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CHILDHOOD AND THE CHILD WITHIN: VIEWS OF AN ANALYTICAL PSYCHOLOGIST

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Introduction

I started my working life as a teacher. I do not think I was particularly good, but I made my efforts, and part of this involved teaching poetry to 11-year-olds. Once I assigned a class to each write a poem on 'Love'. Timmy, a real boy's boy, who would not touch a girl with a barge pole, submitted the following:

> Love is a weird thing,
> It's just like a lizard.
> It wraps its tail around your heart
> And crawls into your gizzard.

Not long after this, and unrelated to it, his mother telephoned me to say that Timmy had been so difficult at home – not minding what she said, playing her up, and being almost beyond her control – that she wondered what was happening at school. I answered that there was no particular problem, and, responding to her distress, told her of the poem he had written. She burst into tears and explained that they had recently moved to London from the States. Since then her husband was away a lot on business, and Timmy had become trying in a way he had never been before.

Then she brightened. Did he really write that? She never thought of him writing poetry, and what he had done was really beautiful. It was obviously a new idea to her: Timmy the Poet. This brought my attention to Timmy's poem. Yes, it was good: love does both envelope around and pervade throughout the inside of one. In an out-of-the-mouths-of-babes frame of mind, I felt that Timmy's boyish doggerel paradoxically expressed an eternal human truth. Here was the Divine Child, the *filius sapientiae*, in a baseball cap.

That is one view of the child. Another would be that Timmy was possibly – because I do not know – distressed not only by the move to London, but by the loss of his father while he was gone on business. With his father away, he would have no choice but to be that much closer to his mother, and at a time in his life when it would be part of the developmental press to move away from her emotionally. Love

for him was weird, because perhaps it meant hating as well, especially if one felt over-enveloped by this love and unable to grow. The feelings that aroused might be not just in the mind, but also in the gut.

These are two Jungian views of the child. The first, I believe, is based upon what Timmy stirred up in his mother's and my unconscious from our archetypal image of The Child, which we then projected on to Timmy. The second is a view of the child based upon actual experience with children, and upon infant and child observation and research.

It is from the second point of view that I am presenting material from analysis with a boy I saw for a year and a half at four times a week. It is only part of the analysis, because I have chosen only one theme, although it seemed to be a main one, in order to demonstrate how the tradition of analytical psychology helped me in my work with the boy I call Theodore. This tradition, which goes beyond Jung, includes the theory of archetypes, how Fordham applied that theory to children, and Jung's notion of individuation.

Clinical background

Theodore was fatherless, as his parents separated permanently when he was four days old. His mother was concerned for his development because of this, added to which he had told her that he felt the father's absence was his fault. She was also anxious about his not doing as well at school as he was capable of. There was a noticeable and, to her, worrying, clinginess. He was unable to be on his own, and, having no friends, he persistently sought the company of his mother or older sister Lexie, and both found this difficult to cope with. For these reasons she referred Theodore for analysis when he was six and a half and in the middle of his second year of preparatory school.

The father lived abroad, and Theodore's contact with him seemed limited to occasional and irregular visits, during which, according to the mother, the father belittled and criticised Theodore, while making much of Lexie's successes. Theodore's own thoughts about his father that he expressed to me in his analysis, were primarily of disappointment and of love for him despite all.

In his analysis I became, amongst other figures, a kind of father to him. I think this was because he felt I understood his boyhood preoccupations, and he unconsciously felt that I must in some way be male. In that way, I was a focus to receive archetypal feeling about the

father. My ability to understand how I – to my mind not a father at all – was this kind of figure to Theodore was helped by Jung's theory of archetypes.

Jung's Theory of Archetypes and Fordham's Primary Self

Jung spent much of his life developing and substantiating his theory of archetypes. His hypothesis was that there are inherited structures in the mind that apply universally to mankind. These structures form what he called the collective unconscious, and are expressed in predispositions to repeat experiences in certain typically human ways. All the archetypes together plus the body formed, according to Jung, the self.

It is this definition of the self – as a psychosomatic whole representing the whole of the physical and psychic potential of the individual – that Fordham uses to postulate a primary self. The primary self, much like a molecule of DNA, contains within it the potential of the organism, and provides the drive to an ordered unfolding of that potential in time and space. The primary self releases potential by reaching out into the environment via what Fordham calls deintegration, by which archetypal expectation meets with external experience. The external experience, which is essential for life, growth, and development, is then taken back into the self via internalization processes Fordham calls reintegration.

Archetypal theory was helpful to me in understanding Theodore's material. Two pictures he drew at the outset of treatment contain, with the hindsight of what followed, a précis of his analysis. Together they illustrated what he experienced as his central difficulty to further development. Clearly it was an oedipal dilemma, about which Theodore experienced very intense feelings despite the fact that he had little contact with his actual father. Archetypal theory makes sense of this because the oedipal complex is an archetypal experience, drawing from internal structures rather than just external circumstances. It is also archetypal because it has a typical, universal form, although the content of the experience is unique to each individual.

The content of Theodore's oedipal conflict was evident in his first two interviews, which I will describe in some detail. Before I do so, I would like to point out that my understanding of the two pictures was not clarified until after the analysis was finished. What I say about the pictures here is not what I put to Theodore at the time. It was only

after I was able to reflect upon the whole of his analysis that I could then interpret the two pictures in oedipal terms. The same sort of thing happens in adult analysis, when the first dream is held to be important because it so often contains the seeds of what the analysis turns out – upon reflection afterward – to be about.

At the first interview, Theodore came up the stairs in front of his mother, and smiled at me apprehensively. When I first saw him, he struck me as an endearing child, with light brown curly hair, blue eyes, and soft, rather pale skin. In the waiting room I asked him if his mother had told him why he was coming to see me. He answered that he thought it was something to do with his memory.

He followed me compliantly into the consulting room, and with my implicit permission, opened the box of toys, took them out, and put them on the table before playing with them. While playing he talked, and told me about an accident he was in. The front windscreen of the car was broken, but all the passengers, that is, he and his mum and Lexie, were safe. He then enquired if I could see a lump on his forehead, which I could vaguely make out. This occurred in a fall in the garden. He then pushed one hand against the other, pressing the fingers on one hand back to nearly touch the wrist, showing me he was double-jointed. I said perhaps he thought he was coming to see me because of the accidents that affected his head or because he had something peculiar about his body. He looked attentively at me when I said this, and afterward his play changed and he became more involved in it.

Upon reflection, I think that by this point in the interview Theodore had revealed several thoughts. He had come thinking it was because of something wrong with him, an injured head with faulty memory. He experienced his psychic difficulties concretely in terms of his body, as what was body and what was psyche had not yet been separated out in his mind. I considered that his anxiety about having an odd and possibly damaged body was related to his concern about his penis. This hypothesis comes from my thinking that in his inner imagery there would be an equation between his penis, his member, and his head, which could not re-member.

His anxiety about this and about what kind of person I was in relation to him was expressed in his play after he took out the toys. In this, he assembled the dangerous alligator family, one of which he had momentarily aimed threateningly in my direction. He separated them from the vulnerable cow family, and placed between them a rubber in the shape of a windmill, saying about it 'he has lasers'. His

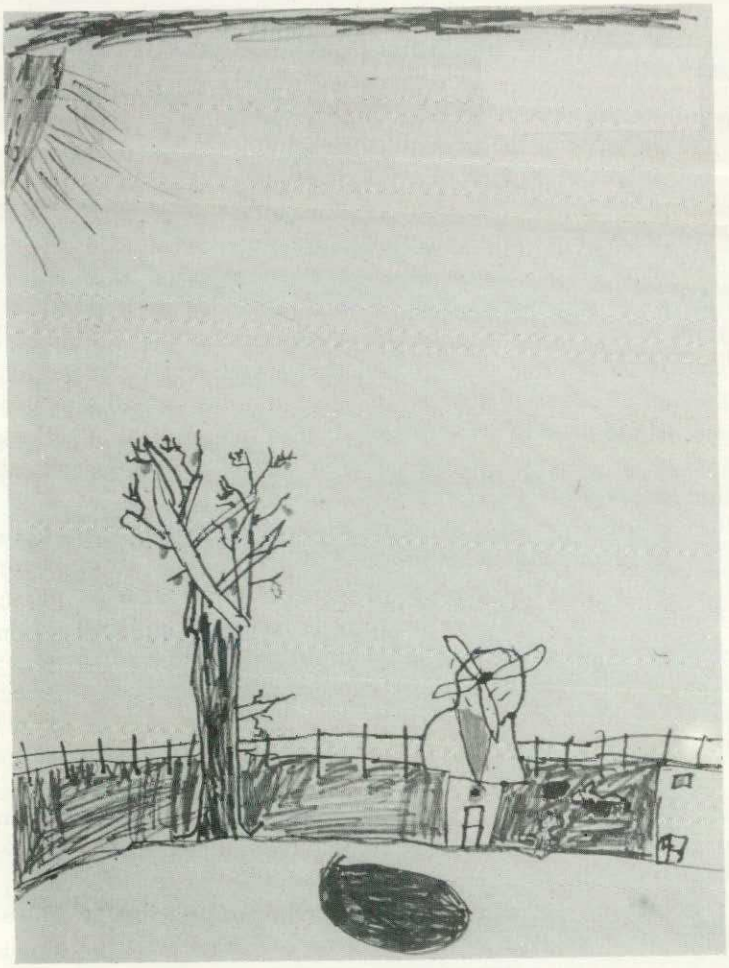
worry about his situation and about being alone with someone he had never seen before led him to want the help of a good father, like the windmill with lasers, that was strong and stood between what was vulnerable (him) and what was dangerous (me), the way the windmill was placed between the cows and the alligators.

The triangle of vulnerable object, dangerous object, and strong, protective father was repeated and elaborated in a picture he drew just after this play. He first drew a blue sky and then on the left side, a tree that had branches above as well as one placed lower down. He then drew the sun, with which he was quite pleased. Next he drew a windmill just to the right of the tree. He noted that the windmill looked like a gold medal, and coloured its centre yellow. Just to the right of the windmill he drew a little man, a stable, a horse, and a little pond. The stable had food in it for the horse, and the pond was for the horse to drink from. Last he added green dots on the tree, representing fruit. All this he did quite pleasureably self absorbed.

This picture represented a situation in Theodore's mind that was clearly part of an oedipal dilemma. The tree in the picture has branches on top, which being the above part, corresponds to breasts. The branch placed about a third of the way up the tree stuck out like an erect penis. The tree was thus the phallic mother, or combined object, which is associated with the object that can provide all, as well as being all-powerful, and therefore terrifying.

After Theodore drew this, he put in the windmill, having said in his play just before that the blue rubber windmill, the model for the picture, was a 'he'. So the figure was that of a man, and from the play just previous, it was a protective figure, keeping the attacker from the attacked. Thus the windmill in the picture was the good father, which, like a medallion, was much prized. The figure was smaller in stature than that of the phallic mother/tree, as the former was felt by him to be less powerful than that of the more primitive image of the mother. Between the images of the mother and the father he drew a large pond, representing something between the parents, such as a relationship, from which each could draw. The windmill/father stood closer to the little man than to the mother, and Theodore said the little man could go inside it if he wished. This expressed Theodore's wish for a close and available father, as well as to have a potent penis (little man) which could get inside another's body.

The windmill/father stood between the tree/phallic mother and the little man/Theodore. Theodore had a wish to be separate from his mother and to have his own autonomy and instinctual life, represented



by the horse, and the stable and pond from which it got its sustenance. This was established in the picture only after the windmill/father had been placed so as to separate the figures representing Theodore and his mother. The placement of the windmill/father also meant that the tree/mother would be safe from Theodore's attacks on her, enabling her to have babies, which he added last of all as fruit.

In the second session Theodore seemed pleased to come back, and looked at and talked about his picture of the previous session immediately after taking out all the toys. In the play that followed, he made

the lorry, which was the largest of the toy cars, go into the stable to feed the animals there, because, as he explained, 'he has their food'. While playing, he turned occasionally to look out the window, and seemed quite bothered by the rain and the sound it made.

In this session Theodore picked up where he left off in the previous session, which had his father and mother together with Theodore positioned off at the side. In the second session he responded to this configuration by imagining the intercourse that ensued upon the parents being together, i.e., the lorry/father that got inside the stable/mother to feed the babies inside.

