bits of the self that threaten to return to hound and persecute the self. This was often apparent in the transference with Mr. C. when he would respond quickly and frantically to my interpretations, as though it was a volley of ammunition that had to be neutralized. This often happened when I interpreted too quickly or too much, so that he felt flooded and overwhelmed, as though by the return of his own words.

At some level, these projected bits are felt to be located within mother's body. To go 'underground' on a tube train is equivalent to entering mother's body and being trapped with the hostile parts of oneself. This implies a mother who cannot contain her own hostility and fears of disorganization and who thus cannot offer secure containment within herself for similar anxieties felt by her infant. These anxieties must be discharged **before** they can be experienced.

Klein (1932) has described the link between claustrophobic anxieties and the boy's fear of being shut up inside the mother's dangerous body, and of how this phantasized dread of not being able to extricate the penis from the mother's body becomes narrowed down to a fear on behalf of the penis. This again illuminates Mr. C's fear of penetration and the defensive function of his homosexuality.

His abandonment in hospital, and being left by Jane, provoked an underlying fear of being left to die. This kind of psychic death is similar to the state described by Khan (1971) as a 'surrender to resourceless dependency'. Although at one level this is a fear of loss of the object, it is also a fear of loss of the self: when projective identification occurs on a significant scale, and when the ego is thus impoverished by the loss by projection of parts of the self, then in such a situation the self is also felt to be lost when the object is absent.

Some useful work has been achieved in this patient's therapy to date. Much important work remains, on issues that have yet to come to light, or that have only been touched on: for example, his complex relationship with his father, involving the reality of father's potency, and the guilt evoked by the fact that father has always occupied such a denigrated position in his mind; the fact of his brother's existence in the family; and the notion, suggested by the gun dream and its associations, that he feels his body to be damaged and thus in need of constant often manic repair. It is as yet profoundly unsafe for him to involve himself in a heterosexual relationship, though he has indicated to me that that is what he wants. What has been achieved to date has been achieved only with considerable struggle. Progress at every stage of his treatment has been dependent on his establishing whether his therapist is robust enough to confront and withstand these painful affects around which he has organized his life in order to evade.

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THE 'MALIGNANT NO' ENACTED

Ena Blyth

INTRODUCTION

This paper is a discussion of the first two years of therapy with a bulimic patient. I describe in detail an episode that occurred after one year, when the patient terminated her therapy. I explore the significance of her leaving, and of her return shortly afterwards, and discuss the transference and counter-transference issues that emerged.

In spite of the wealth of material brought by this patient, and the activity of her life, she conveyed a sense that her inner reality had no meaning either to herself, or to anyone else. This led me to consider questions of identity in my work with her. In trying to understand the complex and often confusing material that she brought, I found helpful the work on identity of Heinz Lichtenstein (1977), and in particular his concept of the 'malignant no'. This is his description for an early failure in the mirroring experience between mother and child, that leads to the inner experience of identity being negated rather than affirmed. I believe that the 'malignant no' is a thread that runs through much of the material brought by the patient, and I shall try to show how the 'malignant no' became enacted between us at the time of her leaving.

The paper falls into three main parts. First, after a brief history, I describe the work up to the time of the patient's leaving. The second part is a discussion of the meaning of her leaving and of her return. In the last part I discuss some of the issues that developed in the year after her return.

HISTORY

Miranda is a teacher. She is in her early thirties, and has an eight year old daughter. She married soon after leaving university, but divorced her husband when her daughter was three years old, because of his affairs with other women. She now lives just outside London, and is active in the social life of the community in which she lives.

Her father - an academic - died when she was in her early twenties. He was a very controlled man, of strong views, who had no time for feeling. Her mother was a journalist, who was often away from home. Miranda was the older of their two children. Her brother, eighteen months younger, she believed to be her parents' favourite.

Miranda's childhood was dominated by her fatness. She describes herself at the age of seven as 'just naturally plump'. But her size, and what she ate, became an issue at home, particularly with her mother. By the time she was fifteen she had become an obese teenager. She weighed nearly fourteen stone (and she is not tall). At about this time she went on a strict diet, and brought herself down to normal weight. Frightened after this of not being able to maintain her diet, she learnt how to vomit after binges. And from the age of fifteen, until just before she came into therapy, she binged and vomitted secretly, almost every day at times.

Shortly before coming into therapy she had a period of behavioural therapy, which had brought the binging and vomitting under some sort of control. But at about roughly the same time a sexual relationship with a married colleague broke up. Because of her distress at this time, she was referred for the present therapy by her G.P.

THE FIRST YEAR

Miranda brought to her therapy the same compliance that she felt she had shown all her life, first to her parents and then to her husband. I had suggested at our first meeting that she might find it helpful to use the couch, and so she used the couch. Her communications were for the most part carefully prepared productions, lacking all feeling or spontaneity. She spoke of having had to develop a mask to hide her feelings, and she brought this mask into the consulting room.

She brought her pre-occupations with what she called her tangled relationships. She did not get on with her head of department at the school where she taught, and felt he unjustly criticised her work. She was resentful of her ex-husband's freedom from the burden of bringing up a child; she wished he would help her more financially. She was jealous of the wife of the colleague with whom she had had an affair. In reaction to his having ended it, she had turned to an old college friend, who was also married, and had embarked on another affair. During the six years of her marriage she had complied with her parents' moral code and had remained faithful to her husband. But since the divorce, she was surprised by the sexual interest she was able to provoke, and surprised too to find that her body was a source of some pleasure both to her lovers and to herself. She had always felt her body was unacceptable. Sex with her husband had been a fairly low key affair.

It became clear that there was a great deal of confusion in her sexual relationships. Though the evidence was that she allowed herself to be exploited by her lovers, she tried to convince herself, and me, of their care for her. She needed them for support and comfort; she turned to

them as to an accepting good father, of the kind she felt she had never known. I tried to help her to see her confusion between sex and closeness, and also to show her how triangular these relationships were. She was able to link her need to involve herself with couples to her feelings about the close bond between her parents, and her jealousy that she had never had the kind of care and protection that her father had given her mother. A sudden insight into the repeating pattern of her relationships - 'like Chinese boxes' - distressed her.

Her relationship to her mother only gradually emerged. She felt that her mother had been less interested in her than in her brother. On one occasion her mother forgot her, and she was left standing on the doorstep when she came home from school. Her mother had often been away from home, or had shut herself away from the children. She had been told that she was a very pretty child, but she was made to feel bad about it because it made her brother jealous, and her mother put her down in order to protect him. It was her mother who had made her feel her body was so unacceptable, who had bought her clothes that did not fit, who had made her wear constricting underwear. But most important of all, it was with her mother that the conflicts over food took place. She was put on special diets, and she was not allowed to eat the good things that were served up at the table. This particularly upset her when she came to realise that her brother was also overweight but was not treated in this way. At mealtimes she was served last. Once her mother forgot to serve her at all.

She had responded to this regime by stealing the food her mother had hidden, and by bingeing secretly. She felt that her parents should have known about her bulimia. They should have picked up the clues and intervened, just as, later, she felt her husband should have done. She saw this ignorance, both on her parents' and her husband's part, as a sign of neglect, of their not having cared enough for her.

I became aware only later that she was setting up a similar situation with me. She was giving me a lot of detail about her relationships to family, friends and lovers, but the purpose seemed more often to obscure than to reveal. For example, it took me some time to learn that a session full of meticulous detail about the people and events of her day at school was often a screen behind which she kept to herself a clandestine encounter with her lover the night before. The wealth of detail that she provided, combined with her controlled way of talking distanced me emotionally, and often I felt that I hardly existed for her.

Only occasionally did her mask of control crack. Once she found herself unexpectedly grieving for the death of her aunt. This was the only person in her childhood who had accepted her as she was, and she died in

upsetting circumstances when Miranda was ten. She had been prevented from attending the funeral and had never grieved for her before.

Fairly soon into the therapy she began to question the need to lie down. She felt uneasy at not seeing my face. She agreed that she needed to watch people's faces in order to monitor their response to her. Without that she could not know what was required of her. She had always done this with her parents. She began to express irritation that I did not initiate more in the therapy, and that I did not elucidate things for her. When I tried to make transference links, suggesting that she might be responding to me as she had to her parents, she rejected them.

She told me she was beginning to feel more vulnerable, and more exposed. She was distressed that she had binged again, the first time for several months.

In a dream she reported at this time - and it was the only dream she brought for the first nine months - she was alone in her own house. It was locked and barred, but she did not feel safe. Then a lot of Chinamen came in. She did not know how. She thought it must be through the window. She was very frightened, and woke in fear. I suggested that she did not feel safe inside herself. I also added that the Chinamen reminded me of the image of Chinese boxes she had used a few weeks earlier at the time of her sudden insight into the repeating pattern of her relationships. Her response to this comment of mine was to tell me something that she had never told her parents: that she had allowed herself to be molested by strange men when she was a child, and that this had both excited and disgusted her. It was her way of feeling someone cared for her. She was ashamed, and had told nobody.

After this she began to see the link between her childhood experiences and the way in which she allowed herself to be exploited by her lovers. She explored with me what these relationsips meant to her, and discovered that they gave her a sense of her own significance. At the same time she put much emphasis on the insignificance of her therapy to her, saying that she was getting nowhere and that I was the wrong person. She underlined this persistent statement by beginning to miss sessions. A pattern began to emerge of a missed session after any piece of work between us in which I felt we had made progress. One such absence occurred immediately after we had worked on her relationship to her lover and she had reached an insight into her need to pay for kindness and friendship from men by having sex with them.

Another theme at this time was the past failures of her parents, and their inability to understand her needs. When I made transference interpretations, she either continued to reject them, or accepted them without conviction.

She went on to stress the uselessness of her therapy and my inadequacy. When I worked with her fear of expressing any outright anger to me for her disappointment with the therapy, she told me she had never been able to be angry with her parents. Her father would have punished her, her mother would have burst into tears. She then told me how angry she had recently felt towards her mother for calling her greedy. In the next session she expressed her 'animosity' to the therapy and by implication to me. She was more spontaneous than usual, and this burst of hostility to me brought back a recollection of her mother's absence when she was a child. She missed the next session once again.

When she returned, she talked about my coldness to her, and said she found talking to men much easier than talking to me. She wondered if this was because she had had a warmer relationship with her father than with her mother. I was beginning to find the transference to her unempathic mother hard to bear. I felt so constrained by it at times and so unable to reach her, that I felt she had put me into a rigid mould, rather like the man in the iron mask. I pointed this out to her, to describe what I felt was going on in the transference. I found that she knew more about the man in the iron mask than I did, and responded positively. She then told me, with surprise and sadness, as though she were seeing it for the first time, how strange it was that her memory of her mother was more a memory of 'gaps' than of presence. And she recalled the only time in her childhood when her mother had singled her out and had given her a treat of her own.

This helped me to see that we had found another meaning to her missed sessions. Through them she was re-creating the gaps in her childhood with her mother.

She was now showing more distress. She had been disturbed by her memories of her mother, and found that thinking of her and, as she put it, 'by extension' of me, made her very apprehensive. She was frightened of losing control, and of bingeing again. And she talked of her fear of being dependent on one person, and how her mother had never been someone on whom she could depend.

She continued to talk about her relationships with men, again revealing her confusion between sex and closeness, and her fears of being let down. Her anxiety increased just before the summer break when she found a new lover, this time a man who was not already involved with another woman. This was her first attempt at a relationship that was not triangular, and she felt she did not know how to behave. She said she had no guidelines; she wondered about mutuality. She became more and more anxious and confused as the summer break approached. And in the counter-transference I began to feel increasingly helpless. During the

last few sessions we worked on her feelings of being abandoned during the summer. She saw these mostly in the context of her fear of losing her new lover. But she acknowledged some anxiety about my coming absence.

On the morning of the last session before the break, she pointed to a bee on the doorstep as I opened the door to her. 'There's a sick bee' she said, 'wanting to burrow its way into your house'. Later in the session she talked about a friend who had once abandoned her on holiday. I used her image of the sick bee to try and reach her fear of being abandoned by me. 'Well, if it's true, it's purely unconscious,' she said firmly.