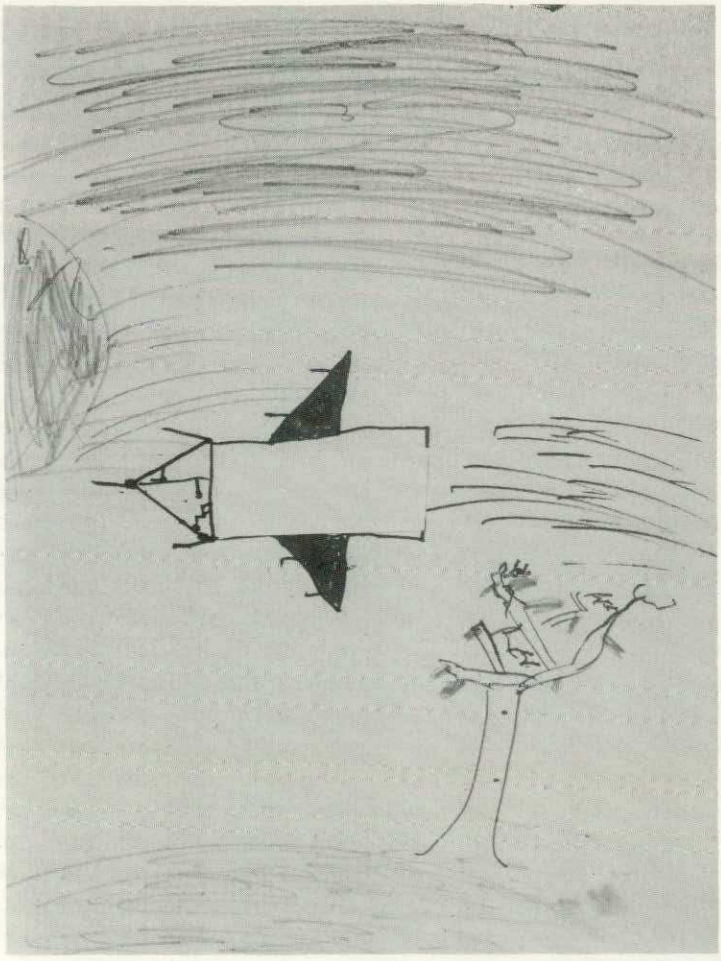
Following this play, Theodore drew a picture of an aeroplane between a large sun on the left and a tree similar to the one he had drawn the previous week, on the right. He drew some decoration on the plane, which identified it with himself as the decoration included his initials. Then he added lines on the back to show its speed, occasionally looking over his shoulder to the window and listening apprehensively to the rain.

The aeroplane which represented Theodore separated the parental figures, i.e. the sun above and the tree below. The speed lines he drew expressed a manic flight away from the father he feared would retaliate against him for his wishes to separate the parents and have mother for himself. The persecutory mood surrounding the manic flight was suggested by the feeling he had about the rain.

In summary, he wanted very much to have a good father, of which he had an idealized, archetypal image, who could confirm and support his autonomy and potency, and protect him from an over-possessive and castrating mother. But if he were to have this father, the father would use his own potency, which is the essence of a good father, to have intercourse with the mother. This would then arouse not only Theodore's hatred and jealousy, but also his wish for exclusive possession of his mother and for the elimination of the father, for which the father would retaliate by damaging the son's potency (the bruised, forgetting head).

Archetypal theory, instincts and infancy

This tale is obviously straight out of Sophocles, but how would this understanding help Theodore? To consider this, I am returning to archetypal theory. In relating archetypes to instincts, Jung stated that the archetypes are the mental representations of the instincts: 'the



archetypes are the unconscious images of the instincts...' (Jung 9, Pt. 1, p. 44, para. 91). Although archetype and instinct can be 'the most polar opposites imaginable, ... "les extremes se touchent"', and they 'subsist side by side as reflections in our own minds of the opposition that underlies all psychic energy.' (Jung 8, p. 206, para. 406)

Jung drew upon the light spectrum as a simile to describe how the 'dynamism of instinct is lodged as it were in the infra-red part of the spectrum, whereas the instinctual image lies in the ultra-violet part.' (*Ibid.*, p. 211, para. 414) That is, bodily. instinctual experiences are at

the infra-red end, and imaginative, spiritual experiences are at the ultra-violet end. This means, to go back to the two Jungian views of children in my introduction, archetypal activity in infants and children is not the same thing as the archetype of the child, because the former is about psychic experiences at the end of the spectrum relating to instinctual activity, and the latter relates to the end relating to cultural and collective images.

Michael Fordham applied his studies of biology, physiology and ethology to examine phenomena at the infra-red end of the archetypal spectrum and study the earliest manifestations of archetypes in infancy. He coined the term 'body-mythology', presumably because if one can talk about classical mythology to describe archetypal imagery at the one end of the archetypal spectrum, then one can talk about body mythology to describe the experiences at the other.

The reason the infant mind is made up of body mythology is because inner archetypal expectation, carrying with it the archetypal opposites of good and bad, has met with external experience of actual bodies and body parts. That is, the inner archetypal expectation in an infant's mind is of a real breast from which it can feed, and experience as either good or bad. Essentially, if simplistically, this mythology is composed of bits that protrude – like nipples, penises, fingers, noses, and faeces – and bits that are orifices – like mouths, ears, vaginas, and anuses. When the 'sticking out bits' combine with the 'bits that allow something to be stuck in', and when that coming together is accompanied by a flow of something between the two – like milk or semen that produce powerful bodily sensations – then a total, mind-body pleasureable experience can occur. When the bits do not come together in a way the infant can relate to in a gratifying way, then other kinds of experience, usually less pleasureable, can arise.

If this goodness is missing, that is, if it is not experienced by the infant to be in his own mind-body, the infant seems to be curious about where it has gone – hey, where's all the action? – and pursues it by projecting himself to where he feels these good experiences are happening inside the mother's body.

Theodore seemed to be doing this when, not long after the two sessions I have just described, he confided in me two secrets on two successive sessions. The first was that he had been sick in the night and his mother had taken him into her bed to comfort him. The following night his mother was ill, and Theodore was convinced that this was his doing, for which he was distressed. It seemed that being in bed with his mother on the first night aroused sexual longings in

him, and that his mother's illness on the second night was a confirmation that his sexual phantasy had been in some way acted out, that is, her illness meant to him that his vomit was like semen that had got into her. What followed this represented the fears of what would happen to him from a retaliating father, and they seemed to be taking place inside the mother's body.

The subsequent play depicted an obstacle course, the first of a repeated theme that lasted throughout his analysis. The typical pattern was as follows. The toy cars, which were identified as brothers of varying ages, were carefully manoeuvered through a narrow passage (vagina) formed by two pencils or other items from the box of toys. When the cars were introduced onto the obstacle course, which was made of pencils, a sharpener, an eraser, and sometimes the animals, competitive, chaotic, and aggressive activity would commence. The cars bashed into one another, then occasionally went 'kissy-kissy-cuddle', and then were smashed up again. One of the cars would be declared winner, and then another would come and strip the former's triumph. This would occur repeatedly in seemingly unending succession. The feelings expressed via the play were rivalry, aggression, and excitement born of fear.

I understood this as a body myth, in which Theodore felt his sexual impulses had enabled him to get inside his mother's womb via her vagina. There he experienced an obstacle to the fulfillment of his wish to have his mother for himself, because of the presence of a jealous and retaliating father. The immense power of this frightening father had been both attacked by Theodore, and also broken up to be reduced into several less powerful brothers, with whom he then competed. The rapid oscillation between the smashing up and going 'kissy-kissy-cuddle' represented the chaotic mixture of good and bad feelings he had about himself and his father as he faced the archetypal experience of his own oedipal conflict.

How could my understanding of archetypal theory and the oedipus complex be put to a six year old? To understand and interpret material relating to archetypal imagery in the infant part of the mind necessitates a particular vocabulary. This was developed by Melanie Klein, whose definition of unconscious phantasies Fordham recognized as the same as that of archetypes. I used this language with Theodore, and it developed in the following way.

> Theodore took out his cars and ... was maneuvering one of them through a very tight space in the entrance to what he said was its 'home'. As he did this, he said, 'Will he? Will he? Will he?' I said, 'You're saying willie,

willie, willie, and maybe you're talking about your willie, and putting your willie, your penis, inside something – inside me, like perhaps you've wanted to put your willie inside mummy and Lexie.' He was lying quietly and listening, looking at the cars. He picked up the cow family and arranged them with the two calves together, rear to rear, and the cow and bull together, feet to feet, front to rear. I said that the two calves were him and Lexie, with his penis inside Lexie, and the cow and the bull were mummy and daddy, with daddy's penis inside mummy.

He continued in his play with the cars, with the lorry [which had previously been designated Daddy] being the fastest and most powerful. I said this was like daddy's penis, which Theodore felt was the fastest and most powerful. There was then a line-up of winners, and the lorry got the cup. I said this was the daddy, who had the best penis, and that he got the cup, which was mummy. All the other cars got ribbons, except the littlest one, which got nothing at all. I said this was him, who felt he had nothing much of his own, but wished he had a penis like daddy's.

I feel that his responses to my comments, i.e., the conjugal positioning of the toys, verified and elaborated what I had said about his body mythology, and the feelings he had about this myth.

Individuation, wholeness, and the infant part of the personality

Whereas Theodore was obviously becoming more aware of his intense feelings of hostility to and competition with other males, he also needed to encounter the feelings about being little and 'having nothing much of his own' if he were to move toward wholeness in his personality. This would mean having the capacity to experience a helpless, vulnerable and dependent infant part of himself.

Just after his first holiday break from analysis, he complained of feeling tired and ill, as had been his mother and sister. Lexie's illness and the subsequent attention she received from their mother stirred up Theodore's jealousy and envy of his sister, and during this period he wrote her a card that said 'Feel better son' rather than 'feel better soon.' On one occasion he said solemnly that Lexie wanted an older brother, not a younger one, and then added sadly, 'Mummy doesn't like me either.'

Out of this rejection and misery, in a period without holiday breaks in which he could feel safe in his analysis, there emerged images of softness, damage, and vulnerability. The first of these was in a picture he drew of his cat, which he told me was chased up trees by Lexie's cat. The cat in the picture had originally been given a nice smile, which was then eliminated. Theodore explained that his cat did not have a

nice smile as the cat had been hit by a car and the accident had hurt the cat's face.

Following this he started to play with the two soft toys I provided, and later he brought a soft toy of his own, a large, soft, brown and white Hereford bull, named Bully. When he first brought the bull, he handled it lovingly. When I suggested that it was a daddy, he readily confirmed this, and cuddled against it and said how much he loved it. As he did this, I said that this was the daddy he loved. He answered rather softly, 'My daddy doesn't love me.' I said he loved the good daddy who did love him, and this seemed to confirm for him that I understood his unrequited love for the father. In response to the good feeling about me that this evoked, he said that just for a moment he thought that Bully was one of the toys I provided for him. I answered that in his feelings he wanted me to give him a good daddy.

Following this was a series of sessions in which his wish for me to give him a good father became his wish for me to be the good father. In one of these sessions, he invited me to his house, adding quickly, 'Or do you see someone else today?' He continued, 'No, it's Saturday, you see only me,' then paused and asked, '*Are* you seeing someone?'

He made enquiries about me, such as did I have another room, and tried again to get me to come and visit him at home, meeting my interpretation of this with, 'Just answer yes or no.' I told him he wanted me to like him best of all, and to be his alone. As he left, he looked at the board which showed clinic room bookings to see if I saw anyone else on Saturdays, but Saturday is not on the board, so he could not find out. Here it emerged he wanted me to be his good father, and to prefer him above all others. His suspicions of his father, whom he felt he could not rely on, was also felt in relation to me. The notion of my and the father's unreliability and being with someone else rather than with him, stirred up his jealousy and made him feel possessive.

A week after this, he invited me to come with his family to the school fête, saying, 'You could come if you wanted to, it won't cost you any money, and you don't have to dress up because it's Saturday.' I said he wanted me to go with him and be his dad, and that as he felt that Mummy and Lexie were going to be together at the fête, he wanted me to come and be with him so he would not be on his own and alone. He listened intently to this, and went to the windows and looked out, saying he was going to count the chimneys. I said he was

counting all the boys and their fathers, the chimney/penises, that would be together at the fête.

Despite my explaining to him that I would not be going with him to the fête, as it drew closer, it was clear that he maintained hope that I would. He told me he was going as a dancing bear and that Lexie was going as the trainer. He wanted to show me the costume, and told me he was going to take a pot of honey to pretend to lick. I interpreted that he felt that if I could see how loveable he was in his bear suit, then I would go to the fête.

A few minutes after this a male patient in a nearby room emitted a bellowed moan. This frightened Theodore, and I asked him what he thought it was. He answered, 'A bear.' I told him that this was in his mind a ferocious bear that would not see what a loveable little bear he was. Thinking of what he had previously told me of his worry about how his father felt at holidays when Theodore, Lexie, and his mother were together, I continued that he feared he pushed Daddy out of the family. And now this was the angry bear/father that had come to get him. Theodore adamantly denied pushing his father out, but went on to add that his grandfather had died when he was six months old. I asked if he felt he made his grandad die, but he called out 'No', and said his grandad saw him several times. This seemed to be as close as Theodore ever got to his death wish for his father, and the fear and guilt this aroused. His phantasy seemed to be that the father's absence was due to the father's awareness that his son wished him dead. In the instance of the grandfather, these wishes were, in phantasy, realized by the actual death.

Thinking about what this did to his mother and sister, Theodore was very low. He confided painfully, 'Mummy's awful to me half the time – no, three-fourths of the time – and nice half the time, and Lexie's awful, just awful.'

Some time after this session he started to bring a small, soft toy mouse, named Magic, which he stroked and loved, and which became linked in his mind to his penis and masturbatory fantasies, as at night, Theodore 'talked to it', i.e. played with it, and it became erect as if by 'magic'. The toy was also, like his penis, soft and vulnerable.

Later, in contrast, he made, in a depressed mood, a Viking comb of many colours. While he did this, he told me the Vikings were fierce, as well as some other information about them he had learned at school which seemed related to an image of industrious, heroic masculinity. I think that the link between the Viking comb and learning is an important one, linking the head and the phallus. Theodore's making

of the Viking comb seemed equated in his mind to making a good penis, and this was reflected in the change of mood as he made the comb. He left the session so proud of what he had done that he wanted to take the comb home with him.

At the end of the summer term he brought me his school report and said that I could read it. He told me his mother had read it to him the night before, and he knew what it said, but had forgotten. I read it aloud, and it had the theme of improvement, especially in reading, making friends, and confidence. He beamed, 'I don't know what you think of this card, but it's the *best* I've ever had! I'm the *best* at *everything*!'

Theodore's analysis seemed to provide him the context in which he could experience the opposites, on the one hand, of aggression, triumph, and hyper-potency, and on the other hand, of vulnerability, damage, and helplessness in the face of loss. These opposites were transcended by the self, and a new image emerged. This was the image in his mind of having a good, loveable (like Magic), potent penis, that could do things such as to help him learn. In contrast to the damaged penis he brought to his analysis in the form of a bruised head with poor memory, it also seemed to be a penis that could repair itself. The school report was an external confirmation of what was happening inside, and his new image of himself as 'best' expressed the confidence he felt in feeling whole.

Theodore's confidence needed the support of his analysis, and with the forthcoming summer break he returned to his complaints about 'boring school' and how he hated it. By the autumn, his mother had decided to move from London the following summer, at the end of his last year at preparatory school. This made for interruptions to his analysis because he missed sessions to attend interviews for boarding school. All these factors resulted in his not feeling contained enough in his analysis to address the image of the bad father within him.

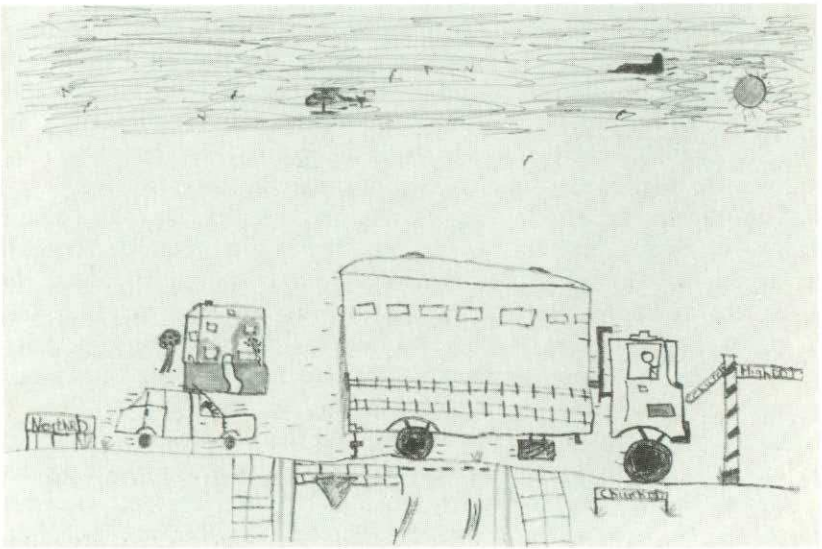
By the time his analysis ended prematurely, I questioned whether Theodore had been able to reintegrate and establish the image of a good-enough father inside him. My doubts seemed confirmed when his mother contacted me after his first year away from London to say that, in response to the parents' forthcoming divorce, Theodore was upset and indicated that he would like to see me. As the family were staying in London over part of the summer holiday, I arranged to see him.

In the first of five sessions that were arranged, Theodore's initial

play and picture expressed his repeated wish to have a father. He had brought with him two lorries and a car, which he acknowledged were father, mother, and himself. He placed the lorry/father so that it was between the lorry/mother and car/himself, and nodded in agreement when I said that this expressed his wish to have a father that would be between his mother and himself, so he would not be too close to her.

He then drew a picture of two cars driving in the same direction toward a 'High Road', with a road to the side leading to the church. In the course of drawing it, he referred to his parents' divorce. When I asked him what 'divorce' meant, he answered, 'It means losing a dad. Mum told me that I'd still have a dad, but I don't understand that.' I said that the large car he drew first and in the middle of the picture was his wish to have a father in the centre of his life, and he heartily agreed. I continued that the smaller car behind it was his mother, as he told me it was driven by her. I said I thought this was his wish to have his parents go in the same direction, and not to be moving apart. The road to the church, which he added after he had drawn the two cars, was his wish for his parents to be getting married, not divorced. He then drew a house where they would all live together, and the honeymoon they would all go on.

He then talked about what he was going to be doing with various



boys from his new school. He talked about school in a way that suggested he liked it and missed it, and I commented on this. He insisted that he wanted to be with his mother and Lexie over the summer holiday, but seemed to appreciate my understanding that he had developed friends, interests, and activities of his own that meant a great deal to him.

Thus, Theodore could acknowledge that there was a gap in not having a father, a situation made permanent, to his way of thinking, by the divorce. This gap was prematurely filled with ideas of marriage, honeymoons, and a family together so that painful feelings would not be experienced (the manic flight on the 'High Road'). He then seemed to turn in his mind to another gap that was easier for him to experience, that of missing the boys at school, the brothers, who in his mind had their origins in the archetypal image of the father. In this way some of the feelings Theodore had about being fatherless could be experienced in regard to his peers at school.

Conclusion

Although Theodore thought of himself as not having a father, in his fantasy images of the father existed and were projected at various times onto me and other objects within his analysis, whereupon some of these images could be discussed and discovered. The inner father, as the course of the analysis revealed, developed, or deintegrated, through the activities of the self-regulating psyche, into archetypal images of the brother. Working on this in the analysis led Theodore to be able to have good relationships with his schoolboy friends, and these relationships helped to sustain in Theodore the capacity to relate to his male peers and to maleness in a satisfying way.

A brother is not a father, and Theodore failed, I think, to come to terms with this. I think this was because it was too much for Theodore to experience the bad internal father who in phantasy hated him because of the son's death wishes toward the father. Instead he clung to an archetypal image of the good father, thus preventing the possibility of these two opposites being transcended to become a new, more humanized and sustaining image of the father.

Although it seemed that Theodore could hold, with some reliability, to what was positive, to my experience, the strength of what is positive is directly linked to how much what is felt to be negative can be contained. So how well and for how long this way of functioning can

serve Theodore can only be answered by the test of time and his own development.

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SELF-DESTRUCTIVENESS IN WOMEN: A FEMALE PERVERSION

SUSAN FISHER

The thesis of this paper is that self-destructive behaviour can be a female perversion. The aim is to relieve unbearable pain, anxiety and tension. Intensely ambivalent feelings toward the maternal object are acted out in two ways – firstly by a perverse mother-daughter relationship and secondly through a destructive attack one one's own body and creations as a means of attacking mother. In adult life, these emotionally deprived daughters of emotionally deprived mothers use perversion to protect themselves from re-experiencing the traumatic feelings of loss, which they actually experienced at birth or in utero. The perversion aims to defend oneself against feeling of emptiness and deadness resulting from early loss. It carries through at least three generations inhibiting separation-individuation and preventing women from living comfortably in their own bodies.

I do not use the word perversion in a judgemental or pejorative way. I use it to mean to twist, distort, disguise, to oppose 'normal' aims of development. These daughters repress their own needs and development in an unconscious attempt to find absolute security with mother. There is an addictive immature clinging to a split maternal object. Daughters redirect hatred toward the (internal) bad rejecting mother into themselves in order to preserve the illusion of having a good loving mother. The perverse relationship is an unconscious collusion between mother and daughter to unite in a stage half-way between infancy and sexual maturity, denying differences and projecting sexual and dependency needs.

As a hospital social worker, I worked with women who had been admitted after 'non-accidental accidents' – walking in front of a vehicle, falling off a bike or out of a window. Later, during my attachment to a gynaeological unit, I counselled hundreds of women seeking abortions. I wrote two papers based on that clinical experience (Fisher 1984, 1986a). The papers, about patients who had repeated abortions, discussed the questions, 'Why do they do it? What is being aborted? and Why do they need to repeat it?'. One patient was having her fifteenth termination of pregnancy. My theory was that the women were unconsciously trying to resolve a conflict about separating from

mother and that the pregnancies had very little to do with either the putative father or adult sexuality. 'Abortion can be seen as a direct attack on the hated, feared "crybaby" part of the self, mother and their stifling union, in an attempt to make separation-individuation possible' (Fisher 1986a, p84). In conclusion I wrote 'There are unseen wounds inflicted on individuals by ambivalent mothers who continue their pregnacies but are never able to love their children.' (*Ibid*, p. 85/86). This paper develops that theme. In 'The Metaphor of Twinship in Personality Development', I discuss the 'sibling-like alliance (narcissistic union) founded on the actual experience of identical twins' (Fisher 1986b). I describe twinship is described as 'a defence against the unfulfilled need for containment, acceptance and love. It inhibits the separation-individuation process and ensuing object relationships (including the therapeutic relationship).' (*Ibid*, p. 272). The perverse mother daughter relationship to which I refer in this paper, is a twinship by my definition. There is no container/contained, only a sense of being stuck together in an adhesive, addictive union.

Clinical illustrations

Although there are many woman I could write about, I will tell you about Veronica and Karen, both of whom left me feeling sad and frustrated because they were not able to use the analytical process to work through their conflicts. Before psychotherapy, Veronica had had three abortions and three miscarriages – she stayed in treatment three months. Karen had had breast cancer and numerous other physical illnesses and died from brain cancer following cancer of the pancreas. She was in therapy for three years, attending only irregularly. Other patients who have come into treatment with defences less firmly established have become less self destructive and developed as individuals.

Veronica was in her mid thirties when referred to me by an abortion counsellor, following the loss of her second twin pregnancy. It was her fifth pregnancy, 6 out of 7 foetuses had been lost. She had one child, an adolescent daughter with whom she strongly identified. Veronica presented as attractive, confident, successful artist, although I experienced her as a very lonely frightened child.

At the beginning of her therapy, Veronica brought the following dream, which represents her unresolved conflict. She was in her own bedroom in the family home when she sensed that she was in danger of being shot or stabbed by someone in the family. Her parents and

two boys were downstairs. Veronica wanted to go to the safety of her mother's bedroom, but was afraid that if she found mother's bed empty it would mean that mother was her murderer. There was no safe place. Veronica wanted to tell me the dream but did not want to discuss it. The dream seemed to be about the danger inside mother's room (womb) and about destructive impulses outside and inside. Mother was idealised as a safe but destructive haven; the alternative positions seemed to be on one hand engulfment/impingement and on the other aloneness/annihilation.

Veronica's mother had one son before marriage, then four daughters before a second son. It was her father's second marriage; he already had two sons making a total of eight children. Veronica hardly knew her parents, they travelled together a great deal, leaving the children with a large household staff. Mother would return to have a baby and leave home again after confinement. She seemed to be a woman who enjoyed being pregnant but not able to be a mother to her children. Veronica remembered receiving her mother's postcards from distant hotels with a pinhole to mark her room. As a child, Veronica would hold up the precious cards to a light in a desperate attempt to see/find mother. I found this image of the abandoned child very powerful and distressing. Veronica was trying to find a good mother to protect her from the bad mother (internal and external). As an adult, she tried to find and preserve an image of a good mother to identify with during conception and pregnancy, but discovered her identification with the bad attacking/abandoning mother during termination of pregnancy. She compulsively acted out her internal conflict.

It was often difficult for me to stay with Veronica's destructiveness. She spoke about the babies she had 'killed' and the narcissistic men she had gone to bed with, seeking love. She needed me to know about, and accept, her destructiveness; she needed a reliable container for these feelings. Shortly after starting therapy, Veronica became pregnant for the sixth time. This time, when she decided to have a termination, it felt more like a conscious decision than an acting out of hateful revenge. She also terminated the relationship with a married man with whom she had been having an on-off relationship for seven years.

Following a brief period of depression, painfully acknowledged dependency needs, anger and sadness, her defensive armour returned. Expressing gratitude, she insisted that she did not need further help. In think she idealised me as a 'pinhole' mother and could not risk devouring or destroying me; however she attacked me indirectly by

attacking her therapy. Perhaps her inability to remain pregnant indicated a deep need to remain empty, avoiding mother's primitive envy and/or rejection. Mother's envy of her life outweighted the capacity to love. Veronica could not achieve a normal happy life nor truly accept her sexual or dependency feelings because she could not risk losing mother.

The tragic death of Karen, a beautiful 37 year old actress, who was admired and loved by many, clearly illustrates this syndrome. Karen recognised in herself a lifelong pattern of unconsciously expressing feelings through her body. She was the sort of patient McDougall described as reacting to almost every stituation that was emotionally arousing (especially anger and separation) with a tendency to fall ill (McDougall 1989). Her attendance was irregular because of her need for medical treatment away from London in a town near her parents. She travelled between her mother/therapist in London and her real mother in the North. We were alternately seen as good or bad. Periods of progress and health were followed by illness and regression. Karen had made previous attempts at therapy, but never wholly committed herself to anyone or anything, always half-in and half-out. Caring friends and professionals were seduced by her frightened, vulnerable 'true self', but since she experienced love as diminishing and damaging no one was able to get close enough to help her. She was unable to internalise loving feelings. Infantile rage at being used to satisfy the needs of others was always present but rarely verbalised. Repeating mother's pattern, she surrounded herself with dependant individuals but then resented their need of her (i.e. she projected her dependency needs into the object then attacked the object).