She was very distressed when she returned from the summer break. The man on whom she had pinned such hopes had rejected her. In her loneliness and distress she had binged again, and that made her feel bad. She talked also about her neighbour's three year old daughter, who had been away from home for a few days, and who had clung to her mother, screaming, most of the day after she had returned. I brought in the summer break and her separation from me, and she said that rationally she could quite understand about my needing a holiday with my family. I said that perhaps there was another less rational response, which was more like her neighbour's child. She then said, 'If I did lie flat on the floor and cling to your leg, I'd be afraid you would boot me away'. The sudden intensity of my counter-transference to her at that moment gave me a new understanding of the intensity of her need and her terror of being rejected.

Miranda was now bingeing more frequently. She felt she could no longer cope with her job or with her daughter. She wanted to be relieved of responsibility, to be 'cocooned', and to have someone care for her. She felt so very greedy that she feared that if she did begin taking things she would never stop. I said I was reminded of a hungry baby at the breast. She then said that she had remembered being told that her mother had not been able to feed her properly, that there hadn't been enough milk. I suggested that she might be afraid that it was because of her greed that there was not enough milk. In following sessions she enacted this fear of her own greed in the therapy, twice missing a session on a Friday at a time that had been arranged earlier at her own request. She became very fearful when I suggested that she might be preventing herself taking what was offered. It frightened her to think she could not take what was given to her.

Miranda had now been in therapy for a year. She continued to explore her acute sense of her own failure and to convey the intensity of it to me in the counter-transference. She was bingeing and vomitting frequently. She felt she had no will-power to stop. She felt all her earlier efforts to

control her eating had been undermined by her therapy, and that her therapy was making her worse.

She was in conflict over whether to continue in therapy, or whether to abandon it altogether. She had always been someone who stuck at things, she said. But to stick at so painful an experience felt like an act of compliance. She was ashamed that she had always complied to her parents and had never, like her brother, had the courage to break free.

I tried to show her that I understood her difficulty in seeing her therapy as something for herself, and in separating that from her struggle to free herself from a repeating pattern of compliance. But I felt I could not reach her. The strong transference to an absent and unempathic mother continued. She felt she was in an empty space with me. My silence, and the fact that she could not see my face, made her very uneasy. She found me impersonal and unwelcoming. She herself maintained this distance from me by being cutting and dismissive of much of what I said. On one occasion I picked up her feeling that I didn't listen to her or understand her. 'Oh, you listen all right' she said, 'because you repeat back to me what I say. But we don't get any further. It doesn't lead to more understanding'.

At other times she felt interventions of mine to be intrusive, as though I was forcing my feelings on her. She found it hard to be angry at the time. But when she reached her anger, often in the following session, and I felt the relationship between us become more directly engaged, she became afraid. She felt very bad about being cross with me, and would frequently miss the next session.

Her attendance was very erratic. I told her that I understood her difficulty in coming, but that she was putting her therapy at risk. And indeed, soon after this, she resolved her struggles over compliance, and the deeper issue of her terror of dependence on an absent uncaring object, by telling me of her decision to withdraw. 'For once in my life' she said, 'I am going to do something for myself.'.

Though she had often talked of leaving, her decision, when it came, took me by surprise. I suggested that she sit in the chair so that we might discuss it. She repeated that she found me unempathic, and that not seeing me and talking to a 'disembodied voice' made her most uncomfortable. I said that was something we needed to work on. She said she knew therapy wasn't easy, but that with someone else it might be better. I tried to help her to understand the strong transference to her mother, and the enactment within the therapy of her need to escape from home. She asked me if I ever saw patients sitting up, and when I replied that I did, she seemed surprised by her own failure in the past to question whether she might sit up.

She had clearly made up her mind. I said that I did not see the therapy as having failed, and that having worked together for a year it would be wrong for us to break off so abruptly, I said I would keep her sessions for her for a fortnight, while she thought over her decision.

The fortnight elapsed without word from my patient, and I took the therapy as terminated. Shortly afterwards, she turned up unexpectedly at one of her session times. She had had a letter from her G.P., asking her to think about her decision. She said she had come to tell me that she had decided **not** to come back. I said once again that I realised how difficult she had found her therapy, and how frightened she had been of coming to depend on someone whom she felt to be so often cold and absent. She replied that what I had said to her in the last session before she left, linking her feelings to her mother with her feelings to me, had made good sense to her. She wondered why I hadn't said it before. I told her that I had. 'Well, not so clearly', she said.

She then said that another of her difficulties was that she was a secretive sort of person. She illustrated this by revealing that she had begun therapy a few weeks before with a humanistic psychologist. She found him very helpful, she said. He believed in catharsis, and got her to express her emotions. I pointed out to her that we had often talked of her need to turn to men in order to avoid difficulties in her encounters with women. She then told me that she was different with different people, and that somehow she was not able to speak for herself. I said that while she was seeking help for her problems from different people, like the humanistic psychologist, as well as from me, she might well have difficulty in speaking for herself. Perhaps the need, in her therapy, was to bring all that together.

By this time she was very much in two minds about whether to come back or not. She then went on to talk about her mother, and her fear that she had made her mother dislike her. She was afraid, she said, of her own destructiveness. I used counter-transference feelings and talked a little about a baby at the breast, and the feelings of destructiveness around that.

By the end of the session she had decided to return, on the understanding that she was not committed to a whole further year, 'though I want to keep the option open', and that she would sit up during sessions.

DISCUSSION: THE 'MALIGNANT NO'

In describing in some detail my interaction with Miranda up to this point I hope to have conveyed something of the unrelenting inevitability

of her rejection of me, and to have conveyed a little of the difficulty I experienced in the counter-transference.

It has been suggested that patients with severe eating disorders destroy the counter-transference (Pettitt 1987). This was not quite my experience, for Miranda did not destroy my feeling response to her. What seemed to be destroyed was its relevance. There were times when I felt we made quite a deep contact in sessions. Yet afterwards it was as though we had not. I began to see this as an enactment between us of the bingeing and vomitting, an interchange in which food was taken in but then had to be rejected. Miranda herself was able by this time to see parallels between her response to the therapy and her abuse of food. She told me once how she had nearly come to the session, and then stopped herself, just as she nearly stopped bingeing, and then couldn't prevent it.

In trying to make sense of the material at a deeper level, and to gain an understanding of the dynamic of the transference to her mother, I have found it helpful to consider Lichtenstein's work on identity. In a series of papers brought together in his book, The Dilemma of Human Identity, Lichtenstein (1977) discusses the links between sexuality and the establishment of a sense of identity. He suggests that an identity imprint - an identity theme - is created for each child in the earliest mirroring experience with the mother, as the child responds to the unconscious wishes and needs of the mother. The over-riding need for the child is then to establish and maintain the identity theme that has been imprinted; this becomes the organising principle for all future psychic activity.

In his chapter, The Malignant No, Lichtenstein suggests that in some cases the earliest pre-verbal experience between mother and child leads to an identity imprint of negation. The child is imprinted by the unconscious need of the mother to deny his identity rather than to affirm it. Relating this to Winnicott's work on the true and false self, I see this as leading not to the 'I am' experience of the true self, but to a false self that hides an identity theme of 'I am only I, if I am not'. Lichtenstein shows what distortions then follow in object-relations and in perceptions of reality as patients of this kind struggle with the impossibility of this theme. They are driven to wrest from all subsequent object-relationships the affirmation that was never received. Patients of this kind feel overwhelmingly negated by the smallest frustrations. They need constantly to provoke primitive responses from others in order to protect themselves from the profound dread of not existing. 'It is not deprivation but loss of identity that leads to murder', writes Erikson (1950).

Lichtenstein suggests that aggression, which provokes fear, and coercive sexuality, which provokes a sexual response in others, are both

ways in which these patients struggle to achieve recognition from others at a primitive level. He suggests that psycho-analysis, a therapy of abstinence rather than gratification, can be too threatening for some of these patients, who instead of feeling recognised and understood feel constantly negated by the therapist and the analytic boundaries. Lichtenstein discusses two of his patients for whom this was so; they terminated their therapy prematurely in conflictual circumstances. For them the inner re-experience of identity denied became unendurable.

Both Miranda's early experience, and her response to the first year of her therapy, point to her being a patient of this kind. I suggest that her inner experience was of receiving a 'malignant no' from her mother in response to all her attempts to create an identity for herself, and that this was repeated in her transference to me during the first year of therapy. Much later in the therapy Miranda found her own words for what I understand Lichtenstein to mean by the 'malignant no'. At the end of the third year, she said with sudden insight 'My mother's needs made her nullify my needs'.

Miranda's early feeding experience was difficult. The evidence points to a mother who was not only not empathically in tune with her daughter's needs, but who wanted to distance herself from her as much as possible. In the therapy this was repeated in Miranda's need to distance herself as much as possible from me. Early feeding difficulties developed into battles over food later. The experience of being either forgotten by her mother, or treated quite differently from her brother, compounded Miranda's feeling of her lack of significance.

I suggest that this was repeated in the transference with me. Her conviction that I was distant, unempathic, a 'disembodied voice' was her projection on to me of her experience of her mother.

It is in this context that I should like to discuss the meaning, as I came to understand it, of her leaving and subsequently coming back into therapy. She herself saw leaving as her first gesture of defiance, freeing herself from the need to comply. It was only after she had left that she was able to recognise the transference to me of her mother. At a deeper level I suggest that she left because she found the re-experience of the 'malignant no' unendurable, and that she needed to put as much distance between herself and me as possible. Finding her way back to me was for her significant. She saw this as entirely her own decision. She felt it was something she had done for herself. She was surprised that she hadn't before had the courage to sit up and face me. I think its transference meaning was that she had at last compelled her mother to look at her. I learnt later how important eye-contact with me was for her.

My counter-transference throughout this episode helped to provide another meaning to the break in the therapy. Winnicott, in his paper 'Hate in the Counter-transference', stresses the importance for the therapist of knowing his own hate and being able to separate what belongs to him from what is his response to the patient. There were times in the few weeks before Miranda left when I was not able to do this. By her rejection of me as a therapist, she put me in touch with primitive chaotic elements of my own unconscious that had not yet been worked through. I was therefore not able to transmute my own hate into creative anger. It could be said that I failed her, and that she left because I failed.

And yet, I suggest, it was in just this way that she was able to communicate to me the primitive and destructive nature of the 'malignant no'. By terminating her therapy, she had denied me in my attempt to create an identity as a therapist. Pearl King (1978) in her paper, 'Affective Response of the Analyst to the Patient's Communications' discusses the meaning of transference roles being reversed. I believe that only by turning the 'malignant no' on me, and thus reversing the maternal transference, was Miranda able to put me in touch with the unbearable nature of her inner world.

I need to stress too the significance in this episode of the letter sent to Miranda by her G.P. Though Miranda herself objected to it, and told me that she was not going to return to therapy in response to it, I believe it to have played an important role in the dynamic. It was a concrete representation of the presence of a third person. It met, symbolically, the need for triangulation at the point where a two-person failure was being re-enacted. The letter represented, I suggest, the intervention of a containing good object into a world of bad objects. For Miranda this was possibly her aunt; for me it was 'a good father', bringing containment and order to the nursing couple, in which the mother had not been good-enough. Kohut (1977) describes the child who uses the father as a mirroring self-object in his attempts at self creation, if the mother fails in her empathic role. This, I suggest, was symbolically re-enacted, as both patient and therapist faced the 'malignant no' between them, and then needed to turn to the father. A two-person failure was symbolically transformed into the creative potential of a three-person encounter.

In trying to relate Lichtenstein's ideas to object relations theory I have found Fairbairn's work on bad objects relevant. I conceptualise the internalisation of the 'malignant no' as the introjection of an annihilating mother. She is the product of all the destructive and chaotic elements that could not be contained by the distant absent mother. Fairbairn writes of the world 'peopled with devils' that is experienced by patients when such

a bad object is released in therapy. I think we can see Miranda's leaving the therapy as a flight from that world, and her return to it the result of having communicated its horrors.