Karen was the middle of three siblings, with a sister eighteen months older who monopolised the feminine role, and a brother seven years younger. Karen knew she had been an unwanted pregnancy. She struggled throughout her life to find a space/place for herself and to be wanted by mother. Karen's mother was herself a second unwanted daughter, so this was a source of identification. Karen strongly identified with the shadow aspects of mother (e.g. masculine, ugly, unlovable) while her sister carried the positive projections (e.g. maternal, strong, beautiful). The split of the maternal object into good and bad daughters was apparent through three generations. Karen's sister had twin daughers – one good and one bad.

Karen's mother was a hard working Jewish Czechoslovak 'butch' woman with a habit of continually smoking cigars. Karen tried to

share her experiences and friends with her mother who always seemed lonely and empty. Mother was perceived as miserable, cold and withholding. She rationed affection as she did biscuits and chocolates. Before leaving the dinner table the children were obliged to say, 'thank you for sufficient', even though they often went away hungry. There never seemed to be enough good things in their lives. Father was a handsome Scottish Presbyterian who was perceived as warm, creative, and exciting. He was the comforting caretaker she longed for, but he was also sexual, violent and intrusive, so his love did not feel safe. Karen turned to father prematurely for affection, causing her confusion and guilt. Love became sexualised. Pregenital and genital love were the same for Karen, so in adult life she tried to find pregenital love with lovers. When Karen was 12 years old she told her mother about the extra-marital affair which her father had been having for many years. Unconsciously, I think she was a sexual love object for both parents. Her parents slept in separate beds and Karen refused to acknowledge any sexual attraction between them. There seemed to be no internal or external image of parental intercourse, only a single needy hermaphroditic parental figure.

A recurrent dream since childhood shows the threatening inner world which Karen was defending herself against. She was balancing on a tightrope; on one side there was a frightening witch and on the other a horrible empty blackness (i.e. black hole). The choice is between an archetypal bad witch/mother and a motherless void.

Karen used her body to express what she was unable to verbalise. As a young girl she begged for braces on her teeth and for glasses she did not need in an attempt to draw attention to herself. We came to understand her colitis and fear of vomiting as an attempt to deal with her fear of losing control. She suffered from amenorrhoea for two years during treatment for cancer. When her menstrual periods resumed she could hardly wait to tell me that she was a 'real woman' again. She emerged full of energy and radiantly beautiful but sadly the joy did not last. Attention was soon redirected back to mother who became ill. It was as if Karen was not allowed to have such happiness.

A few months after Karen returned to London 'recovered' from cancer of the pancreas, her mother had a serious heart attack. Karen rushed to her bedside to give the tender care and cuddles which she herself had always longed for. Four weeks later, mother died of a second heart attack. At the memorial service Karen planted a fruit tree and set off fireworks to celebrate mother's life; her ashes were

spread under the tree. The maternal grandmother, who lived nearby, did not attend the service, still rejecting her second, unwanted daughter. Three generations were clearly involved. The grandmother could not acknowledge good loving feelings, so mother (second generation) redirected hatred toward her own body. Karen (third generation) later attacked her own body.

One week after the memorial service Karen was rushed to the hospital in which her mother died, complaining of severe pain. Karen was wearing mother's dressing gown, identifying with mother. Tests and examinations showed no physical disorder so Karen returned to London and therapy –trying to deal with her loss. Six weeks after mother's death, Karen was admitted to a London hospital for her final illness. What was first diagnosed as a stroke turned out to be an inoperable malignant brain tumour. Initially, she completely lost her ability to speak clearly, but she struggled to tell me that she had been secretly scratching her skin for many years. Her body bore the scars of self-mutilation. Karen fought for her life, against cancer, for five years, then she began the fight for a peaceful death. Karen died five months after mother. As she wished, her ashes were spread under mothers's tree. A later memorial service was attended by hundreds of friends, colleagues.

Mother-daughter relationships

The Kore-Demeter myth is about mother daughter unity – every woman carries aspects of her own mother and her own daughter and that every woman is a daughter to her mother and a mother to her daughter. Kore and Demeter represent the archetypal poles of maiden/-virgin and mature/earth mother i.e. the spectrum of a woman's personality. 'Demeter-Kore exist on the plane of mother daughter experience which is alien to man and shuts him out' (Jung 1938). This myth links generations, past present and future. 'One of the forms (daughter with mother) appears as life; the other (young girl with husband) as death. Mother and daughter form a living unity in a borderline situation – a natural unit which, equally naturally, carries within it the seeds of its own destruction' (Jung & Kerenyi 1985). The Kore-Demeter myth ends with compromise: Persephone living with her husband in the underworld for one third of the year and the other two thirds of the year with her mother on earth. Demeter makes the soil fertile and

Persephone gives birth to a son. Life goes on – both women are autonomous and creative.

Karen's experience of the mother-daughter relationship was not of two separate objects with introjected aspects of the other; it is of two undifferentiated women clinging together in a stage between the two archetypal poles (neither virgins nor mature women). Karen and Veronica remained stuck, unable to separate from their mothers, unable to enjoy their own lives. They sacrificed individuality, personal development and marriage for an illusion of security with a good mother.

Bettelheim (1976) and Seifert (1983) have both analysed the well known fairy-tale Snow White. Bettelheim sees it as a tale about the resolution of oedipal feelings – the theme being the mother's fear that Snow White will excel her. He points out that deepest tragedy results when parents are unable to treat their child as a child (not as a competitor or a sexual love object) and accept that they will eventually be replaced by the child (Bettelheim 1976).

In Seifert's (1983) view, Snow White is a story of rebirth, 'old' as an enemy of 'new', and of the conflict between narcissism and mature Eros. He sees mother as a woman caught up in a competitive power struggle for recognition and validation of her own worth, depicted by beauty. Specialness is based on devaluation of the other. The mother does not attempt to kill or attack herself, she is only interested in eliminating the girl.

In the Snow White story, there is no expectation that mother's hunger for attention and validation will be solely satisfied by her daughter or that the daughter's needs will be solely satisfied by her mother. In contrast, the mothers of Karen and Veronica looked on their children for validation and fullfillment. There was not a conscious life or death struggle between my patients and their mothers, but an unconscious wish to hurt or damage.

Discussion

The mothers of self-destructive patients are portrayed as narcissistically wounded, deprived women – empty with an insatiable hunger for attention and love. They look to their daughters to fill their emptiness. Daughters are left with an insatiable hunger for love and attention from a mother who is feeling empty and hungry herself, so a perverse mother-daughter relationship fills the emptiness. You will recall that Karen was obliged to say, 'thank you for sufficient', even when she

left the table hungry. The perverse solution is to cling together in a sado-masochistic embrace, each hungry and angry. This group of women patients are often creative artists (e.g. actors, painters, writers). In their work they continuously re-enact the alternating pattern of seeking attention and rejection. Likewise, in analytical work there is an alternating pattern of seeking attention and rejection.

Kay's paper titled 'Foetal psychology and the analytic process', contains a clinical example of a baby who seems to express the sort of feelings seen in some of my adult patients (Kay 1984). A mother brought her baby daughter to him (as a general physician) because the baby refused to feed. The mother herself was deprived, feeling angry, frightened and appeared inadequate. The baby picked up these emotions and resented mother for it, so turned away from mother, refusing to feed. The baby, like my patients, was so angry and frightened by what mother was unable to provide that she did not take in the good which was offered.

Obviously, not all narcissistic mothers have perverse relationships with their daughters. Welldon says that perverse motherhood occurs as a breakdown of the inner mental structure, when mother feels impotent in dealing with the huge psychological and physical demands of her baby along with an inability to obtain gratification from other sources (Welldon 1988). A mother may split off and project her needs (e.g. dependency and sexual) into her daughter, then relate to the daughter as the rejected split off part self objects. Clinical experience has lead me to believe that projective identification can begin in utero. Rosenfeld, when discussing work with autistic children by Felton, mentions a 'osmotic overflow' or 'pressure'. Feelings, experiences and memories existing in the mother, which are unbearably disturbing to her, are activated during pregnancy by the presence of the foetus. These disturbing factors 'leak out', so the (unborn) child is deeply affected and overwhelmed by the process. The overflow is of something which the mother is determined to hide forever (Rosenfeld 1987).

A mother who has deep contempt for her own body, femininity, sexuality, and dependency needs transmits these messages to her daughter, so they become part of the infant's inner world. If, from birth, a woman is an object of disappointed for being a girl, it provokes in her an intense dislike and hatred for her own body (Welldon 1988). Unconscious revenge against oneself for being a woman may begin in infancy. Veronica's mother longed to give her husband a son, so probably resented Veronica for being another daughter. Karen's mother rejected her own femininity, so Karen could not take pride or

pleasure in femininity. She had particular difficulty wearing skirts or soft fabrics.

Another patient put this problem very well when she described herself as 'inconceivable'. What she was trying to say was that she had been unable to conceive a child, but the real true message was that she had been unable to conceive herself. There was no intercourse between her internal parents –they were impotent/unproductive. A mother perceived as totally bad and an inaccessible father can not conceive a healthy infant. The fathers of these patients were unavailable, physically and/or emotionally, therefore the mothers were needed like a drug. For the daughter, without a father figure, there is no experience of otherness needed to bring about separation. For the mother, without a husband to support her physically and emotionally, there is a need to cling to her child. Karen and Veronica each had a series of unsatisfactory sexual relationships with narcissistic men, trying to find a good mother/father.

I have found Glasser's core complex theory especially useful in understanding my patients (Glasser 1979, 1986). Writing about the nature of perversion, Glasser describes the core complex as a deep seated conflict between the longing to merge into a blissful union with another person (i.e. curl up inside the womb) and the defensive aggression needed to escape from being engulfed, enveloped, or intruded upon, leading to feelings of isolation or annihilation. Karen and Veronica illustrate the half-in half-out position in their relationships. Inside mother's room/womb – there was no safe container.

Glasser stresses the difference between aggression and sadism. The aim of aggression is self preservation and the destruction of the object, as in the Snow White fairy-tale. Sadism is concerned with survival – the aim is to cause the object to suffer, to inflict pain, while maintaining a sado-masochistic connection. The object is controlled at a safe distance, i.e. neither dangerously close nor dangerously far away. When objects are perceived as self objects, to hurt oneself is to hurt the object. These daughters do not want to destroy mother, only to hurt her by hurting themselves. An illness becomes an unconscious link with mother because both bodies are attacked. Veronica's repeated terminations are clear examples of a desperate attempt to deal with a split object by identifying with a loving maternal object and then attacking a hateful maternal object.

Guntrip's theory of the anti-libidinal ego helped me to find an image of Karen's destructive cancer cells attacking healthy cells, as a reflection of her inner world. The theory is of a sadistic anti-libidinal ego

which reproduces the hostility of the object thus rejecting libidinal needs. The anti-libidinal ego is identified with the hostile rejecting object and hates the libidinal object, so the person is divided against herself. A final split occurs between the active part left to carry on in a sado-masochistic manner and the most deeply withdrawn, passive regressed ego seeking to return to the womb (Guntrip 1968). After a split of external good and bad mother, a daughter splits the bad internal mother into regressed and sado-masochistic parts and identifies with the split off part objects. Initially Karen identified with the sado-masochistic part, but in the final stage of illness, she had regressed to become passive and withdrawn.

There is an important link between perversion and self attacking psychosomatic illnesses and the need for love and attention. One could hypothesize that Karen's breast cancer was an attack on the bad breast/mother and that scratching was an attack on the bad container/mother. Perhaps the chronic pain which took Karen to hospital, weeks after mother's death, was the psychic pain of separation. No physical cause was found. Woodman says that it is only when the psyche is strong enough to know that it is unloved that the somatised pain can be released (Woodman 1985). McDougall may offer an explanation for Karen's death. She explains that when the lost object cannot be mourned because it cannot be given up, a part of the subject dies physically and psychic death threatens biological survival (McDougall 1980). Herman writes: 'A daughter's deepest impulse is to want "to die" with mother: not to live "alone"' (Herman 1989).

A final clinical example comes from a colleague's HIV positive female patient. The patient pursued casual sex with a man (father's age) in the high risk group as a revengeful attack on mother. Many women whom I counselled with unwanted pregnancies acted out sexually in a similar manner (by seeking sex with men whom their mother would not approve of). I am deeply concerned about the very real possibility of AIDS becoming the next popular self attacking solution along with 'non-accidental' accidents, abortion, anorexia nervosa, bulimia, drug abuse, etc. Unconscious hatred is being channelled back into psyche/soma to save the previous generation and the next generation. The closing sentence of Stoller's book, Perversion: the Erotic Form of Hatred, is, 'perhaps some day perversion will not be necessary' (Stroller 1975). I sincerely hope that he is right, but meanwhile we must recognise the dangers facing this and future generations and face the disturbing reality of perverse mother-daugher relationships and self-destructive women.