THE YEAR AFTER

When Miranda returned to therapy, she sat up, and for the first week or two, stared at me intently. There was a disconcerting quality to her very fixed look. It gave simultaneously two quite contradictory messages. On the one hand, its inscrutability made it impossible to pick up any hint of what she was thinking or feeling. Yet at the same time her eyes conveyed so intense a primitive terror, that I felt it important not to look away, even though it was hard at times to maintain eye contact.

Later I came to see the contradictions in this stare as reflecting both her terror of the destructiveness of her two-person world, and her defence against it, her world of secrets.

In this last part of the paper I explore how important secrets were to Miranda, and discuss the use to which she put them. I shall describe some of the themes that emerged in the year that followed her return to therapy. In trying to understand Miranda's object-relationships, and the importance of her secrets to her sense of identity, I have found helpful both John Steiner's (1981) work on perverse relationships between parts of the self and Joyce McDougall's (1986) writing on the addictive personality. I hope to show how Miranda found precarious identity for herself by creating a perverse* three-person drama - with all its self-destructiveness - in order to protect herself from the threat to her existence of the two-person failure.

I have referred already to Miranda's revelation that she had been seeing another therapist for a while before she left. At the time she told me this I had felt simultaneously startled, irritated, and curious. This response of mine to the sudden revelation of a previously held secret was often repeated during the next year, as she divulged more of her secrets.

To take one episode: I was working with her on what it meant to her to watch me so intently. Her stare 'locked' people, she told me. She feared she was boring. Her mother rarely looked at her. She hadn't been able to talk to her mother. After this interchange, during which I failed to see how close 'looking' and 'locking' were, she told me suddenly that she was having an affair with the husband of a cousin. Once again I found myself startled. Later, when I came to reflect on the material, I realised that she had used her secret both to provoke interest, and to move away from the experience of not having been seen by her mother, and from the

*I use perverse, as John Steiner does, to refer to distortions of the truth

repetition of that experience in the transference.

This oscillation between needing to be seen, and the terror of being seen - which led to secretiveness - was repeated over and over again in our work. She often spoke of the significance to her of the face, and of eye contact. She underlined this by the potent contact she established with me through her eyes, and the curious counter-transference response it provoked in me. It suggested to me a re-creation of the face that was not there for her - the inscrutable mother - and the terror of the uncontained destructiveness of the baby at the breast. I felt it showed her failure in the feeding encounter to find her mother's face for appropriate mirroring. Later in the therapy this was borne out, as she began to use the limits of the analytic session to re-create an early feeding experience. When I worked with her extreme anxiety at a change in session time, she revealed that she had been a Truby King baby, fed inflexibly to a rigid time schedule. On another occasion she told me she had felt 'put down' by me when a session came to an end. She also said that she had been rushing about before she came, leaving herself no time to digest insights she had gained in her last session. I suggested that for a Truby King baby feeds might also have felt rushed, with no time to digest. She responded by telling me that not only was the Truby King time schedule rigid, but babies were 'put down' immediately after being fed.

A baby who is put down immediately after a feed is denied a time of rich interaction with the mother, a time when mother and baby are very open to each other. Malcolm Pines (1984), in his paper on mirroring, describes the mutual cueing that then takes place between mother and baby, from which the child begins to become aware of who he is, both for himself and for his mother. This is the beginning of the sense of identity, the beginning of separateness.

It seems to me that it was at this stage in Miranda's early development that she failed to find appropriate mirroring from her mother, and that the 'malignant no' became established for her. Having enacted this with me in the therapy by leaving, she now needed my face in order to re-negotiate this early position. And once she had ensured that my face was there for her, we were able to begin working on her secrets.

A clue to the significance of secrets is given by the surprising derivation of the word 'secret'. It comes from the Latin 'secernere', which means to separate.

I began to learn that Miranda used secrets not only in the service of splitting (to separate the good male psychologist in secret from the bad female therapist, for example), but also in order to separate herself from her compliance to her parents.

The two secrets that had been of greatest importance to Miranda in her childhood were her secret bingeing, and her encounters with the strange men who molested her. She felt they were her only escape from compliance, and that they gave her a significance that she could find in no other way. She had felt her parents had undermined all other attempts at autonomy or self-assertion.

During the second year she brought these issues more directly into the therapy, working on the conflicts surrounding both her eating disorder, and her sexual relationships as they were experienced in the present.

I only gradually learnt what her bulimia meant to her, and the shame and self-disgust it caused her. She described the day-long pre-occupation over what food to buy, the foods she could or could not eat, what triggers invariably brought on a binge, and her embarrassment at having to conceal from friends the reasons for her strange choice of menus. On one occasion she told me that she had been pleased the evening before because she had not binged. She had bought a Chinese meal for her daughter. It was not normally food she could eat without losing control. This time she had eaten some, and had been able to stop when she was no longer hungry. She had not needed to binge to finish it all.

As she told me this she became increasingly anxious and self-deprecating. She felt what she was saying was trivial, she felt it absurd to be pleased about so insignificant an episode. She felt diminished in my eyes.

This helped me to see how much her sense of significance, her pecarious sense of identity, depended on the secret world she had created round the abuse of food. She gave up her secrets only with the greatest difficulty. For they were held in place not only by shame and self-disgust, but by her strong drive for an area of autonomy, an attempt to separate herself from the false self of compliance.

I link this to Lichtenstein's exploration of the defences against the 'malignant no'. He writes of the need to provoke primitive responses in others. It suggests to me that Miranda's abuse of food fulfilled this function internally: she used food to tantalise herself, stimulating her need for food in order to feel real. She herself felt bulimia was the only thing she had 'for herself. Without it, she said, she would just disappear, 'be nothing'.

As she struggled, during this second year, to free herself from her bulimia, the nature of her relationships to men became more apparent. The more she tried to stop bingeing, the more she turned to her lovers. She told me a great deal about her need for closeness, and how she depended on her lovers for comfort and support. She was much more

secretive about her sexuality. There was a teasing quality to her communications. The partial disclosures, the sudden revelations, hastily withdrawn, had a provocative quality. She seemed to be trying to make contact with me by exciting me. Once again I felt this reflected an internal world in which secrets were used to tantalise and provoke.

In this context she made it clear that she was fearful of turning to me for comfort and support. She described her feelings for her lover, who was 'like a good father' to her, someone who had 'picked her up' when she was distressed. We were now able to bring this into the transference. She could not trust me to pick her up if she was distressed, she could not look for closeness from me. It would make her feel too dependent.

I now made interventions that showed her how the absent mother, the mother who had not cared for her, had become internalised. I suggested that in allowing herself to be so exploited in her sexual relationships she was not caring for herself, as she felt her mother had not cared for her. I also suggested that by bingeing she was attacking a bad mother inside heself. She was responsive to both suggestions.

In the counter-transference at this time I felt she was in a three-person world, in which she needed me to be an observer of her encounters with someone else. Sometimes I felt I was the mother of her childhood, who had not intervened to prevent her childhood sexuality; sometimes the father, whom she was trying to excite.

By this time she was trying to break free from a sexual relationship with one of her lovers. She was no longer enjoying sex with him, but she found herself unable to tell him what she felt, continuing with him in self-abasing sexual practices, under the conviction that his will was more important than hers, and that she was responsible for maintaining his potency.

As we worked on this addictive relationship, her struggles against dependence in the therapy, and her contempt for her own neediness became more apparent. This was particularly so as the summer break approached, towards the end of the second year.

For example, just before the break, she had been visiting in hospital a friend who had recently had a baby. The baby was screaming. The new mother had not wanted to pick him up because she felt too tired. Miranda could not let the baby scream, so she had comforted him. I said she was also telling me of her fear, that like her tired mother, I would not pick her up when she screamed. Miranda, who rarely cried, burst into tears, saying she thought there was no place for feelings like that. She ought to be able to cope. I picked up her contempt for feelings like that, and suggested that she was finding it hard to come to these last sessions

because she believed I shared it.

Her return after the break was turbulent, and provided more examples of her struggle against dependence. She missed the first session, without letting me know. In the next, she told me she had actually come the week before, believing that I would be back from holiday on the same day as she was. How stupid to think that, she said dismissively. I said 'There's a time when a child feels her mother is so much part of her that they do both return from holiday on the same day'. Well, she'd never had that feeling with her mother. Her mother was just 'vague'. She told me that not coming to the session and not ringing had not been retaliation. I reflected her loneliness and abandonment the day before, and suggested that she had wanted me to make contact with her, but that like her mother I was 'vague'. This led to memories of being miserable at school, and of being forgotten by her mother when she returned home.

Within a few days she had decided to interrupt her therapy for a couple of days in order to visit a friend in Scotland. She was going, even though it meant missing sessions. There followed material about how hopeless her neighbour was in not understanding her three-year-old daughter. They'd been playing a game of tying themselves together with tape. Her neighbour had broken free, thinking that that was the game. The child was very upset, because the game was not the breaking free but the tying up. I said that by going away for a few days she was exploring for herself the issue of being tied up or of breaking free. Miranda's response was startling. She began to cry, and said 'I'm crying because you can understand that'.

At the end of the year after leaving her therapy she had a dream. It was the first dream she had had about me, she said. 'So now you're part of my unconscious'. She was buying my house, she said. There was a muddle about the completion date. She was with someone, she didn't know who, or indeed what sex. And she was trying to take over the house, but I was still there. There were lots of people in the dream, coming through the walls of the house. She thought they were my people. At first it looked quite a small house, but when you went in there were more and more rooms. It was really quite a large house.

We worked together on the dream, and at the end of the session she made a link herself to the first dream she had brought to her therapy, the dream about the Chinamen breaking into her house. That dream, she said, had been full of terror. 'Not like this one, which has in it the possibility of negotiation'.

I have referred earlier to the addictive nature of some of Miranda's relationships. The work of this second year showed me more clearly their

importance in the structures with which she maintained her sense of identity. As the year progressed the addictive quality of her need for her lovers had become more apparent. Her struggles to free herself from them, her perplexity at her own self-destructiveness as she clung to them, and the unconscious manipulation with which they fulfilled roles necessary to her, made me think of the addictive personality that Joyce McDougall describes in her chapter on the transitional theatre in her book, Theatres of the Mind. The absence for Miranda of any internalised care-taking mother, both to protect her and to soothe her, was marked. So too were the psychic mechanisms of splitting and projective identification that McDougall describes. In the transference these were reflected both in the quality of the emotional contact she made with me in the first year, as the 'malignant no' was re-enacted, and by her intense ambivalence to me during the second year, as she swung between attempts at contact with me, and retreats into distance. McDougall describes the effort that goes into maintaining a feeling of identity in this way. She stresses how fragile these psychic structures are and how strong is the unconscious need for them, which makes them so resistant to modification. She describes too the quality of the transference, so tormenting for the patient, where 'the I's identifying landmarks are as confused as they are in external relatinships', and where the therapist is felt to be the source of the confusion. But if both the love and the hate can be accepted and understood by the therapist, and the therapist experienced as a substitute transitional object, then, writes McDougall, 'between the I of the analysand and the analyst a genuine encounter may take place'.

My counter-transference response to the work during this second year led me at times to feel that Miranda was trying to draw me into a collusion with a part of herself that watched fascinated as she provoked self-abusive sexual encounters. In trying to understand this, I found helpful John Steiner's paper on perverse relationships between parts of the self. Here he describes the complexity of the internal world, in which healthy parts of the self may knowingly collude with destructive narcissistic elements. Pressure is put on the therapist to act out parts of the self in perverse collusions - and once again I am using 'perverse' here to refer, as he does, to perversions or twisting of the truth.

I quote: 'An important feature of the perversion is the way confusion is created when the patient acts as if he has no insight, but in fact seems to have considerable insight which is ignored'. The link with Freud's concept of disavowal is strong. Miranda's frequent disavowal of her own self-abuse and of her self-destructive patterns -though she recognised them - was marked. She acted as though she did not see what in fact she saw clearly.

Looking back on the work of this period, I came to understand that parts of Miranda's inner world formed a triangle in which a sado-masochistic couple - abuser and victim - performed for an observer, who found gratification in watching, and who was tantalised by secrets. In the transference at different times I took on each of these three roles. It was only later, during the third year of the therapy, that Miranda was able to recognise the projections and to see that the abuser, the victim, and the cruel observer - as she came to call him -were parts of herself.

Some time after this Miranda showed me the significance of her image of Chinese boxes. One Christmas, she said, her daughter had worn a hideous mask, with fangs that dripped blood. Miranda had been frightened, and had insisted she take it off. She did so, only to reveal another mask below.

As in a mirror, this episode seems to reflect Miranda's predicament.

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THE DEATH OF A PATIENT

Sheila Chesser

Alice was 41 when she came to see me. She looked frightened and did not smile a greeting. She was a square woman, solid and feminine, but with a boyish air. Her face was round, with eyes set far apart, there was apprehension in her gaze. Her clothes were casual, windcheater and jeans. Over her shoulder she carried a heavy bag of books.

She came to see me after a visit to a university clinic because she said she felt that things were getting out of control. In a matter of fact way she told me she had been born and educated in Australia and wished to further her studies in England; she had come to Britain to escape her past. The thought of starting again in another country had buoyed her up for a while. With more depth of feeling she said she was employed as a lecturer, and had started a relationship with her supervisor while she was working on a thesis. Now she had the idea that he was stealing her ideas and adding them to his own work. She was by this time having a sexual relationship with him.

Alice was unable to work on her thesis, and felt degraded and soiled. She told me that her reason for visiting me was her inability to manage this relationship.

While talking of these conflicts she said she had had therapy at infrequent intervals, and her last experience was with a psychiatrist in London. She described how he had sat opposite her, and she had developed the idea that he had a permanent erection. This had alarmed her and she had left after a few months work. Before that she had, on two occasions, been in psychotherapy in her own country. Overall she felt she had gained little within herself from these encounters. At each new attempt to get help, she had felt driven to terminate treatment without consulting the therapist. This I took to be a warning about what might happen between us.

Because of her previous experience of psychotherapy, Alice said she was in a panic about what she saw as the nature of therapy. She thought that either I would draw her into an uncomfortably close relationship or, not unlike her supervisor, I would steal ideas from her, and abuse her privacy.

When giving her history she said she had got little benefit from being the youngest of three children - the baby of the family. Her brother was seven years older, and her autistic sister was three when Alice was born. In early childhood the girls shared a room and so there was little chance for Alice to feel she had space of her own.

She and her sister were always dressed in identical clothes, a reason cited by Alice for the impression that she was supposed to be like her sister; she felt she was supposed to be part of her, and her sister part of Alice. But she had a reason all of her own, she told me, for wanting to be part of her sister. It was that she saw the autistic child as being her father's favourite, and if Alice could be a component of this child, she could also be loved by her father.

When recounting these feelings she told me of a memory about being locked out of the house by her mother, but then said she could not recall if she had been locked out, or her sister had been locked in. I remarked that it was as if she and her sister were experienced by Alice as being the same person. The locked in part and the locked out part were indistinguishable from each other. They seemed to be not unlike feelings that were either under control or out of control. She said that her sister part certainly was out of control. She went on to say that in spite of having the idea that she was supposed to be like her sister, she picked up from her mother that as a baby she had been different, a 'new' experience. Her mother had said she was relieved to find that Alice was 'normal'; she did not cry and make a fuss like her sister.

Sis was noisy, she banged her head, rocked her body, bit her arms, which led to having her arms put through the outer shells of tin cans. She threw her food about, and was incontinent. Alice remembered that her sister made howling noises and the tin cans rattled against the sides of the bed in which she was tied.

On the other hand, Alice's babyhood was described by her mother as idyllic. Her mother told her she lay in a pram gazing at the leaves of a tree. She needed little or no attention, and made no demands. She was never troublesome, and always good. To use her mother's words, recounted by Alice, she only needed to be fed and watered.

During Alice's early childhood their father was at home only at the weekends. A lot of her mother's time was taken up with Sis; nevertheless mother had many lovers and was going to have another child. Alice told her father about mother's men friends, whereupon her father went away and left the family. Alice felt desperate about his departure. She had relied upon him to protect her from her mother, and she felt she had caused him to leave by making known her mother's infidelity.

About the time of her father's departure, her mother was accused by the local authority of physically abusing the children. (This fact was confirmed in her father's papers when he died in 1969). The autistic girl was sent to a 'home', and was not seen again by Alice. She died at the age of 21. Alice went to live with her maternal grandmother; she was seven at

the time. She believed that she saw her parents separately from time to time, but this memory is vague. The boy was the only child who sayed with his mother.

Alice's brother was a shadowy figure. She described him as not reaching his potential. He joined the army on leaving school, and although she did not correspond with him, or have any idea of his whereabouts, she thought that he was married and had a family. She had the idea that he lived a conventional and uneventful life.

The family had lived on a sparsely populated island. As soon as she was old enough, Alice, with her unhappy and hurt feelings, spent a lot of time alone on the beach. She said it was as if she could tear herself away from the mad parts of herself. She remembered rowing out to sea when quite young and having the feeling that no-one was caring what she did or where she went. She described this as a feeling of being relieved of a heavy load of pain.

Out of the reach of other people she pulled the claws off live crabs, and caught flies and removed their wings. She had a beloved cat that she threw against a wall. She said she was fortunate that the cat survived, as she needed it to take to bed with her.

Life with grandmother, in another part of the country, was even harder than with mother. Alice no longer had the freedom of the beach, nor did she have her cat to comfort her. She felt she was treated harshly and was lost and neglected. Her grandmother was a staunch Christian Scientist, and any ailments were treated either as imaginary or as curable through faith. She remembered she was not allowed any toys or animals with which to play, nor any books to read except the bible.

Alice's grandfather was a kind man, but because he was afraid of his wife, she explained to me, she only had a tenuous relationship with him. She thought he was sorry for her, and sometimes tried to help.

Although she did not get on with the other children at school, Alice was always top of the class. She threw herself into school work and engrossed herself in books. She went on to university, having chosen to study musicology. She said she did not know why she made this choice of subject. Her mother had occasionally sung to her, and her grandmother had played hymns on the piano, but, she added as an aside and showing her outrageous sense of humour, she chose music because she had lived with the sound of her sister's tin cans and her howls and grunts during her earliest years.

She specialised in the cello, but she could not get on with her tutor and so was driven to put her foot through the cello and changed her subject to iconography.

TREATMENT

Because she was so frightened, sometimes trembling with fear,Alice could not always come through the front door. If she did not arrive in my consulting room after I had pressed the buzzer to let her in, I went downstairs to collect her and she would be nowhere to be seen. At other times she would come to the house, but would turn away and flee before she rang the bell. At times she got as far as the consulting room.

As if struggling to survive, she would walk about the room in an agitated and distraught manner. Most of the time, however, she gazed out of the window as if to remove herself from me. I experienced this as Alice pushing me to look out of the window, pushing me to look away from her.

She missed many sessions, and was often silent during the time that she was able to be with me. Occasionally she phoned to apologise for not attending her session, or she might write a note to me. Sometimes I tried to telephone her but there was no reply.

She was aware of her suspicions about me, and what she thought of as my power to seduce her with ideas. The part of her that wanted to escape came into play six months after the start of psychotherapy, when Alice said she could not relate to a woman; she felt hostile towards me; if she needed help she would call a bloke. I said she had told me when she saw me first that she was afraid I would draw her into a relationship that was too close for comfort. I thought she was feeling that now, and feeling hostile about it. She had endured her mother's hostility, and perhaps she was now seeking my hostile rejection.

On many occasions she had threatened to terminate therapy. She said that therapy was weakness, it was 'crutchery', and she was not 'mad' keen on it. When talking of how she needed to escape from the conflict of feeling tied to me, she mentioned the reverse wish for the peace that she sometimes felt during the sessions.

There seemed to be an appeal for understanding from me when she said that she did not think of herself as quite human. Alice described herself as a porcupine or a hedgehog, bristling with defences and fortifications. I remarked that she was feeling like the tiny things mutilated by her on her visits to the beach. Being spikey herself was not only useful in keeping her distance, but was also a tool used when there was a need to scratch me, inflict sensations of pain upon me, the pain that she had felt all through her life. She was having to keep me at spikes length.

When Alice had been coming four times a week for about two years she mentioned, as if in passing, that she was sure that her mother had wanted to kill her. I said that telling this seemed like a gift of her deepest pain. And she was also linking her mother's murderous thoughts with feelings

that she might be having about me. Was it that I was the violent mother/therapist who could not tolerate the mess that she thought she was in?

I was aware in the countertransference that I wanted to attack Alice, to attack the side of her that was so ill, so weak, so helpless against her own inner attacks. Alice seemed to understand violence as if it were love, and she wished to force me into violence so that she could feel that I cared, but also so that she would be able to denigrate and criticise me. She complained that the couch was not painful enough, it should have spikes on it. She added that she thought I was a poor thing because I did not attack her. For Alice, people only seemed to relate through pain and abandonment. Her mother's death wishes against her meant to Alice that she cared - that Alice had some value to her mother - that she was loved.

In a session close upon the one about her mother's wish to kill her, her thoughts turned to suicide. She had many methods lined up. The ways and means towards suicide were well researched by Alice. There was a chemical used in photography, she told me, from which she could make hydrogen cyanide; three breaths of the fumes would kill. There were sleeping tablets that she could take with alcohol, or she could cut her femoral artery while in the bath. She added that she might take an overdose of a diuretic. These closely thought-out ways of killing herself were a dire warning to me.

Rosenfeld (1983) is helpful in describing the use of diuretics by hypochondriacal patients, and its symbolism. He writes:

Some patients take diuretics in large doses in order to expel persecutory objects that have become anchored in the body fluids. At present I feel that every time the persecutory objects are expelled through the body fluids... one has to be much more alert as regards the possibility of the patient commiting suicide.

In response to the fear of her mother's death wishes, it appeared that she attempted to triumph over death through thinking of ways to die. It was difficult to help her to modify the mental pain, to bring alive the parts that wanted to live, to find a space in our relationship in which she could safely feel my concern for her, find an area in the transference where she would be able to hold on to nourishing food for thought.

Although Alice was not an adolescent when she was seeing me, Hurry's valuable paper MOTIVES AND REASONS FOR SUICIDE IN AN ADOLESCENT GIRL (1976) contributed much to my understanding of the meanings of 'her ambition to be dead' sic. Hurry brought to my

attention the danger of Alice putting into action what was so vivid in her phantasies.

While Alice was talking about suicidal thoughts she told me that each thing that she valued in life seemed to have an element in it of how it could be used to kill herself. An example of this was her interest in photography.

She was an accomplished photographer. Her subjects were buildings of historic interest. After three years of psychotherapy, she gave me a mounted and framed photograph of London Bridge. I felt this was a move to build something between us, but at this time she was repeatedly threatening suicide, as if death were the only way out, and we would not be able to bridge the gap between us. She now told me one of the methods to be used was to swallow the batteries used in her camera. This she assured me would certainly kill her. I said that at the same time as building bridges between us, she wanted to break the tie with me by killing herself. The first seemed like a pull towards life, the second was the influence of her destructive part. This destructive part posed as a friend, and attacked anything that might fulfil a need, like the bridge building.

As far as I could tell, she had not made a suicide attempt earlier in her life, although this seems improbable to me now. Alice idealised death as a solution to all her problems and, in retrospect, I think that dying may also have seemed like a way of uniting with me.

Her wish to see whether I cared enough to protect her lay in these 'cool' reports on methods to be used in order to die. Behind the threats lay her fear of being abandoned and left prey to her own explosive impulses. Both her parents had left her and it was clear that she felt that I would also abandon her. All I could do was to be there with her, and try not to let my alarm about what she told me interfere with my listening process. Shortly after giving me the photograph of the bridge, she swallowed a handful of pills. She woke up on her bed and wrote the following letter:

Dear Mrs Chesser

Having effectively brought back my rational self - I find myself wondering if you would be prepared ot have me back. That you should not wish to do so, I'd perfectly understand. Still, one can but ask.