Summary

The paper explores perversion in the form of perverse mother-daughter relationships and self destructive behaviour. Perversions fill the void and deadness left by the actual trauma of early emotional loss. Deprived daughters attempt to resolve both their own and their mother's unconscious conflicts and tensions and find absolute security with mother. Self destructive behaviour is intended to preserve an unconscious alliance (sado-masochistic embrace) between mother and daughter; however, it inhibits the separation – individuation process. Mothers and daughters addictively cling to each other, as split off part-self-objects, hungry for love and attention. When objects are perceived as self-objects, to attack oneself is to attack the other. Patients use splitting, projection, denial, and projective identification to defend themselves against the loss of the maternal object. The syndrome can extend through at least three generations.

Two clinical examples are given – Veronica who had five therapeutic and three spontaneous abortions and Karen who died with brain cancer after fighting off the cancer of breast and pancreas. The Kore-Demeter myth, and Snow White fairy tale are used to give a 'normal', historical view of mother-daughter relationships. Core complex theory is used as a basis for understanding sado-masochistic behaviour. The link between perversion and psychosomatic illness is explored.

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'I CAN'T SUBLIMATE'. SOME THOUGHTS ABOUT SUBLIMATION AND CREATIVITY

ELISHA DAVAR

Introduction

The discrepancy between anticipations and expectations and the changes that come about as a result of the therapeutic process can act as a powerful incentive for further learning and understanding. I was prompted to write this paper out of a puzzle as to why a particular therapy did not go the way the client and I hoped it would.

In this paper I have explored some aspects of our work together. In particular I have focussed attention upon this client's internal life which was dominated by a search for an ideal object. This quest was intensified by the deprivation the client experienced in her early life. As a compensation for her deprivation she became internally identified with an experience of becoming an ideal and single object of devotion in her mother's eyes. This left her with a problem of struggling with the issue of relinquishing her importance for the sake of projects she might undertake. These struggles were exemplified by my client's frustration in attempting to find substitute satisfactions for original experiences; she often felt these to be a masquerade, leading her away from original longings.

In order to understand this client's dilemma I have raised the question of what kind of stages would have to be lived through in order to find substitute experiences satisfactory. The idea of an internal space in mother's mind and what it is filled with plays a central role very much in line with Bion's (1967) thinking. In this case the mother, out of deep anxiety and insecurity, was unable to protect an open space in order to hear her infant daughter's pleas. Mother used her narcissistically, in the sense that she was unable to suspend judgement and action in order to find out what her daughter needed. Instead she responded out of a projection of her own anxieties that went contrary to her daughter's genuine needs.

Finally I have related this original situation and its lack of resolution to the difficulty of finding a channel for inner expression and sublimation.

Clinical material

Miss L told me two years after her therapy was over that although she felt less anxious, calmer and, more her own person she could not 'sublimate' to use her own words. By this she meant that she could not utilise her skills and talents creatively. Miss L had undergone seven years of psychoanalytic psychotherapy which started with twice weekly therapy, went up to three and even four times a week, and eventually ended at her own initiative.

Miss L was the eldest daughter of Jewish parents, both of whom were doctors by profession. She was born in Eastern Europe and the family moved to a neighbouring country when Miss L was two. She had a half sister who was eight years older from her father's first marriage and a sister two years younger than herself. It is also probably significant that her mother had a miscarriage before Miss L was born and had tried to become pregnant for many years. Miss L was also unable to become pregnant and had three miscarriages in spite of very much wanting a child.

One of the important features Miss L described in her growing up was that her mother found her stubborn, uncompromising and lazy and that there was a quality of anger and dissatisfaction that characterised her from an early age. Another significant feature was that Miss L grew up in an atmosphere of perpetual parental tension. Miss L's mother was the authority figure in the home, while father was described as a weakling who irritated them. There were many conflicts over authority but Miss L sensed that the children were used as a palliative for marital tensions.

After completing a university degree at the age of twenty Miss L met an Englishman with whom she became involved and they moved to the West. They were married for fifteen years but Miss L felt very unfulfilled in the marriage. She demanded a role of authority from her husband but at the same time attacked him for trying to impose his authority. She felt similar issues that were problematic in her parents' marriage were being unsuccessfully worked out in her own marriage. Eventually an overall sense of stultification and a growing absence of a sexual relationship led to a breakdown of the marriage. She now has a relationship with a married man who lives in Western Europe but frequently comes to England on business. This relationship is important to both of them.

When Miss L came for therapy at the age of thirty four she wanted a psychoanalytically based therapy. She was perplexed by her life and

could see no direction for the future. She hoped she would become pregnant, but also doubted it. She worked as a teacher from time to time but this was not very satisfying. She had thought about training either as a counseller or as a therapist or even as a psychoanalyst, but did not know how to implement these wishes. She felt she was wasting her life, living in a vacuum and often felt numb and paralysed. Previously Miss L had been quite politically involved as a committed communist but had turned away from this and had found nothing else to take its place. She felt lost, bewildered and a misfit.

On the positive side some of her strengths were that she was able to make and sustain good friendships. People liked her, found her interesting and humorous, which she was, and respected her integrity and unusually perceptive intelligence. Her friends said of her, at least at the beginning of her therapy, that people were either in her good or bad books. Miss L would build people up and then discover some fault in them and become disappointed and critical, although this evened out in the course of time and did not seem to matter in her older, long established friendships.

The main issue that we tried to tackle in the therapy was her feeling of paralysis and lack of fruition. Nothing could go or lead anywhere, whether in terms of career or relationships or having children. We tried to work and think together as to why this might be so. Very slowly in the course of the therapy it became apparent that, by means of her charm, Miss L tried to establish herself as having a special relationship with me. She felt she was my friend; she would show a mixture of genuine and exaggerated concern over the long hours that I worked, whether I was tired, and she worried over my general sense of well being. The sessions had an excessively sweet quality. At the same time she would often come in and scan my face for any signs of disapproval or wandering of attention. I was never allowed sufficient space even to think my own thoughts, and there was a pressure to be totally preoccupied with her. She also refused to use the couch, and in so doing attempted to control me and to watch for any sign of straying of thought. I think her refusal to use the couch also indicated how deprived she felt herself to be, and how important was facial contact as a means of holding herself together.

Later, perhaps after two years when Miss L felt safer, she would sometimes get angry and jealous when seeing evidence of other relationships. She objected to the scarves on the coat rack; she claimed these belonged to my wife or other women and she was going to take them away with her after the session. Miss L also began to show her

fury with my other clients saying that when she heard the bell she would go downstairs and tell the next one to 'F...ff off. Mr D is busy with me this evening'.

We spent a long time taking up the jealous and murderous feelings towards others behind the facade of niceness on various unconscious levels. For instance Miss L had established herself internally as a baby monopolising all the attention, having murdered other rivals. This theme was pertinent because although she was very attached to her younger sister who was thinner and prettier, she was also very jealous of this sister's success with boyfriends.

The theme of the inner baby also mirrored an aspect of her relationship with her mother which had been passionate, intense and close in early childhood. Miss L's mother had been an adored figure while her father was denigrated and despised. In fact her father would often throw jealous tantrums saying that no one loved him, not even his children. So a matriarchal monopoly was operative with husband and children competing with each other for mother's attention. Later in life Miss L came to believe the view that her mother was an extremely anxious, intrusive, controlling woman who would never leave her alone and played on her helplessness. By this time too, her father had died. Nevertheless in terms of transference dynamics, I, too, seemed to be an adored, admired powerful figure, yet Miss L would often forget or blatantly dismiss what we were speaking about as irrelevant while appearing terribly attentive and cooperative, thus always undercutting my importance and value.

Breaks were initially very difficult and usually seemed to involve Miss L's returning to a lost, bewildered state sometimes punctuated with bouts of rage quickly doused with tranquillisers. Alternatively she would go and visit her mother and sister but found that she was hating her mother more and more.

Another level we explored had to do with her feelings as a woman towards me. As some of her hatred, envy and jealousy became more apparent, I was allowed to see just a little of the intensity of feelings expressed towards me and how tantalised and deprived she felt. Although Miss L could never bring sexual feelings openly into the session, she once sent me a letter which spoke of masturbating to a fantasy of us having intercourse and declaring her love for me. This letter had been written when she was doped with valium after feeling terrible and in a rage. So apart from the level of wanting to be 'my only child' there was also the level of wanting to be 'my only woman' in a more blatantly sexual sense, though of course these two levels often

intermingled. Eventually Miss L gave up her marriage, at first moving into a separate bedroom. About a year later her husband moved out and took a flat of his own. Some months later she became involved with the married businessman whom I mentioned earlier. She prefers being the 'mistress' who is always desired and desirable rather than what she calls the 'pillow wife' who becomes taken for granted and a convenience.

Soon after she became involved with this man she defiantly announced to me 'I wouldn't go with you anymore'. It seems this relationship confirmed her sexuality and desirability as a woman and so her fixation on me decreased. Significantly too this businessman had been at her school and came from her home country. As a fourteen year old she was keen on him but he preferred another girl. Thus, many years later, being able to have this relationship reversed her narcissistic wounds and was reparative. It also provided her with a continuity of experience from childhood as he too was Jewish and foreign.

The advent of this relationship marked the final phase of our therapy together. In the end Miss L left me; something that would have been inconceivable in the earlier years of therapy. Her gains seemed to be a greater stability, a lessening of anxiety and a continuous sense of self. She had managed to give up a frustating marriage and had moved into a relationship which gave her both a measure of separateness which she desired, as well as a sense of intimacy. Most importantly it affirmed her sexuality as a woman. Nevertheless she still felt unfocussed about career possibilities and although exceedingly intelligent and academically brilliant, she still works in an office job. Occasionally she is offered some work teaching, which is more challenging. She would very much like to do work which involves people, like counselling, but so far has failed to gain placements on courses.

Once or twice a year we still meet. On the last occasion Miss L said; 'I still can't sublimate. My inner voice is so demanding and strong.' She elaborated by telling me that if she went to a film or appeared happy like other people it was in essence a fictitious activity and felt insincere. What she thought was essentially sincere was being faithful to this voice that drowned out all others. She also spoke of her wish for peace of mind and an acceptance of limitation, though she viewed this as a capitulation in the face of challenges. Miss L also spoke about her sadness at feeling herself still to be a shapeless 'blob'.

After this meeting I tried to examine more closely why the therapy had not been more effective, particularly with regard to an inability to help her further her career. I was puzzled because we certainly

worked on major issues like the meaning of her paralysis which seemed linked with envy and being filled with dead objects that could not provide nurturance. During the course of our work together there had been a shift towards something more hopeful and lifegiving. Nevertheless Miss L still remains in state of frustrated hope because her talents are largely unused and it is this area I want to examine in more detail.

Discussion

As Freud's Instinct theory evolved, the process of sublimation which was an addition to the Instinct theory acquired different shades of meaning too. For instance until Freud's paper 'On Narcissism' (1914), the process of sublimation was regarded as the 'deflection' of the infantile sexual instincts from one object onto another. But as Freud was struggling with the idea of sexuality becoming transformed into higher cultural achievement, he introduced the idea of a modification of the sexual libido into narcissistic libido and he spoke about a 'resexualisation' of the social instincts via a phase in which narcissistic libido is withdrawn back into the ego. Later in 'The Ego and Id' (1923) Freud suggested that the struggles which once raged in the deepest strata of the mind (between Id and Ego) and had not been brought to an end by sublimation, were now contained in a higher region between Ego and Superego. In this zone of the mind, the Superego, which is equated with the model of the father, attempts to enforce an identification with the Ego. This has the quality of a dictatorial 'thou shalt' and when it is successful an 'instinctual defusion' takes place in the name of cultural achievement.

Freud's ideas about the process of sublimation are difficult to follow. They involve a mixture of an energy model with changes of the quality of energy, and social value judgements which are concerned with animal instincts and their transformation into higher social and cultural achievements. But the thrust of the theory seems to be concerned with a conversion of raw energies into more refined energies. Out of this struggle of opposing forces, social and cultural achievements emerge.

Miss L was obviously using the term 'sublimation' in layman's language. However as such it still corresponds largely with Freud's ideas on the subject. Miss L felt herself to be dominated by an inner howl and could not deflect her attention away from herself to other kinds of projects. Furthermore, when she forced herself to 'comply' with societal pressures and go to films and try and be happy, it felt like an internal tyranny which can be understood in terms of the Superego forcing some

kind of socially compliant response as an Ego activity very much in keeping with Freud's 'thou shalt' Superego. And so Miss L felt herself to be restricted, internally compelled and unable to sublimate.

Winnicott (1988) tackled the issue of sublimation from a different angle. Stressing the theme of the omnipotence of the young infant, he arrived at the innovative idea that the infant creates the breast/world anew and this is an absolutely neccessary illusion for later development. In the course of time transitional objects provide an experience which allows the infant to play out and recreate in a modified form the theme of absolute control and creation. The result is that the infant is able in part to relinquish this early illusion. Similarly religious experiences and creative activities are the product of a negotiation between the struggle to give up and to have this illusion, and the emergent true self which is more concerned with the arena of shared communication is also a product of this struggle. In Miss L's case it seems that the phase of her early omnipotence was interfered with by her mother's need to be centre stage. Therefore she was always trying to recover this neccessary, initial experience of being at the centre of things rather than on the periphery as an audience to her mother's centre stage experience. Now this theory seemed to speak to one aspect of Miss L's experience of wanting to be totally important or special in the eyes of the other, but it did not address the issue of her feeling of destructiveness towards others and here Kleinian theory proved illuminating.