Perhaps I can correct a feeling I owe you something of an explanation, though I'm still sufficiently befuddled to doubt my capacity to write something intelligible. I think I said that during my quiet spells I was wholly taken up with a process of

maintaining an equilibrium between negative destructive forces and the more balanced attitudes of my more balanced mind. When that equilibrium is disturbed it's the forces that take over and inexorably follow a course bent on chaos, pain, failure, destruction. There is no way I can stop it once it gets going. The only resolution comes when I engage in pseudo-suicidal games. And games they are since the odds are almost inevitably set at 60% in favour of survival and 40% against. The element of risk is somehow cathartic and with it I regain my more rational mind. Unfortunately, I know of no other way to get it back once I lose it to the darker, more obsessive forces in my character. The experience is totally exhuasting -so before I fall asleep or give in to a sense that I have forfeited all rights to ask for anything I shall stop and put this in the post. One thing is certain and that is that I've not the resources to sustain another bout of this for the moment.

With apologies,
Alice

She had not turned up for her session. This often happened, but it worried me. I tried to telephone her as was usual when she missed sessions, but there was no reply to the telephone. This was also usual. When I received her letter I felt that once again she was building bridges. In the letter was a declaration of her dependence and appreciation; nevertheless, evidence of how worthless and unloved she felt was also contained in the letter.

It was not surprising that Alice should think that I would not take her back, as both her parents had gone away from her: her father when she had betrayed her mother, and her mother when the family broke up.

When she came for her next session she said she felt afraid, deserving of punishment, and filled with self-hatred. She told me that she expected me to reject her. I took her back to the letter, and said what she described as bringing back her 'rational self' through the violence of the overdose seemed like her mother's violent and murderous feelings bringing Alice to her senses. Like some sort of game, the game now being played out which she called her pseudo-suicide. After her mother's violence there may have been feelings of great relief about surviving her mother's attacks, which were now being acted out in Alice's game. I also said that perhaps she wanted to involve me in these games of violence.

I put it to her that there was also an element of restoring self-esteem, and searching for an identity in this attack on herself - the hope of restoring a

benevolent part of herself by taking things into her own hands in death - yet this part of her self might be discovered through life-giving work with me.

Life was a battle for both of us. For Alice because she felt trapped by me: she felt she was hovering between the mad, bad, autistic sister part, and the more sane part. For me life was a battle because I felt I must try to keep in touch with both parts of her. I tried to keep her alive, and I needed to speak to the part of her that wanted to live.

At Christmas, shortly after the letter, Alice brought two bottles of Punt e Mes, beautifully wrapped in seasonal paper. The message on the card was: 'If it should happen you are not familiar with the contents it is best as a normal aperitif with ice and a dash of soda, and a slice of lemon'. My own paranoid feelings took shape, I tried the drink and thought there was nothing normal about it, nothing could be so bitter. I threw it away. I think that my attitude to her gift may have been picked up from Alice's paranoia: I felt she wanted to kill me. She wanted me to experience what it was like to swallow camera batteries, or take a deep breath of a noxious substance.

It may seem that I have underated the force of Alice's mother's cruelty towards her, but this cruelty was there in the treatment situation, to the fore most of the time. I showed her how she wanted me to inflict pain upon her, and she wanted me to suffer as much as she was suffering. I was also able to stress her endeavour to protect the 'caring mother' side of her, because this was also evident. I said that in her letter she was taken up with maintaining the equilibrium between negative destructive forces, and the balanced attitudes of her more balanced mind. The latter was the part that she wanted to preserve when she expressed the wish to return to me. It was on this more balanced part that she built her love of music. This belonged to her creative parts, her self-nurturing parts, her modifying parts.

She did not make a further suicide attempt, but during the next phase from the third to the fifth year, she tried to break the ties with me through hypochondriacal symptoms.

Six months after the suicide attempt, she would often arrive at her session puffing and panting. She complained that the consulting room was too hot, that she felt blood was pumping in her ears, and that she was sure her pulse was 120. She would then sit on the couch and proceed to take her pulse. At this time she was constantly going to the clinic because of one symptom or another and was very often referred to hospital for investigation. Many of the tests proved negative and this seemed to disappoint Alice. She spent time in the library looking up medical

conditions into which she thought she might fit. I felt I was failing her. She went out of her way to make the doctors doubt their judgement. During the sessions she would mock them and laugh - "They don't know what they are doing", with a sneer in her tone of voice. Like her Christian Science grandmother, they seemed to be saying that there was nothing the matter with her, her illnesses were imaginary, or the sickness could be cured through faith. And, of course, it seemed to Alice that I was saying that too.

When feeling let down, she seemed to render me null and void. Like an autistic child with her therapist (Tustin 1972) she was in a state of helpless despair: her symptoms seemed to have to be acted upon rather than used as a form of communication. During this time she could not call to mind a caring therapist/mother.

Throughout the last three years of psychotherapy she arranged to go into hospital due to one 'disease' or another. The only help and care she could accept at these times was of a physical nature, where feelings were not to the fore, and her body was nurtured and kept clean. Help of the 'fed and watered' variety that her mother had given her.

Her real need was to be cared for in a psychiatric hospital, but when this was put to her, she vehemently refused the referral and, of course, it was as if I were saying I could not help her myself.

I think Alice's spells in a general hospital were in part to avoid a psychotic breakdown, and were also a way of trying to repair the link with her mother. The link to the 'perfect' mother and baby as seen in her mother's eyes, the baby that needed little or no attention. It was as if my undivided attention was stifling her. She wanted to cut the tie, break away.

It was at this stage in the psychotherapy, when Alice had a constant preoccupation with ill-health, that she told me that she had had a severe depression following the course of treatment with the psychiatrist who she thought had a permanent erection. During the time with him she had developed a rash on her arms and labia. Now an alarming symptom developed resembling the rash. She said it was as if something that she had kept hidden had been found, the symptom came about if someone said fuck. She had painful sexual arousal and contraction of her arm muscles.

Her description of these attacks sounded to me like the arm movements of a distressed baby suffering from a nappy rash, and I was also reminded fo the autistic sister tied in her cot by her arms.

Alice's body language seemed to be about her skin not protecting her from sexual attacks, there was no enveloping warm skin, only a scorching

cover. It was as if she had no outer protection, body boundaries did not exist. She felt she had again become linked with the abused autistic child.

Even people who said fuck as a figure of speech seemed to be abusing Alice. In all her relationships she felt abused and misunderstood. The consultants at hospital were men who inflicted further abuse, and Alice also spoke about her early unsuccssful sexual relationships. She had had sexual relationships with several men during her teens and twenties, but none of these friendships had materialised into a long term relationship.

One of her demands for abusive surgical methods of treatment arose during an investigation when she was in the fourth year of therapy. Alice was found to be thyrotoxic and was treated with drugs. She insisted on surgery. She was much of the opinion that if she got the evil part surgically removed, things would improve. After the operation I thought that she might be taking an overdose of the drug supplied by her doctor. During the session she would take out a silver pillbox and swallow a pill. Again she seemed to make something happen by swallowing - not a camera battery to kill herself - but a pill to get rid of something inside her that seemed bad, and to make room for a good introject.

Three months later, during the middle of the night, she was admitted to hospital because she was passing a kidney stone. She had hypercalsiuria. This could have been part of the hypochondriacal delusion because she knew that if she took massive doses of Vitamin D it would be likely to cause kidney stones. There seemed to be a need to expunge the delusion; there always seemed to be something more to be got rid of.

Both Rosenfeld (1984) and Kernberg (1985) associate severe hypochondriasis with borderline conditions. Rosenfeld writes:

Hypochondriasis is a defence against a schizophrenic or paranoid condition, and not a conversion of a psychotic state into physical symptoms. Kernberg notes: *Hypochon-driasis is more likely to be related to a character pathology than to symptomatic neurosis, and is a condition often found in borderline pesonality organisations.*

It was difficult to keep in mind how helpless and vulnerable she was, and what this meant to her fragmenting self. She was desperately anxious to attempt to retain an internal structure, and felt this could only come about through violent surgical measures to remove the ailing parts.

Up to this point little had changed. Alice appeared to suffer as much as ever. However, at the beginning of the fifth year of therapy, she bought an elegant new wardrobe. She covered herself with finery and looked quite different in expensive clothes. It was as if her body was of value, and a good new possession.

Time passed and she also bought a music deck. She was interested in early English music, and built up a collection of records and tapes. She scoured London for forgotten and lost 78 rpm's and, with a few friends and colleagues, listened to music.

As if picking up an old skill in a different form, she acquired a violin. With a great deal of enthusiasm she practised, and arranged for regular lessons with an established musician. Of course she had twinges in her wrist and corns on her fingers, and of course she declared she was going to fuck this up too, but she didn't. Again she scoured London, this time for forgotten pieces of music and lost scores. Very gradually she improved her dexterity. I think it was a hard and difficult road, but eventually she plucked up courage to go to a summer school each year.

Two years later she met a Belgian who was a musical instrument maker, and also a violin player. They fell in love, had long telephone conversations, corresponded, met again, went to other summer schools, and eventually were married when Alice was fifty. Her husband was about the same age, and had a grown up family by a previous marriage.

For about a year before her marriage we worked towards finishing therapy, and Alice stopped seeing me regularly when the marriage was arranged. Three months after her wedding she returned to London from Belgium to tie up some loose ends in her job. She was feeling ill and was referred to hospital for investigations. It was discovered that she had inoperable carcinoma of the bronchus. Following the diagnosis she was in and out of hospital, and was having chemo-therapy, but she visited me when she could.

'It's not fair', Alice told me when her cancer was diagnosed. The doctors still seemed to her to be in the wrong. She wanted to be kept in the dark, she felt she should not have been told about her illness. She would have gone through any kind of torture to be kept alive, contrary to and in contrast to her death wishes. Alice was racked with fear and anguish. She felt powerless over this disease, there was now no defence against helplessness, nor did death any longer seem to be a way of uniting with an ideal object, for she no longer felt in control of death.

Alice returned to Belgium for Christmas, and did not telephone for two months. During the interval I wondered what had happened to her, but then there was a message on the answerphone saying, 'This is Alice, I think this is the last telephone call I shall ever make, I don't know what else to say'. I telephoned to ask her if she wanted me to visit her. Some days later I went to her flat in London. She smiled and was obviously pleased to see me. Tears flowed down her face. Although I had been nervous about seeing her, I was relieved to find that she was recognisable.

She had, however, all the features of being on cytotoxic drugs, with no hair and her face round and puffy.

She explained to me that, unlike the past, she no longer wanted to die, and this was one of the difficulties that she was encountering. She wondered if she would be able to get into a hospice at the end, where death would be 'dealt with for you as a matter of course'. She then told me that she had tumours in her head and spine and was completely helpless. I needed to make few comments. She went on to say that some people felt overwhelmed by her appearance. I told her that I did not feel overwhelmed and that she could get someone to phone if she wanted to see me.

After twenty minutes I got up to leave. Alice put out her hand and asked if I would kiss her. Her tears flowed faster and I felt I wanted to cry too. This was the last time I saw her.

Throughout her long therapeutic wilderness leading to a fertile relationship with me, Alice's greater use of an internal good object was manifest, leading to the release and use of her creative ideas and talents, such as music, playing the violin and embarking upon marriage. The narcissistic wound created by her mother's infidelity and abandonment was, in part healed by our relationship and by the love of her husband. Previous to her terminal illness she had begun to experience affects instead of expressing them in concrete terms through her body illnesses.

Because of her terminal illness, there ceased to be a way towards union of healthy parts of herself. She may have returned to the childhood feeling that her mother wanted to kill her. Was this illness experienced as her mother's final cruelty? Perhaps the cancer became the equivalent of the dead autistic part growing within her. The part her mother thought of as being the other side of Alice. The reawakening of these early feelings might have accounted for her considerable fear and horror.

I could not tell whether all or any of these ideas were true. At this stage I could not search for meanings except in my own head.

Because Alice was still blaming the doctors for their perceived culpability, she may have been feeling guilt about her past wishes to find an illness to fit her, but this was not discussed between us and, as far as I know, was not conscious. It was as if no amount of suffering and treatment had put her together again.

Alice's musical interests had lead to companionship and marriage, but had not magically saved her from death. Though death had been the stage most coveted during the first few years of treatment, death was not now welcomed, was no longer a solution. At last she had opted for life and it was too late.

This paper is an epitaph to a patient who taught me a great deal.

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BOOK REVIEWS

MOTHER, MADONNA, WHORE : The Idealization and Denigration of Motherhood

Estela V. Welldon. Free Association Books, November 1988
Pp 158. Paperback £11.99.

Estela Welldon describes her main themes in this book as perversion and motherhood. She uses these themes to try to counteract society's unhelpful idealization of the mother. In doing this she confronts the plight of women who denigrate themselves in motherhood as a way of unconsciously taking revenge on their own mothers who abused them as babies. She defines this misuse of the mother's function as a perversion and carefully clarifies the psychoanalytical meaning of this word. It is well known, she says, that the definition of true sexual perversions should always include the participation of the body; because in this sense the body has so often been identified with the penis and genital orgasm the concept has not been applicable to women.

For women, writes the author, womanhood and motherhood are inseparable from each other and from the concept of female sexuality. Unlike men, women do not focus their sexuality on one organ but they are aware of its presence throughout their bodies; it is therefore the whole body and its mental representations which is used to express the sadism and hostility which are the essence of perversion.

Throughout the book the differences between male and female sexuality and the impossibility of understanding one in terms of the other, are emphasized with a determination which women readers will welcome. Nevertheless the writer's insistence that, because their sexuality is much less focussed, "women have a completely different psychopathology from men", leads to some inconsistency. For instance she explains that the psychological causes of perverse behaviour are similar in men and women; among these are the parent's (usually mother's) opposition to the child's individuation and the denial of generational differences which contribute to an essential split between sexual maturity and pregenital fantasy. The author observes, however, that there is an important difference between male and female perverse action and this lies in its aim. In men it is aimed at an outside part-object, but in women it is usually against their own bodies or creations (babies) also used as part-objects. This statement mentions babies as an integral part of motherhood but it also raises the question of whether a mother's

incestuous abuse of her child is different in aim from a father's. The chapter about prostitution indicates it may not be.

I think that what Estela Welldon says about a male oriented view of true sexual perversion not being applicable to women, her implicit assertion that women are not aware of specifically sexual parts of their bodies and her theory about the differences between male and female aims in perversion may hold true for her description of motherhood as a perversion but they are more difficult to fit in with other forms of female sexuality and perverse activity in women.

Women, says Welldon, have not been neglected, they have been misunderstood; society's wish to sanctify the mother as madonna has made a major contribution to this misunderstanding. The all-powerful position of the mother has been regarded as sacred and this is especially dangerous because it is often the only power to which women have access. However, just as in the 1960s professionals faced with stark evidence that babies had been battered by their mothers remained incredulous, so now does the idea of the mother, on her madonna-like pedestal, committing incest with her daughter or son seem too appalling to contemplate.

Perversion is a three generational problem; in describing this important dimension the author attempts to counteract the extreme nature of her clinical examples of motherhood as a perversion by relating to all mothers the difficulties of extracting themselves from the snares of the past. However determined we are to avoid repeating our own experiences with our children, she says, we often find the mother within us speaking out. There does still seem a gap, however, between the horrific examples she gives and this rather more generalized comment. In this context the writer might have addressed commoner problems of mothers using children as part-objects for example by denying them access to their fathers in order unconsciously to repeat their own past or to wreak revenge.

Estela Welldon sees society as oriented towards a male map of life which disregards important features in the female one. The "biological clock" assigns to women an inevitable path of different phases from the beginning of menstruation to the menopause. It provides a sense of urgency and is a notion which helps to explain how sexuality embraces the entirety of a woman's body and life. Accompanying this is the concept of "inner space" to which the author gives a rather different meaning from the one originally ascribed by Erikson; she uses it to explain the sense of loss that some women feel after childbirth or a

hysterectomy. I see this concept as a central theme in the book; for instance it is particularly relevant to the quotation of Zilbach's ideas about female "active engulfment" of the sperm during heterosexual intercourse, a notion which is developed in discussion about the perverse mother's engulfment of the baby, allowing it no separate identity and gaining a sense of elation from making it respond to her own needs. The baby is never allowed a space of its own and it is sometimes only the unengulfed father who can intervene to rescue the child from this symbiotic existence.

The idealization of motherhood is maintained by splitting the two aspects of madonna and whore, a point which is illustrated by the observation that maids or cooks used to initiate young boys into sexuality and be regarded as useful, whereas had their mothers done the same thing there would have been uproar. This split makes it all the harder for women enmeshed in the compelling needs of perverse cruelty to their children, to seek help. It also, as the author points out, partially accounts for the fact that men can go to prostitutes with impunity in that society is unwilling to recognise that they have their own personal difficulties as much as do the prostitutes; one might add that this leaves them to some extent in the same plight as the madonna mothers.

Although this book is about female perversion the interweaving between male and female abuse in different generations makes it necessary for the writer to turn considerable attention to men and the chapter on the symbolic mother as whore is as much about the men involved as the women. As in all perverse activity the search for blissful union with the mother, frustrated in the early months, is present for both sexes but complicated by hate. The essential features of prostitution, the anonymity and payment of money, are equally important to both parties and although in fact the woman has the power, the use of projective identification allows men and women to reverse roles, in turn becoming the denigrated parent of either sex or the humiliated child. It allows each to split off their sadism from the rest of their lives in which men may preserve their wives from sadistic attacks on their mothers by taking their anal filth to prostitutes, or women may be loving and caring; though the masochistic element in both tends to remain. The author sees paternal incest as a sort of apprenticeship for prostitution and states that many prostitutes are indeed abused by their fathers. The child has to pay with her body for her father's care and an extremely important element in the situation is secrecy. The child may be used as a part-object by father in order to keep the family together and in the same way perhaps prostitutes are used to keep families together. Once again the three generational

aspect is very important; many incestuous fathers were abused and humiliated by their own mothers and use their daughters to convey their revenge.

I found this book rather confusing. The author's main themes about perversion and motherhood seem difficult to follow from time to time and I think her theory of female sexuality contains inconsistencies. Nevertheless the book's condemnation by some feminists is a mistake because by refusing to accept the reality of Estela Welldon's experience of women in her clinical practice they are effectively endorsing the view of the mother as madonna. They are thus paradoxically reinforcing the isolation of such women. Their attitude also, as the author points out, reduces women to a passive part-object role; the receptacle for the acting out of men's incestuous wishes, thus denying them the ability to take action themselves. It is an important and disturbing book which gathers its power from the direct clinical experience which inspired it; in facing the awful truth that a mother may cripple the emotional and sexual development of her child by using him or her as a vehicle of revenge for life long hurt, Estela Welldon is doing women a service.

ANNE TYNDALE

PROJECTION, IDENTIFICATION, PROJECTIVE IDENTIFICATION

Edited by Joseph Sandler. H. Karnac (Books) Ltd, 1988 with permission of International Universities Press Inc., Madison, Connecticut. Pp.216.

This is a collection of papers and subsequent discussions from the First Conference of the Sigmund Freud Center of the Hebrew University of Jerusalem, when Joseph Sandler held the chair of Professor of Psychoanalysis. Papers were given by Joseph Sandler, W. W. Meissner, Betty Joseph, Otto Kernberg, Raphael Moses and J. Bilu. Sandler has kept the individual intervention from the floor of the conference, which gives the book a sense of immediacy and a feeling almost of personal participation to the reader.

Students (and practitioners) of psychoanalysis often find difficulty with the concept of projective identification. Perhaps one of the successes of this book is in giving an historical perspective to the terms projection, identification and projctive identification which, together with the

contemporary discussions and arguments, both open up the questions and provide some answers. In the many and varied (and always interesting) clinical examples, the reader can see how analysts of different theoretical background perceive and use the concepts and for this reader at least, it was gratifying to recognise that the concept is an integral part of clinical work.

Joseph Sandler and Meir Perlow's paper gives us the historical background to the concept of projective identification derived from projection and identification, under the broader umbrella of externalisation and internalisation. They discuss Freud's use of the term projection as turning outwards, fending off intolerable ideas, externalising, as well as his acceptance of Ferenczi's understanding of the concept in the infant's differentiation of self from the external world. From these ideas developed Anna Freud's use of projection as a mechanism of defense and Melanie Klein's emphasis on the ego's expulsion of sadistic impulses into the external object. Identification comes under the broad (and much discussed) heading of internalisation, which also includes introspection and incorporation. Sandler distinguishes between primary identification existing before firm boundaries between the self and object are established, and secondary identification where "subject embodies in the self-representation attributes of the object, real or fantasied".

From these definitions, Sandler in his second paper moves onto the concept of projective identification as introduced by Melanie Klein in 1946, and described by Hanna Segal (1973), "In projective identification parts of the self and internal objects are split off and projected into the external object, which then becomes possessed by, controlled and identified with the projected parts". He goes on to break down the concept as a means of understanding it from his own frame of reference as a mechanism of defence, an early form of empathy (Segal), the differentiation of self from object and the linking of these broad concepts with psychotic states. He also mentions the importance given to projective identification as a mechanism central to the countertransference, quoting Bion's container model theory whereby a mother contains the infant's anger and distress, as well as love, and responds appropriately, having identified with the infant's needs. In analysis, the analyst contains the patient's feelings and fantasies and returns them in the form of appropriate interpretations, allowing the patient space in which to accept the "bad" parts of self, without resort to previous defences. Sandler accepts this theory but feels it is stretching the point too far to call it projective identification. He warns against using projective identification as a "pseudoexplanation", maintaining it is more a descriptive concept

than an explanatory one and should always be put in context. Due to its close link with our understanding of countertransference, it is tempting to feel that all our responses to patients are due to projective identification - that which has been "put into" us - whereas it is necessary to distinguish between what belongs to the patient, from that belonging to the analyst.

Meissner clearly states his position of finding projective identification too broad a concept to be useful to him in his clinical work. He prefers to use the interplay of projection and introspection. He focusses first on Freud's original notion of projection as characteristic of symptom formation in paranoia (1911). Broadening the concept he quotes Jaffe (1968) and Rapaport (1952), whereby projection is seen not just as a defence mechanism in paranoia, but found in many other states, and in many individual personalities seeking to diminish internal pain. It can only be meaningfully seen in relation to the correlated process of introjection understood by Searles (1965) whereby a paranoid schizophrenic patient is threatened by persecution from objects in the outer world and by introjects within himself.

Meissner then focusses on Klein's particular understanding of the way in which the child, fearing and hating persecuting objects (paranoid-schizoid position), splits off and projects bad parts of the self into the mother. She contains the projected parts and "she is not felt to be a separate individual but is felt to be the bad self" (Klein 1946). An important point is that Klein shifts from Freud's idea of projection as pathological symptom formation, to projection as a central part of psychic development. If this is accepted then projective identification cannot be seen as a defence used only by psychotic patients, though Meissner seems to imply that this is so. He feels that post-Kleinian developments of the theory (he quotes Rosenfeld and Bion), emphasise the psychotic-like elements of splitting, confusion, fusion with the object, and inability to separate the real object from its symbolic representation. He goes on to state that Bion's idea of projective identification as a mutually beneficial symbiotic relationship between container and contained, reduces the concept to a metaphor which can be loosely applied to almost any relationship.

Meissner thus concludes that projective identification is only useful in a quite limited way, described by Klein as an intrapsychic mechanism occurring as part of a psychotic process involving diffusion of ego boundaries and loss of ability to differentiate self and object. He then goes on to give clinical examples of patients where he feels that projection and introjection are the mechanisms involved, rather than projective identification. My own understanding might be that the latter

process was perfectly illustrated in his clinical vignettes.

Sandler's summing up of Betty Joseph's paper emphasises the fact that for most clinicians, projective identification does not have just one meaning but various meanings. Betty Joseph concentrates on the clinical aspects of projective identification, giving clear examples of how she sees it operating, as well as a facinating insight into her own responses; in one patient (a small child), who fantasies projecting her whole self into the object, feeling trapped, and not able to be in contact with her own self; in another, where Joseph emphasises the omnipotent balance achieved by a patient who then cannot afford to accept returned parts of self in the form of an interpretation, as it threatens that balance; in a third patient, where projective identification becomes a form of communication in its own right, where the empathy of the analyst identifying with the projected parts of the patient enriches the countertransference and a bridge is built between the analyst and patient. Her descriptions are illuminating; how she is pushed and pulled to feel and to react in the countertransference; her capacity to contain and not respond too hastily with an ill-timed interpretation; her honesty in acknowledging the confusion projected into her. These insights give the reader not only the feeling of being in the session (and which therapist is not innately curious about other peoples' work?), but also a very precise understanding of the concept of projective identification. In this way Betty Joseph links the theory with the practice in a very satisfying manner. The lively discussion following her paper also makes very interesting reading.