Melanie Klein's (1923) early views about the process of sublimation were concerned firstly with symbolic activity. Symbolisation represented the sublimation of the original but by now lost sense of fulfillment. However by 1930 Klein had focussed her attention on the aspects of envy and retaliation by part objects which pushed development in the direction of symbolisation. Inevitably, in her theory of sublimation, creative activities court the threat of envious retaliatory onslaughts. Klein linked these to the original source of all envy i.e. a mother's capability to be able to bear children which she regarded as the greatest source of envy. Now this type of theory seemed to highlight a level of internal destructiveness in my client's inner world. For instance Miss L often used to bring a leaf or a twig to the session and as she would speak she would slowly shred the leaf up as if she were killing something alive. Hyatt Williams (personal communication) has commented on how adolescent girls, as opposed to adolescent boys, tear at loose bits of wallpaper in the consulting room. He sees this as a feature of unconscious destructiveness representing an attack on mother's inner babies.

Although Kleinian theory does go a long way in explaining the envious attacks on creativity that caused Miss L's psychogenically based infertility and inability to sublimate, I did not wish to type caste her in terms of existing theory. That kind of thinking often forecloses one's openess to new impressions and idea building. So I found myself thinking about Miss L in terms of what was particular to her from my own countertransference reactions and I came up with several distinct impressions.

Firstly I remember that Miss L had a very poor sense of boundaries during the first few years of the therapy. For instance she might report a dream in great detail taking about twenty minutes to do so and mixing up all the dream associations with long reality references so that the essence of what was dream and what was reality got lost. It seemed her dream life was not in any way bracketed off from her waking life. The two ran into each other. Another example that springs to mind was my once saying that I imagined that she did not behave the same way inside the session as outside it and immediately realising as I said it that it was probably not true. Miss L was puzzled and remarked 'I'm exactly the same inside and outside the session' and I realised that in all probability the domain of private and public were not differentiated either.

So it struck me that boundaries had not been established and that there was also some kind of principle at work that made all experiences equal and flattened out distinctions between them. Meltzer (1973) explores the basis of creativity in the concept of the 'combined object'. He points out that the emergence of something new comes from the tension inherent in differences rather than a combination of similarities.

Another noticable feature was Miss L's high degree of overall anxiety, particularly about changes. This feature was inseparable from that of blurring distinctions and wanting sameness to prevail. I previously commented on Miss L's watchfulness and being attuned to my every mood. Thus she was supersensitive, vigilant and always checking that I was the same. Sometimes I seemed a different person to her with another voice which she did not recognise. If my mood was anything but constant, consistent and totally friendly this caused alarm. If I cut my hair this threw her as she walked into the session. So we both had to be preserved in an unchanging constant continuity that was deadening.

Her anxiety about change of any kind was also manifested in a fear of aging and dying. Miss L seemed to have a frozen sense of space

and time and dreaded the idea of getting old, though she often played with the image of herself as a little old lady. However, she could not seriously accept that the passage of time would bring changes whether one wanted them or not.

Connected with her anxiety about change was her intense feeling of loss, disorientation and bewilderment when a change had occurred. For instance even though she travelled often to and fro between Europe and London to visit her mother, each time she would feel utterly bewildered and unsettled by the change. Despite the fact that in her head she knew these were familiar experiences, she was unable to accept them as such. The agility that she had for speaking different languages was lost at these times, and she felt foreign, clumsy and awkward and unable to communicate adequately in a different language. Then after several days she would begin to feel herself again and use the language with ease.

It was precisely in this area of anxiety over sameness, difference and change that our difficulties lay. Earlier I mentioned a dominant matriarchal complex as a feature of the transference. Mother as represented by me was not allowed to be absent nor was Miss L allowed a separate or private space. She experienced me as making excessive claims over her. This transferential feature of a strong wish for symbiotic bonding corresponds a great deal with the need in early infancy for in touchness and tuning in. I do not think Miss L's mother could ever offer this kind of in-touchness as she was so preoccupied with her own anxieties that she was probably unable to put her infant's needs before her own.

The first developmental phase is symbiotic. In the next developmental phase, the infant, through exploration and play, moves beyond mother's face and gaze and begins to show more curiousity, interest and preoccupation with the world beyond mother. This phase depends partly on the mother's internal capacity to bear the mental pain of separating and having the confidence that the infant will survive, develop and profit from these experiences. This was, judging from the transference-countertransference interaction, the most difficult issue for Miss L to face. Separation seemed to be equated unconsciously with negation or death and this must have been rooted in and coloured by her mother's earlier experiences.

Chassequet Smirgel (1985) has pointed out that for creativity and sublimatory processes to develop there needs to be a well established regard for parental lineage that has not been unconsciously denied or disavowed. If it is disavowed, instead of relying on the continuity that

is passed on over the generations, fictitious, quick solutions will be found in the form of projective identifications that bypass the longer, slower processes of internalisation of parental identifications.

I think this was also true for Miss L. For a start she felt her mother to have no real mothering capacity or genuine in-touchness beyond her own projected anxieties and she turned away from her mother and was very critical of her. Both parents were communists in the thirties; they denied their Jewishness, preferring to immerse themselves in the dominant anti-Jewish culture. They brought their children up as socialists and atheists so that they too were in revolt of their parental identifications. So I think the generations before were symbolized by negation and absence rather than continuity. This theme, of course, was embroidered upon with the onset of the war. For instance Miss L's father, then a young doctor, was saved from death because an older doctor gave him his armband and died instead. These themes of separation and differentiation leading to extinction became unconsciously patterned and were then embroidered and interwoven with historical events which confirmed the unconscious patterning. Also at a conscious level of anxiety life always walked in death's shadow and this probably reinforced the unconscious patterning.

It seemed to me that in early life Miss L was hampered by her mother's inability to tolerate the mental pain necessary for separation. The earliest phases were also loaded with projections of the death of a previous unborn infant, a disavowal of an inherited line, the unconscious guilt of father's war experience in which his life was saved at the cost of another's. These antecedents obviously do not contribute to a secure primary experience in infancy!

In a later and crucial stage of early development, mother and baby, both having turned away from each other to take in more of the world, come together again but as more separate figures and are able to share pleasure and have curiosity in something that is different from either of them like a game or a bedtime story. Here there is a third entity which absorbs the aspect of their shared pleasure and is not enviously destroyed. It is also still firmly lodged within mother's sphere of primary influence as opposed to father's but it can signify the entry of father's role as an intervening symbol paving the way towards further differentiation.

It is between these two sets of experience, the one of early in-touchness and the later one of a shared mutuality in something other than self by the mother-baby duo that Miss L lost herself. She could not move into the phase of experience of an absence of maternal

presence with a basis of internalized experience of shared mutuality in something else. So she was always thrown back onto herself or the internalized experience of herself and mother as one, albeit rather deficient, and this was at the centre of her experience of herself.

It will be obvious from what I have been saying that for any form of sublimatory process to begin to occur, something other than baby's preoccupation with mother or mother's preoccupation with baby needs to take precedence. The sharing of a game or a bedtime story seems to loosen the intensity of the bond between mother and baby and allows for something else to stand as important. This also seems to be a precursor to the formation of a triadic mental structure in infancy having some of the qualities of a transitional object.

In Miss L's case, not being preoccupied with herself and trying to implement her career plans, i.e. placing a third entity in a primary position was experienced as a neglect of attention to herself and was accompanied by an inner voice that was demanding, tyranical and urgent. This also seemed to lead her back to the sense that the only genuine experience was within the mother-baby duo, all other experiences being regarded as fictitious or inferior.

This evidence was well borne out by our last meeting. Miss L told me that she felt she shouldn't have to go through the hurdles of doing courses like everyone else in order to become a counseller. She felt that the recognition was owed to her on a plate so to speak. This was a fantasied short cut method with her as inner baby in a privileged position, being fed counselling umbillically and not having to go through the stages others would have to negotiate. It seemed also to offer a fantasied solution in which she would still have precedence and the counselling activities would never have to assume greater importance than herself. Of course at the same time she recognized that this path would not lead her to be a counseller and that the only way forward was to place other activities in a primary position and learn to tolerate the internal crying that accompanied this gesture.

But moving into this area of psychic activity was extremely anxiety provoking for her. For instance when at the age of twenty she literally tried to escape her mother's dominant influence by having a relationship with an Englishman and moving to the West, it proved a suffocating experience and she often returned to her mother for escape and comfort. Later when she had a relationship with someone who was closer to her home background, possibly nearer to her mother's sphere of primary influence, this allowed for more potency. Perhaps on a symbolic level the move from East to West was too far from the

familiarity and context of her own experience to allow her to combine new and old fruitfully.

In the later stages of the therapy Miss L had loosened her tie with me (as representing mother) and was having a relationship with someone else which allowed the three of us a varying degree of importance. Also this man was far more manly than her husband who had been described as a big teddy bear type of figure. I think the matriarchal monopoly so prevalent in the transference had altered, thus allowing a degree of male identification and internalisation. This satisfied her narcissism too in a curious way insofar as she would never be his wife but would always be desirable through her scarcity. This seemed a compromise solution that worked and kept all internal parties in the triad satisfied but not without a price, as no internal party in the triad could ever assume too great a degree of significance.

This seemed to leave Miss L at the end of her therapy with the feeling that she was a mixture of a woman and a 'blob', unformed but with a right to exist whereas before she had not even felt that right. She also parted feeling that neither of us would die as a result of the separation: 'a major triumph' to use her own words.

I do not know whether more attention to this area or more therapeutic time would have boded for a more 'successful outcome' or whether this was an optimal result. In any case Miss L wished to leave of her own accord and to take responsibility for herself and this was a shift in line with adult wishes. At the moment Miss L prefers to struggle alone. Perhaps the shift from the maternal duo towards the triad will lead her eventually towards greater fulfillment.

Conclusion

In conclusion, if I compare Miss L's case with those of other clients I have seen, many of whom had very negative experiences, what I am struck by is that the process of sublimatory activity always depends on the establishment of an internal triadic structure, such as I described, with discrete, separated entities that can be combined and contained in something new and different. Other clients I have seen, some of whom were more chaotic or near psychotic at times in their therapy nevertheless had more clearly separated zones pertaining to their internal experience. Meltzer (1973) makes the point that at a fantasy level the baby's faeces need to be separated from the milk that nourishes it. If this kind of necessary splitting fails in early infancy

such as in Miss L's case, and the faeces contaminate the milk, a fusion will result that mixes elements that initially need to be separate. This in turn will infiltrate and influence later developmental phases resulting in a combined internal object that has insufficient introjective aspects of both parents further resulting in later developmental structures that are pseudomature but essentially impotent. To put it more simply, Miss L's primary experiences were so influenced by her mother's primary experiences that they hampered her development in early and consequently later life.

To come back to the puzzle with which I began this article I found myself thinking that an important missing link in Miss L's story had to do with all that is meant by 'shared pleasurable experiences' in early infancy. These experiences of course depended to some extent on her mother's capacity to have, enjoy and facilitate such experiences. Not surprisingly Miss L thought that she was stuffed with food to shut her up when she was seeking love so that this vital experience was largely absent. But when I think of a theoretical mother who offers such an experience – meaning one who is relatively anxiety and envy free and can experience delight in shared pleasure, I realize few of them exist and that we know very little about the essential features of this kind of experience and how it can act as a catalyst for the development of later symbolic expression.

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COGITO ERGO SUM? – EXCERPTS FROM THE ANALYSIS OF AN INTELLECTUAL DEFENCE

SYLVIA MOODY

In this paper I shall present eighteen months of therapy with Mr G, a twenty-three-year-old post-graduate student. He was referred to me in June, 1987 through the Reduced Fee Scheme.

Mr G's presenting problem was anxiety about taking examinations. He felt that he had got the importance of academic qualifications out of proportion – and that this was because his father, whom he described as academically brilliant but completely inhuman, placed enormous emphasis on these. Mr G. felt that he must pass examinations in order to meet his father's expectations and to feel self respect; yet every qualification gained seemed to bring him one step nearer to being 'inhuman' like his father. He felt that he existed only on paper – like a C.V. – and that his qualifications were his whole existence; he said that if he failed to gain his Ph.D., he would 'disappear'.

He had periods of being depressed, and had been prescribed medication for this. He dealt with his problems chiefly by drinking: he regularly got drunk in the evening and then spent most of the following day in bed.

History

The salient points of Mr G's history were elicited in the initial interview.

Mr G is the younger of two children. His father, a civil servant, now fifty-eight, has been academically successful (he obtained a first at Oxford), but is described by Mr G as an 'oversized child'. He is reportedly ill-tempered, 'paranoid' and dismissive of other people, especially those without academic qualifications. So important is academic success to Mr G's father that he pretends that both his children hold university degrees, which is not the case, and sometimes pretends to hold degrees himself in subjects which he did not in fact study. He

Qualifying paper for Associate Membership of the British Association of Psychotherapists. Awarded Lady Balogh Prize, 1989

also disclaims his origins, which are Scottish, evidently feeling these to be 'infra dig'. The only academic course which Mr G's father failed to complete (for reasons not yet clear) was a post-graduate degree in biochemistry – the very course which Mr G is himself following.