Otto Kernberg's contributions to the conference include his assertion that projective identification is a more primitive defence mechanism than projection and that it is more usually found in borderline or psychotic personality organisation. He feels that as projective identification is based on splitting, and projection based on repression, the former is relatively unimportant in the neurotic patient except in a regressive phase, of which he gives a valuable example in a clinical vignette. If projective identification is as primitive a mechanism as Kernberg states, with boundaries between self and object in a fluid state of development, it is difficult to see how the infant can project parts of self into the object. As Sandler points out, there must be a boundary for the infant to project out of himself into another. Kernberg sees this state as one of repeated attempts by the infant to establish boundaries in the to-and-fro process. This is an interesting idea and he reinforces it with his clinical examples. I agree with Sandler that in psychotics we may often see this kind of early projective identification but that the mechanism also operates in our neurotic patients and indeed in us all.

Kernberg gives us some most interesting insights into his technique and his handling of the countertransference. He describes with honesty his anxiety and fear in one session with a paranoid patient who he felt might physically attack him, and how he acknowledged his anxiety to the patient, thus temporarily abandoning his therapeutic neutrality. He used the situation to interpret to the patient his transference and illustrates to his reader the interplay of projection and projective identification within the session.

The two final papers apply the concepts in a broader sense; Raphael Moses in the political process, demonstrating the group phenomenon from the individual, and Yoram Bilu in an attempt to show projective identification in an historical case of dybbuk possession. Moses defines his terms succinctly and illustrates their application from the particular individual to the general group in political behaviour. He emphasises what several speakers had already noted, that in projective identification one of the prerequisites and results is that of controlling the object projectively identified with, and gives examples of political groups projecting into their leader and pushing him into identifying with their demands. This in turn allows the leader to identify with ideas he feels unable to express, and at the same time to maintain a less extreme position publicly. Moses feels, however, that we need to be careful of the concept of projective identification, as its meaning is in danger of being lost if it is too flexible in interpretation.

Bilu's paper is an interesting socio-cultural study of dybbuk possession in a Jewish woman in a nineteenth-century Eastern European Hasidic community, where her father, a Rabbi, "masculinised" his daughter, calling her his son and giving her the learning and duties more appropriate to a son in that community, this in spite of there being five sons. On his death, she and the youngest son became separate leaders of their father's sect, so that the daughter effectually became a Rabbi. She and her brother inevitably clashed as each felt that they were the true inheritors of the father's leadership, and gradually the daughter's behaviour led to the idea that she was possessed by a dybbuk, as she sank into depression and finally, madness. Bilu points out that this extreme case of projective identification shows the control exerted by the projector, as the woman lived out the fantasies projected by her father and was in effect possessed by him, in the shape of the dybbuk.

I think the book succeeds in several ways. In presentation, Sandler has made this conference on some very important issues seem alive to the reader, especially in the way he has kept the discussions following each paper in the original, showing strongly held views jostling for position.

His masterly summing up of salient points from each paper before opening the forum for discussion, gives a feeling of continuity, as he reminds the reader of what has gone on before, and gives the pointers for where the discussion may lead. As can be seen from the lively debate following each paper, projection, identification and projective identification are controversial subjects. Every shade of opinion seems represented, from those who feel projective identification is not only a part of every person's psychological structure, but is also an integral part of a therapist's work, to those who feel that projection and identification are the concepts with which they can work comfortably, and that projective identification is not a useful one. For the reader, much is explored. He must of course come to his own decision about the usefulness of the concept in his own clinical work.

HELEN ALFILLÉ

WINNICOTT

By Adam Phillips. London: Fontana Press. 1988. Pp 180. £4.95

What factors contribute to a baby's earliest developmental well-being? What makes an infant thrive? Winnicott was clearly fascinated by mothers and their babies. He was impressed by the efficacy of the 'ordinary devoted mother' and his chief interest lay in discovering how mothers related to their infants and what the 'nursing couple' actually **did** together.

His observations led him into centering his findings on the crucial importance of 'environmental reliability' based on caretaking by the 'good enough mother' and the notion of a 'holding environment' became the cornerstone of both his developmental and psychoanalytic theories. Thus the main emphasis in any truly Winnicottian analysis, would be on warmth and nurturance, protection and safety.

From Adam Phillips' well-organised and clearly written book, one can see that Winnicott's ideas provide a nice corrective to the harshness of Melanie Klein and Anna Freud. Indeed, one could say that he steps neatly into the unoccupied space between these two theorists, and, with his two-body schema, as opposed to Klein's one-body and Freud's three-body framework, he bridges Klein's infant's internal, psychotic world and Freud's oedipal triangles.

Winnicott describes a therapeutic approach which includes explicit nurturance. His emphasis is on need rather than greed, on hurt rather than anger. He sees a definite message of **hope** in the antisocial tendency and he welcomes moments of 'resourcelessness' in his patients - 'we are poor indeed if we are only sane'; unlike the more orthodox tendency to disparage 'unintegration'.

Phyllis Grosskurth in her book **Melanie Klein,** quotes Mrs Clare Winnicott 'slamming out of the room' after Mrs Klein had given her a 25 minute uninterrupted interpretation of a dream. It's true, Kleinians are so often intrusive, Winnicottians give space. This is partly due to the fact that Winnicott stressed the importance of external reality and the environment, and its root in fantasy. For Winnicott, fantasy was a key into reality - 'the infant's first method of finding it', while taking it from the other side, reality is the link to understanding fantasy.

Phillips writes a tactful and fine summary of the basic points and concepts of Winnicott and the book is an excellent and very affordable introduction to Winnicott. It gives us some important biographical details and it is the closest we have to a full biography of Winnicott which has yet to be written. It is clearly a useful supplement to Winnicott's selected letters **The Spontaneous Gesture**. One can see the influence of his family on his chosen professional interests: the 'multiple mothers' and the remote preoccupied father, although I did discern a marked unconscious identification with father, who was a corsetier, a common interest in an attempt to re-shape women. Father's influence is there, even if it is carried through mother.

On reading Phillips' book, I understood anew why Winnicott is growing in stature as a therapeutic influence and how the unthreatening nature of his theories is most conducive to psychic growth with the potential for discovering one's 'True Self'.

JUDY COOPER

'CONTAINING ANXIETY IN INSTITUTIONS' SELECTED ESSAYS, VOL. 1

Isabel Menzies Lyth. Free Association Books, London 1988.

It is of great value to have Isabel Menzies Lyth's paper published in book form. A Kleinian analyst and a consultant with the Tavistock Institute of Human Relations from its early days, she has been able, in her own words: 'to bring together in my practice two main professional interests, the individual as a person in his or her own right - psychoanalysis - and the individual in a multiplicity of interpersonal, group and community relationships - social science -or, to state the matter somewhat differently, to relate the internal world of object relationships with the external world of society'.

It is this linking of the inner and outer worlds which makes Isabel Menzies Lyth's papers so relevant to those of us who work in both worlds. In her application of analytic thinking to institutions and working groups she has contributed much to the understanding of organisations themselves and to their influence on the psychological well-being of the individual, whether as provider or user of helping services.

In this volume there are six major papers and several shorter ones, in all of which understanding deriving from analytic thinking is applied - through action-research projects or staff group consultancy - to the work of organisations offering a helping service. One further essay outlines her views on the maternal role within the context of present day society.

Her classic paper, 'The Functioning of Social Systems as a Defence against Anxiety', is still as relevant today as it was when first published in 1959. Here she applies the theory of defence mechanisms to institutions, as a result of working on a particular organisational problem with the nurses in a large teaching hospital. She develops Elliott Jaques' theory of social defences, and shows how these devalue the worker, detract from job satisfaction and ultimately hinder the fulfilment of the primary task of the organisation. This theory has application far beyond the nursing profession and the hospital.

Using the action-research methods of the TIHR, development of theory has gone hand-in-hand with the facilitation of practical achievements in the institutions concerned. The paper entitled 'Action Research in a Long-Stay Hospital' gives a most moving as well as instructive account of how staff were enabled to reorganise a children's ward around the needs of ill or disabled children who had to be away from their own home.

In these and other papers on children and adolescents in institutions, as well as one specifically on methodology, she sets out her methods in such a way that underlying principles can be readily identified and reapplied to other situations. This makes the book of great practical value. Particular concepts amongst others which she elaborates, are those of social defences; working through anxiety; worker-participation in the psychodynamic process of building models for change; task and anti-tasks; the provision of models for identification for children and others with undeveloped personality. Readers who are interested in management will find, in all her papers, a strong emphasis on the delegation of responsibility and discretionary powers as a means for providing effective models, and for combining individual job-satisfaction with a high level of achievement in the organisation's primary task.

The book starts with an interview, entitled 'Relections on my Work', in which Isabel Menzies Lyth speaks of the development of her work and ideas and discusses her approach to present day problems. Through this opening discussion, not only are the papers - which span nearly thirty years - brought into context, but her personality comes across with an immediacy and vitality which makes this chapter a pleasure to read.

Throughout the book, views are stated clearly and firmly. She considers that analytic training by itself is insufficient for consultancy to organisations and staff groups; and emphasises that a combination of understanding and skills deriving from social science as well as analysis is essential for this work.

I thoroughy recommend this book as essential reading for any psychotherapist who is also working in the helping services, in whatever capacity. I also recommend it to those who are solely involved in depth psychotherapy, as providing analytic insight into the psychodynamics of the external world in which we all live.

SALLY HORNBY

HUMAN NATURE

By D. Winnicott. published by Free Association Books. 1988.

Human Nature is an account of how the imaginative world of the individual is rooted in the imaginative elaboration of his embodied experience. Winnicott gives a thoughtful and provocative account of the phenomena of early emotional life, prior to the stage when the child begins as a whole person to face the complexities of the triangular relationships of the Oedipus Complex of classical Freudian theory.

Winnicott, however, is concerned not only with developing our understanding of psychopathology, but also in specifying the conditions pertinent to healthy living. What are the environmental conditions, given physical health, that are necessary for the achievement of psychological maturation? He is also concerned with the implications of his theory for therapy.

For Winnicott, the story and the potential hazards for a person begin before birth. "The point of view that I am putting forward here is that at full term, there is already a human being in the womb, one that is capable of having experiences and of accumulating body memories and even of organising defensive measures to deal with traumata (such as the interruption of continuity of being by reaction to the impingements from the environment in so far as it fails to adapt). (p.143).

The development of the human infant is to be understood in terms of his personal context which may be more or less adapted to his needs. He can be traumatised or impinged **upon**. This can block or stunt his emotional development. Early experience, both intra and extra-uterine, affects the developing self of the human individual.

Integration is the primary task for the individual. "Integration means responsibility, and accompanied as it is by awareness, and by the collection of memories, and by the bringing of the past, present and future into a relationship, it almost means the beginning of human psychology". (p.120).

Winnicott postulates three states - primary unintegration, integration and disintegration.

For the infant there is, "a simple state of being, and a dawning awareness of continuity of being and of continuity of existence in time". (p.135).

A secure base to the personality is founded on good infant care. Integration is promoted by environmental care. The infant falls to pieces unless held together, and physical care is psychological care at these

stages. The infant's development as an embodied person needs the embodied love and care of his mother.

"As the individual becomes able to incorporate and hold memories of environmental care and so to become capable of self care, integration becomes a more reliable state and dependance is lessened. (p.117).

Winnicott stresses the importance of the quiet states, the importance of what looks like play between the infant and the mother. He sees this as primary to the excited instinctual state. Successful care is more than the satisfaction of instinctual demands. Through these repeated contacts, memories and expectations are built up, leading to a state of confidence that the "object of desire can be found, and this means that the infant gradually tolerates the absence of the object". (p.106). Through the experience of omnipotence, which is totally dependant on the mother's adaptiveness, the baby can then be assured of his own potency and begin to accept that objects appear and disappear in external reality. The early illusion of omnipotence is necessary for our later capacity to tolerate separation and loss.