Mr G has provided very little information about the rest of the family. His mother, aged sixty-two, is a lecturer. He reported that he gets on well enough with her, but describes her as superficial and insensitive to other people's feelings. She herself does not place the same emphasis on qualifications as her husband, though she has remarked that 'a lower second is not worth having'.

Mr G has an older sister, aged twenty-five. She went to work straight from school, and is now in the marketing division of a large bank. She still lives at home, though she reportedly hates her father; however, Mr G feels that she is not dominated by their father in the same way as he himself is – in fact she rather despises him.

Mr G has had little contact with his grandparents, all four of whom he describes as 'odd'.

Mr G had little information about, or memory of, his early years. His mother had told him that he was a placid baby, and that both his father and his sister had been jealous of him. His father could not bear to see him held in his mother's arms.

At the age of 12, he was sent to a boarding school, when his parents moved from the south to Yorkshire. He was very unhappy there, and after six months transferred to a day school near his parents' home. He dates the onset of his anxiety about academic work from this time. He found it difficult to do homework at a normal hour, and usually began it after midnight when his parents had gone to bed. He eventually gained 4 'A'-levels, one in Economics, which, incidentally, is one of his father's 'pretend' degrees. He went on to university and successfully took his B.Sc. degree. He then took a year off, but found this period difficult, as he seemed to have no identity. He then began to study for his Ph.D. (being financed for this by his father) and recently took some preliminary exams. He was awaiting the results of these at the time I first contacted him.

Mr G made a number of friends at university, though he felt they would not stay friendly with him if he failed his exams. For this reason he did not contact any of them during the period in which he was waiting to hear the results. He appears to have good social relationships with people at a superficial level, but has not felt intimate with anyone. He did not report any serious involvement with women or any kind of sexual liaison.

During his period at university, Mr G sought psychotherapeutic help because of his anxiety over exams and his difficulty in relating to people 'as human beings'. He attended both individual and group therapy and found this useful in that it helped him to see that people could have a value which was unrelated to the qualifications they held.

Therapy

Phase one: cogito ergo sum

Mr G was reportedly keen to begin therapy as soon as possible because of his anxiety about his examinations. However, he did not respond to letters inviting him for an initial interview for over a month (he said later that he had not been home to collect his post during that period), and on the day appointed for the first therapy session he telephoned to request that the starting date be postponed for a further fortnight. This reluctance to begin therapy contrasted with the commitment he showed once he did arrive. At the beginning of the first session he handed me ten weeks fees in advance in cash, and thereafter attended regularly and punctually – at least in this first phase of the therapy.

In appearance, Mr G was tall, thin and gangling. He wore spectacles and had a serious but pleasant look. His movements were brisk and he had an easy social manner. He made a boyish rather than a manly impression.

During the first month of therapy, Mr G talked exclusively about two topics: his father and the importance of qualifications. He felt that it was only through the holding of qualifications that one could have power and command the respect of others. He recognised that this was a view which he had learnt from his father, and yet he could not help feeling that it was universally held. He felt that without qualifications he would be nothing, and yet the acquisition of them did not give him a real identity either. In fact he felt they had stolen his identity. He had put himself entirely into them (he spoke of them almost as a concrete entity) but they were something outside himself.

His father he repeatedly described either as an oversized baby or as an inhuman intellect who, if deprived of his qualifications, would simply collapse; he both encouraged Mr G to acquire qualifications, and at the same time resented his success. Mr G felt that he was completely dominated by his father (in the sessions he has never

spontaneously made any mention of other family members): he felt that he was a tenant in his own life and that his father had the freehold. He often felt invisible, hidden from himself. He could not tell where he ended and his father began. The only way he could find some freedom in life was in physical pursuits – he enjoyed Karate, squash, motor bike maintenance, etc.

I pointed out to Mr G that he had delayed contacting me until he heard he had been successful in his examinations. (He had finally telephoned to arrange a preliminary interview on the day the results were published). Evidently he felt that he must come armed with qualifications if he was to be acceptable, or even visible, to me; he felt he had nothing else to bring.

Indeed, during the first weeks of therapy, my impression of Mr G was of a very 'thin' human being. It was hard to know whether I had Mr G or his father on the couch, and the pair of them seemed to have only a paper existence. Similarly, Mr G appeared to be unaware of my existence, or at least not to regard me as human. He showed no interest in me, and was surprised, even contemptuous, when I suggested to him that he might have thoughts and feelings about myself and the therapy sessions. He said it was not at all important what he felt about me – I was a trained psychologist – and therefore not typical of the human race as a whole. I told Mr G that he wanted to keep us both as paper people because he feared that, if he saw us both as human beings, he would have nothing to offer to the relationship.

In subsequent sessions, he began to muse on the fact that his obsession with qualifications was preventing him from relating to people, and that he was missing out on life. At the end of one session he suddenly said he was thinking about 'Zen and the art of flower arrangement'. He felt he was unable to enjoy life's simple pleasures.

He now began to be exercised by the question of how he could make things other than qualifications important in his life. He felt that the only answer was to destroy the power of qualifications – but he was terrified that this would leave him with nothing at all, not even a paper existence. I told him that my image of him at this time was that of a prisoner standing on the threshold of his prison contemplating release into the outside world. Clearly at that moment he had no roots in, or knowledge of, life 'outside'. Demolishing the prison would not give him this – it would simply destroy the world he already knew. Knowledge of the world could only come from experience of the world.

This homily had some effect, and in subsequent sessions Mr G

reverted often to the metaphor of the prison, usually remarking that he had been going the wrong way about seeking release. He should stop concerning himself with qualifications and just think about other things. He began to talk a little about the people he met at the hostel where he was staying, and about various interests he had.

However, he still made no mention of any thoughts or feelings he might have about me (though it was clear in various ways that the sessions were of great importance to him). When I pointed this out, he said that he feared he might suffer rejection if he allowed anyone to become important to him. He felt the real him was so little and so insignificant that I wouldn't want to be bothered with it. In this connection he was able to see that he was crediting me with his father's views about what was important in a person, and he began to talk about the necessity of separating himself from his father. He felt that in espousing his father's views, he had rejected himself. Yet he felt so entwined with his father, that it was hard to get rid of him without getting rid of himself too.

Around the fourth month of therapy he began to acknowledge that he did have feelings of his own, but they were depressing ones, so he tried to push them away, usually by getting drunk. However, he was beginning to think that it would be better to have his own feelings, even if they were bad, than to adopt the sort of unreal identity that qualifications had given him. If he could believe that it was his view of the world, not the world itself, which was depressing, then there was some hope, some possibility of change.

In this connection, he began to consider the possibility that other people were not inhuman like his father, but had feelings. He found evidence for this in radio programmes in which members of the public telephoned in with their personal problems.

He also began to consider the role of drink in his life. He did not drink during the day, but most evenings he went to the pub and got 'blind drunk'. He would spend most of the next day sleeping off his hang-over. We identified two functions of his drinking; firstly, it enabled him to escape his depressed feelings and to make at least superficial social contact with people; secondly, by jeopardising his career, it offered the prospect of the ruin of everything his father held to be important.

After this he stopped drinking heavily and had increasingly long periods of not drinking at all. He was surprised that he felt none the worse for this. He began getting up early in the morning and jogging, and took a series of fill-in jobs while waiting to begin his Ph.D. studies.

He also stopped taking his anti-depressants. I said that this was prompted by his new-found desire to own his feelings, even if they were bad or depressing ones. They made him feel real, even if painfully so. Shortly after this he had a bout of physical illness – unusual for him – and we speculated on whether he was using physical means to sabotage his efforts to leave his psychological prison.

He talked increasingly of opening up a gap between himself and his father, and putting the inflated view of the importance of qualifications where it belonged: in his father's space. Separation from his father also opened up the possibility of 'getting rid of' his father without simultaneously destroying himself.

In the last two weeks of this initial six-month-period, he talked of how he felt his feelings were coming out more easily. He also reported dreams for the first time: in these he was usually challenging his father ineffectively in some way. He felt that the dreams were a way of bringing his difficulties out into the open. They were dreams which he had frequently had when he was an adolescent, but they had not recurred until now.

Phase two: To be or not to be

This second phase of the therapy was a critical period. In the previous six months, Mr G had talked almost exclusively about one topic: his stultifying identification with qualifications. In his exhaustive discussion of this subject he had said much that was useful to our understanding of his situation, but his tenacious clinging to the topic of qualifications (labelled by him as 'the problem he had come to talk about') represented the very identification he wished to escape. He himself was aware of the fact that his ratiocination in regard to this subject was becoming tedious. Whereas previously he had talked almost non-stop about 'the problem', he now begun to leave increasingly long silences between his remarks, and it was clear that he was confronting the question of what it was he would be bringing to the session if he could no longer bring qualifications. His feeling that he had nothing else of value to bring led him to start missing sessions, as will be reported below.

Mr G had often voiced the opinion that he could only find a real identity by destroying the importance of qualifications, and he felt that this was a task which he had to undertake single-handed in our sessions; my role was that of commentator on the struggle. I had

occasionally made the counter-suggestion that his real identity would be discovered not in the absence of qualifications but in the presence of a relationship with a person, i.e., myself, with whom his emotions and feelings were engaged; one could only exist in relation to another. Mr G had always dismissed this idea, but at this point in the therapy he suddenly presented it as his own view.

Apart from marking a change in his thinking about identity, this episode illustrated a process which was often observable in our intercourse, i.e. that Mr G constantly presented as his own view some suggestion of mine which he had roundly dismissed when I had first made it. I often felt as if I was reflecting something in him which he had forgotten was part of him, but which, when it was reflected back to him, he recognised – in the terms of cognitive psychology, his recognition was better than his retrieval. Thus this mirroring process was itself an experience for him of existing in relation to another.

Shortly after this, I found myself in a position to reflect back a feeling which he himself had retrieved. In a session taken up with the usual ponderings on qualifications, he made a comment about 'his father's insane world'. It was his first reference to the possibility that there really was something crazy about his father's opinions. When I subsequently repeated his statement in some relevant context, he told me in surprise, 'You're right, my father's world was crazy – I never realised that before'. He was astonished when I pointed out to him that I was using his own words. The theme of his father's 'insanity' was prominent in subsequent sessions, and it seemed that his realisation that a feeling of *his* had been reflected – and respected – by me was another important step in giving him some sense of a reciprocal relationship existing between us.

I have discussed this at some length because it seemed to mark the beginning of a real relationship with me and to be an interesting example of how our verbal interchange mirrored the process by which this relationship came about.

During the next few weeks, Mr G frequently referred to his realisation that his father inhabited a crazy world. He described this world as a lifeless system of thought, and said 'it was crazy to want to be conscious in such a world'. I pointed out that his habit of sleeping his life away was an acknowledgement of this; it was a way of keeping his sane self intact, safe from craziness. Mr G now remembered that his penchant for sleeping during the day dated back at least to the time he began to attend infants' school at five. He recalled that his mother had to drag him out of bed to get him to school, and that,

when he was at school, he had a sense of unreality: he felt he was observing himself being at school, as if viewing himself on television.

He now began to toy with the idea that it was in sleep that he was truly alive and in touch with his real feelings. He saw this alive self as existing 'below' his father, intact, but completely concealed. He was thrilled with this glimpse of a real self: he felt that this self had a future, whereas the 'paper existence' he lived in his waking hours was a dead thing – his father's 'lifeless system of thought'. He now saw the task before him as clearing his father out of the way so that he could emerge as his true self in a space that was inalienably his own. A dream he reported at this time showed how unequal he still felt to this task.

In this dream, Mr G was a lorry, or the driver of a lorry. He was delivering some goods to an unspecified destination. He got lost in a maze of country lanes, and stopped to ask the way from a family whom he passed on the road. They seemed like a very normal ordinary family. They gave him some rather unlikely directions, which involved crossing a river. He took off his shoes and socks before fording the river, and then found himself on a road to nowhere. Eventually he found a parking space. At that moment his father came along in a bigger lorry and tried to move into the same space. Mr G blocked his path for a while, but in the end, his father's lorry moved forward to crush Mr G's smaller vehicle, and at the last moment Mr G leapt out of the driver's cab into nothingness.

The dream well illustrated the fact that Mr G's real-life quest for normalcy and a space he could call his own had ended not in his being obliterated by his all-powerful father, but in his escaping destruction by leaping into nothingness, i.e. into sleep. The question now was whether Mr G could claim space for himself in his waking life. However, before describing his struggle to do so, I should like to consider his dream life a little further.

Mr G rarely reported a dream, and those dreams he did report always had the same theme: a failed attempt of his to challenge his father in a duel of some kind. The weapons used included stones, lorries (as in the dream described above) and academic qualifications. In other words, his dreams were obvious metaphors for the struggle upon which he was engaged with his father, and as such needed little interpretation from me. In fact, Mr G would precede his recital of a dream by informing me of its meaning. If I asked him to associate to the dream in question, he would – rather patronisingly – explain its metaphorical significance again, indicating by his manner that I was being tiresomely slow on the uptake.

I suggested to him that his cut-and-dried way of offering me his dreams complete with interpretation represented another suppression of his alive self: his dream lay before me like a dead offering, fixed, or transfixed, by his textbook interpretation of it; as such it could not be the vehicle of any interaction between us. He treated this suggestion with considerable scorn.