Otherwise if the cild has to adapt too early to the mother "there is a false self which develops on a compliance basis and is related in a passive way to the demands of external reality" (p.108). The false self then organises to protect the true self. This may lead to a sense of futility and a constant search for that which seems real.

"Chaos is at first a broken line of being, and recovery occurs through re-experience of continuity; if the disturbance is beyond a degree that is tolerable, according to early experiences of continuous being, then by crude economic laws a quantity of chaos enters into the individual's constitution". (p.135). This can happen when there is a "degree of chaotic environment which can only result in a chaotic defensive state in the individual, with a result difficult to distinguish clinically from the mental defect that belongs to poverty of brain tissue". (p.136). The continuity of being is maintained by the continuity of the environmental provision that is adapted to the infant's need. "By environmental failure I mean failure of secure holding, and failure beyond that which can be borne at the time by the individual". (p.117).

Winnicott's developmental sequence is, "First, then, there is no chaos because there is no order. This can be called unintegration. Chaos appears in relation to integration, and a return to chaos is called disintegration". (p.136). Unintegration is not chaotic per se. The infant needs to relax and to rest and to regress to unintegrated states and to be able to tolerate a painful state of "mad" disintegration.

However, "The good enough environment is absolutely essential ---for the natural development of the human being who is starting to live". (p.129). Active adaptation permits the individual to be. But for the infant, "There is no reason for an awareness of the good enough environment". (p.129). He need not know of the environment. "Primary narcissism, or the state prior to the acceptance of the fact of an environment, is the only state out of which environment can be created". (p.130). There is no sharp differentiation of self and other. The response meets his gesture. This adaptation is physical. The mother has to meet the gesture. A capacity for reverie is not enough.

The mother through her ministrations protects the infant from a harsh exposure to the limits of his omnipotence. The boundaries between the ME and the not-ME are blurred.

Winnicott argues that this illusion of omnipotence is necessary for accepting and even making use of disillusionment. If the introduction to reality is "not softened by the temporary use of an illusory state of omnipotence there is splitting. "Splitting is an essential state in every human being, but one that need not be significant if the cushioning of illusion is made possible by the mother's management". (p.136). In the absence of active adaptation that is good enough the splitting becomes significant, and leads to the establishment of a False self relating on a compliance basis to external reality while the root of the true self, with spontaneity, remains related omnipotently to a subjective world and incommunicable.

However, in normal development, if the mother is good enough "there is expectation of persecution, but also the experience of care as a protection from persecution". (p.124). Thus the mother's survival and continuous non retaliatory care is necessary for the mitigation of persecutory anxiety and the gradual acceptance of disillusion. A process of integration becomes possible, based on the survival of the relationship with the mother.

"The attainment of unit status and of the depressive position makes possible the dramatisation of chaos, of splitting and dissociations in the personal inner world, and the complex results of personal instinctual experiences being incorporated into these dramatisations". (p.137).

If this process is not successful, the person is traumatised. Winnicott's theory is one of trauma, and the defences organized against the re-experiencing of the trauma. There is a need for this initial trauma to be re-experienced in the transference and brought to the level of conscious awareness to be integrated and understood. "Disintegration after the individual has attained unit status is an organised undoing of integration,

brought about and maintained because of intolerable anxiety in the experience of wholeness". (p.137). This is where the concept of repression becomes meaningful. Because as with other survivors of trauma, he "suffers from reminiscences". For Winnicott these memory traces are personal and not part of a racial unconscious. They need to be understood in terms of the personal history of the individual. Therefore, for him, accurate history taking, if possible, is important.

Therefore regression to points of early failure has a function in therapy. It gives an opportunity to see the aetiology of early pathological responses to impingement, as well as an opportunity to re-integrate them, but in a context where the individual is held. He, hopefully, can tolerate the threatening disintegration, and even states of unintegration, to begin on a new path of integrating a self that is more securely based in the continuity of his experience.

This stress on the positive features of regression has obvious similarities with Balint's account of regression in **The Basic Fault**. It also finds echoes in the work of R.D. Fairbairn in his stress on the controlled release of "bad objects" in the analytic situation.

Classical analysis operates in the undoing of repression. The patient is enabled to work through "the intolerable pain that belongs to consciousness of coincident love and hate, and fear of retaliation. Allied to this is inhibition of instinct". (p.137). By enabling the patient to become conscious of the conflict and to tolerate the anxiety that belongs to free instinctual expression, the individual becomes capable of compromise.

But the adult patient, who has suffered from early impingment, needs to return to a state of unintegration to achieve a creative contact with reality. He needs to relinquish the holding function of the False or caretaker self to the analyst. He needs to return to the phase of primary narcissism i.e. to an unawareness of environmental care and of dependance. He needs to withdraw and to return from the withdrawal.

This capacity to regress to a state of unintegration in therapy depends on "the existence of a capacity for trust, as well as on the therapist's capacity to justify trust, and there may be a long preliminary phase of treatment concerned with the building up of trust". (p.141). This means that the therapist is giving good enough adaptation to need.

The therapeutic handling of the withdrawal and the return from withdrawal is important. "On the return journey the patient needs the therapist in two roles - the worst imaginable, in all respects, and the best - or an idealised mother figure engaged in perfect child care. Gradual recognition of the identity of the idealised and the very bad therapists goes hand in hand with the gradual acceptance on the part of the patient

of the good and the bad in the self --. At the end, if all goes well, there is a person who is human and imperfect related to a therapist who is imperfect in the sense of being unwilling to act perfectly beyond a certain degree and beyond a certain length of time". (p.142). The integration of the self is related to a toleration of the integration fo the images of the other. Regression has a positive quality as it permits the correction of early experiences. It leads to a true restfulness and acknowledgement of dependance and a regaining of independance.

Human Nature perhaps represents the most coherent integration we have of Winnicott's work. It, like this concept of the mature individual, is not based on an identification with, or a compliant acceptance of classical Freudian theory.

Winnicott is not a drive theorist like Freud but an Object relations theorist. His account of the child's emotional development stresses how the child's development is structured by his experience of empathic care or the lack of it. The parents also need to be able to distinguish reality from fantasy. Premature eroticisation may be seen not only as an efflorescence of polymorphous infantile sexuality but as a disintegration product arising from failures in emotional relationships. The biological basis of the instinct has been distorted by anxiety.

His work has clear conceptual similarities with the writings of Balint and Fairbairn, though these are not developed in the text. It differs from Klein and his stress on the importance of the reality of the parents. For him the paranoid-schizoid position of Klein would represent an organised defensive withdrawal from integration, not a development stage.

The book is full of valuable insights concerning the role of early bonding and the importance of early skin contact with the mother. Many of his insights, speculatively derived from his clinical experiences, both as an analyst and as a paediatrician have been validated by later empirical research. His work also has practical implications for child care. For example, it is important to the child's experience of continuity of self, not to be exposed to too many caretakers. Developmental research has established that the infant can discriminate and prefer the mother almost from the beginning.

Winnicott also provides us with a potential research programme for the study of autistic, psychotic and psychosomatic disorders. Much of his work is validated by the growing research literature inspired by the work of Bowlby. Research in developmental psychology as elabored by Stern has confirmed his hypotheses concerning the capacity of the neonate and even the foetus to be affected by the environment.

Winnicott in his book demonstrates his own capacity for integration and from learning from the imaginative elaboration of his own experience. Integration as he emphasises is a continous process throughout life. The book is not offered as a final synthesis and makes no claims to Truth, though with the empirical references it gives, we have criteria for developing a research programme to study and validity of his theory. In as much as it is not a final synthesis making absolute claims to truth, it leaves us free to carry on our own processes of integration, in an attempt to synthesise our own experiences but with "an acceptance for the fact of an environment". (p.130). Though perhaps perceived through a glass darkly, there is an external reality.

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THOMA, HELMUT AND KACHELE, HORST, PSYCHO-ANALYTIC PRACTICE 1. PRINCIPLES
Berlin, Heidelberg, New York, Paris, London, Tokyo : Springer Verlag (1985) 444 pp; £32.35, hardback edition only

'Principles of Psychoanalytic Practice' is the first volume of two which investigates and critically discusses the theory of psycho-analytic therapy. As the authors state in their introduction to the book, particular stress is laid - directly and indirectly - on the psycho-analytic therapist's contribution to the analytic process. The book deals with the main concepts used in clinical work to-day and the various chapters cover subjects like 'Transference and Relationship'; 'Counter-Transference'; 'Resistance' and 'Interpretations of Dreams' but it also examines issues like 'The Initial Interview'; 'Rules'; 'Means, Ways and Goals' and 'The Psycho-Analytic Process'. Each chapter gives a short historical account but emphasizes more recent developments and points to the achievements and short-comings of present-day theories of clinical practice and technique as they have emerged in the psycho-analytic movement worldwide. It is only natural that because the far more extensive contributions to this topic come from the United States, they are given extensive space but the English and British Object-Relation-Theorists are also discussed. There are often interesting attempts at linking and at times even integrating developments from Ego-Psychology and Object-Relation-Theory. The authors adhere to a one-,two-,three person psychology underlying clinical practice as discussed by Michael Balint. This is in accordance with their stated goal to give the theories of the therapist's contribution to the psycho-analytic process, as it evolves in the therapist-patient interactions, a central place. It is, however, their testing of the function of the various conceptual models, the discussion of their advantages and disadvantages when applying them to clinical practice, which makes the book interesting to read. It often stimulates further thoughts about the subject-matter concerned.

The authors query the usefulness of Freud's metapsychology, coined mainly in metaphors of the science of his time, for the clinical practice of to-day and they warn that neglect of research and development of theory will isolate and so in the long run endanger our clinical work in the consulting room.

Chapter 1 'Psychoanalysis: The Current State' devotes a whole subsection to it. In the last chapter 'Relationsip between Theory and Practice' pertinent questions are raised like 'The Context of Justification of Change Knowledge'; 'The Differing Requirements for Theories of

Pure and Applied Science' and 'The Consequences for Therapeutic Action and for the Scientific Justification of Theory'. The authors maintain that more understanding of developments in neighbouring areas of science may lead to a more unifying theory and with it clarification of the goals of psycho-analytic therapy.

The English reader may at times be surprised about the author's demands for 'strategies and goals' in our clinical practice but it has also to be said that they give due weight to the positive results which therapists who use a more intuitive approach, we may say a more creative approach, may achieve. The author's geographical base is the University of Ulm/Germany where they are both psycho-analysts and academic teachers at the Medical School. Hence it is not surprising that they scorn training institutions which run their courses as 'Evening Schools' as they say. This in contradistinction to a full-time training as they wish to see it introduced. Having been trained in England I also have my geographical base and feel slightly apprehensive that a full-time training may lead to too much institutional anchoring of a training which aims at preparing therapists for individual two-person clinical practice. It could become counterproductive for the creativity and personal style of the individual therapist practising in his own private consulting room. In this context it may also be worthwhile to mention that this book, which covers such a wide range of publications from various parts of the world, inevitably raises one's interest in the difference of the various cultural areas and their influence on research and development of theory and practice of psycho-analysis.

'Clinical Practice in Psycho-Analysis' is a stimulating and learned book. Its wealth of information (there are nearly 1000 references covering the important relevant publications) makes it a most suitable reference book whenever there is a need for information concerning the conceptualisation of our clinical work. Only the very learned reader may wish to read it in one go. The translation is excellent so that the book reads well and it is carefully laid out and produced. The second volume, which is expected to be available around Spring 1990, will deal with the application of the 'Principles' of the first volume to case studies and other clinical material.

One critisism of the book is directed towards its publisher; it is the prohibitive price and unavailability of a paperback which is regrettable.

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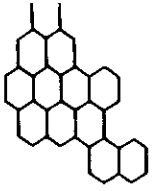

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References for books should include the author's name and initials, year of publication in brackets, title of book, place of publication and name of publisher, e.g.

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

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