Mr G had now been in therapy with me for about nine months. It was appropriate, therefore, that it was at this time that he began to experience the birth pangs associated with the emergence of his alive self. That this self existed he was now certain. But whether it could survive in the 'world outside' was a matter on which he felt grave doubt. The immediate question in his mind was, of course, whether it would survive contact with me.

The first intimations that Mr G was debating this question came in a session in which he started to speculate about what sort of relationship he might have with other people. He began by remarking that he needed another person to reassure him that he existed. I commented that he was now allowing me an active role in our relationship rather than leaving me as an observer. He wanted me to recognise his real self, the self which had been denied recognition by his father. He said he had recently been asking himself what it was that made people like one another. He felt that his relations with people were social and superficial; he was not really intimate with anyone.

Another recent development, he added, was that he had started to read more serious newspapers. The example he gave was that he had exchanged the 'Sun' for 'Which' magazine. He felt that this represented a turning away from fantasy towards reality. I interpreted that his new interest in consumer choice was a way of approaching the difficult question he was now asking in our sessions: would he be worth choosing? Would he appeal to me if he offered me qualities rather than qualifications?

This marked the beginning of a difficult period in the therapy. Mr G, who had until this time attended his sessions regularly, now began to miss sessions, always the first one of the week (Tuesday evening). He never telephoned to let me know that he was not coming (a contrast with his scrupulousness about paying my fees), but gave me a lame excuse when he next saw me. He began to talk a lot about qualifications again, though he seemed to realise himself that this was a sterile activity, and he fell silent for increasingly long periods. He reported quite cheerily that he had begun drinking and taking anti-depressants again. In one session he said he disliked having time on his hands in

the evening or at the weekend; he didn't know how to fill these gaps except with drink or sleep.

I said he was wondering how to fill the gaps that were opening up in our sessions. These gaps had been lengthening gradually, and were now extending to whole missed sessions. It was in these gaps that his alive self was hidden. He was taking flight in various ways from the prospect of this alive self emerging before me. The gaps represented the space he wished to claim for his real self, but he feared to occupy it. He was terrified that I, like his father, would try to crush what was alive in him.

He replied that his worst fear was that he would come alive, but no-one would notice it; he would be invisible, superfluous. At the office he sometimes felt when he left the room that no-one had left the room. His absence and presence were the same thing. I remarked that he felt the same about the sessions. He didn't trouble to telephone me when he wasn't coming because he thought his absence or presence were the same to me. His true self was invisible in the sessions – hidden in the gaps – so he felt he would not be missed.

Mr G's reply to this was to miss the next three sessions without telephoning to say why. There was only one more session left before the Easter weekend, and it seemed that he was disappearing into a boundless gap. Consequently, towards the end of the time of the third session, I telephoned him at his hostel. When he heard my voice, he first feigned surprise, and then began to offer the usual lame excuses. I told him that we both knew perfectly well that he was hiding, and that it was important that we discussed this. He undertook to come to the following day's session, and in fact did come.

His first act was to hand me a cheque for a month's fees in advance – he said he hoped this would appease me. I said that he still felt that all he could offer me of value was his paper existence. I surmised that during the past week, when he had made no contact with me, he had been wondering if I had actually noticed his absence, if I would ever take any action which would signify that I had missed him. He replied in a strangled voice that this was in fact the case – he had assumed that I would not make any effort to contact him.

He began to talk about the annoyance he felt about the fact that qualifications had stolen his life. He spoke of a recurrent dream he had about failing an exam and feeling powerless. He said he *did* know about human feelings – he could write a novel if he wanted to – but his father had always taught him to see these as trivial, petty, even criminal. They had to be kept hidden. I commented that one motive

behind his failure to contact me at times when it was common courtesy to do so was that he wanted to give me a taste of what he had suffered, i.e. an experience of having one's feelings, one's very existence ignored. It was the only way he could convey to me a message about what he *felt*. (Indeed in the 'counter-transference' at this time, I was coming to have a strong conviction that I myself did not exist on a Tuesday evening and was consequently beginning to accept his absences as normal.)

I interpreted his dream about failing an exam as being concerned with his anxiety about his ability to pass the test of being a worthwhile human being. In our sessions he had written the definitive textbook on his life as qualifications, and this had been fully annotated, indexed, revised and reviewed. Now he was faced with writing his novel, i.e. his life as a human being with its attendant feelings, passions and desires, its involvement with other people – and he was not sure if this would pass muster. He then claimed that it was his relationship with qualifications, not people, which was his problem. When I suggested that his 'problem' was now his relationship with me, he made no answer.

For the next three months he maintained his routine of not coming to the Tuesday session and not telephoning to make his excuses. He came to the other two sessions, but regularly dozed off during them. He always began the Wednesday session by cheerfully announcing that he had had a 'lapse' after work the previous day and gone to the pub. He said that despite this lapse, he felt much more 'in existence' the rest of the time.

In an important session around this time (on a Thursday, the last session of the week), he mentioned a 'trivial' incident which had made him feel really alive. He had been walking down a corridor at the office and had suddenly bumped into one of the girls there, whom he rather liked. She had smiled at him and, without thinking, he had smiled back. For the first time, he thought to himself: it's possible just to like someone. I said that this momentary experience of the smile had given him a greater sense of existing than all the years of intellectual argument. He took up this theme, saying that in the past he had always felt he had to prove or justify his existence; he thought that one motive for going into academic life was that he felt this sort of training would enable him to argue more cogently for his existence!

After a pause he said – rather coyly – that he now realised that existing meant liking someone. He then fell silent and dozed off. When he awoke, I said that he was now absenting himself from the sessions

through drink or sleep not because he felt his presence and absence were the same to me (he had seen recently that they were not) but because he was beginning to feel truly present and this brought feelings of liking towards me. He was terrified that I would scorn his feelings. He said in an uncharacteristically agonised tone that he felt he just 'would not be any good', adding that he knew he kept suppressing himself, but that at some moments, he felt he was going to 'burst through the cracks'.

His departure on this occasion was very different from usual. Usually, he would say a cheery 'thank you' and briskly exit. On this evening, he got up and remained standing for several seconds staring at me as if about to make a declaration. After an awkward pause, he departed.

It transpired that this was indeed the point of a new departure. Throughout the summer, although Mr G continued his routine of 'rule-governed absences', he began to talk increasingly about his sense of being more human. A visit during the summer to his first home left him with a vague memory of a time when he had been 'a normal human being', and he felt that this geographical closeness to this experience had brought him psychologically closer to it.

His feelings of being invisible now became a dominant theme. He said that his chief worry was not so much that people would not notice him, but that, if they noticed him, they would disapprove of him. He talked too of the embarrassment he felt about having feelings – he regarded these as pathetic, wierd, fallible. Yet he was beginning to realise that other people, whom he was now 'keeping an eye on', lived their lives largely through these 'embarrassments'. I suggested he was deliberately making himself invisible so that I (and others) would not detect in him the feelings he found so shameful.

In September (the fifteenth month of therapy), there was a marked change of atmosphere in the sessions. Mr G, who had in the past rarely seemed to be conscious of my presence as anything more than a piece of 'professional furniture', now tried to introduce a more social feeling to our meetings. No longer did he arrive and leave with eyes averted and a formal greeting or valediction. He would linger at door, smiling charmingly into my eyes and making small talk. Once, as he was leaving, he responded to a comment of mine by saying indulgently 'Don't start!', much as if we were a long-married couple about to have one of our familiar arguments. It seemed that a new, and more interactive phase, of our relationship was about to begin.

And yet ... it still did not begin. We remained for some weeks in

this tantalising position, poised for a relationship which was always just out of reach. It seemed impossible to get past Mr G's constantly expressed fear that, if he showed any feelings, they would be rejected. In the transference I felt stuck with a view of myself as the inhuman omnipotent rejecting father whom Mr G described so often and so vividly.

While we were faced with this impasse in the sessions, Mr G was obliged to make a move in his professional life. In October, he had to make a definite decision about whether he would continue with his Ph.D. He had held back from making this commitment because he equated becoming more highly qualified with becoming inhuman like his father.

A remark he made around this time to the effect that his father was like a 'big kid who was beyond help' prompted me to offer him a different explanation for his dilatoriness in furthering his career. I suggested that, while he consciously felt his father to be omnipotent, he unconsciously saw him as fragile, in need of propping up, and therefore feared that, if he became more successful than his father, the latter might simply disintegrate. I reminded him that the only course of study which Mr G's father had failed to complete was the same one which Mr G himself now hesitated to pursue.

This led to interesting revelations. Mr G now began to report incidents which demonstrated how much his father depended on his, i.e., Mr G's, approval. For example, on one occasion when Mr G had failed to admire a paper written by his father, the latter had been depressed for several days. It became clear that Mr G and his father were living as mirror images of one another, each dependent on the other's approval, each diminished by the other's success. It was as if they were condemned to the sort of eternal torment favoured by Greek myths about the Underworld: in their case they had to sit facing each other for ever on a see-saw. The rise of the one inevitably meant the fall of the other, and neither could get off the seesaw without causing the other to crash to the ground with possibly fatal consequences.

Mr G now also brought material which suggested that his father, like himself, had longings to be human, or at least curiosity about this condition. Mr G recalled how his father had often questioned him in extraordinary detail about his relationships with people, asking him exactly what he and the other person had said or felt on particular occasions. He recalled, too, that his paternal grandmother had seemed to be totally inhuman (even 'loony'). It seemed, therefore, that Mr G's father, like his son, felt shut out from humanity, a prisoner in a world

of qualifications. I suggested to Mr G that one of the chief reasons he found it hard to become human was that this would entail leaving his father, 'the big kid who was beyond help' to the fate which Mr G himself was trying to escape. Getting off the seesaw would leave him with 'survivor's guilt'.

All this new material and analysis had been very useful and Mr G obviously felt that we were making good progress. And yet, after almost eighteen months of therapy, he still had not come alive, he still had not expressed any thoughts or feelings about me, and – he had still not spontaneously mentioned his mother or his sister. All these omissions seemed to be linked.

During the last month of the period of therapy described in this paper, a change took place in my understanding of what was happening. In response to a comment of mine about his mother being absent from his life, Mr G surprised me by revealing that he was in fact in constant contact with his mother and sister – he often telephoned them from work. His father, by contrast, was not allowed even to know Mr G's work address or telephone number.

This brought into focus a clear split between Mr G's inner world, which he shared with his father, and his outer world, which he shared with his mother and sister. And it seemed that his mother had a secret and conspiratorial relationship with her son. I recalled that Mr G had produced only one clear memory from his early childhood: that his father could not bear to see him held in his mother's arms.

At this point I came to the realisation of how much I had been the mother in the transference all along. I suggested to Mr G that he and his mother had both wanted to be intimate, but had been frightened to show their feelings in his father's presence. Mr G had created the same situation in the sessions. Beneath his conscious fear that I would reject his feelings (me as the father) there was a much more terrifying fear that I would respond to them (me as the mother) and that this would bring down the wrath of his father upon us. Even more frightening was the prospect that our intimacy would result in the collapse of his father, who would not survive his son's success in becoming human.

An explanation now suggested itself for Mr G's penchant for dropping off to sleep during the sessions: since his father could not bear to see him enjoying intimacy with his mother as an alive and curious infant, Mr G could perhaps only enjoy his mother's embrace when he was 'dead to the world' in sleep.

It remains to be seen whether Mr G and I will be able to negotiate a relationship with his father which will release us from the seemingly

eternal torments of the Underworld to the more manageable conflicts of the Oedipal realm.

Theoretical issues

One obvious theoretical frame in which to fit the above clinical picture is Winnicott's formulation of true and false self existence. Mr G had preserved at least the germ of a true self in existence, and, though this was so well concealed as to be invisible even to him, he was sufficiently aware of its aliveness and potential for growth to want to search for it in therapy.

The false self which Mr G presented to the world was an intellectual construct, 'a lifeless system of thought'. Trapped in this world of logic, Mr G had had the use only of argument in his search for a true identity; he devised quasi-philosophical arguments to prove his existence, but these could always be refuted. Unable to escape the dead world of logic, he took refuge in drink, drugs, sleep.

On the other hand, this false self, though lifeless, had value in Mr G's eyes in that it gave him a feeling of potency, indeed of omnipotence. It allowed him to determine the behaviour and feelings of others in accordance with his own laws of logic. It was a narcissistic phenomenon, which, in Kohut's terms, would be seen as resulting from identification with an idealised parent.

In the sessions, needless to say, Mr G took refuge in what Winnicott describes as 'free association with a coherent theme', or as Khan more succinctly terms it, 'the intellectual defence'. The essence of this defence, according to Khan, is that the function of the patient's verbalisations is exhibition not communication. (Kohut's concept of mirror transference is similar to this.) The patient allies himself with the analyst in order to 'peep at' himself from the outside. Communication then is likely to come through acting out, and it is therefore very important to distinguish acting out which is communication from acting out which is simply a defence. In Mr G's case, both functions were present, though, in my view, the former predominated.

Both Winnicott, in discussing false self existence, and Kohut, in discussing pathological narcissism, see the origin of these phenomena in imperfect mothering, in particular in the failure of the mother to 'mirror' the existence of the alive infant, i.e. to validate and preserve that alive self by her constant reflection and reinforcement of it. This enables the infant to survive the myriad deaths he experiences, and

the myriad destructions he visits on the mother, and frees him thereafter to lay aside his omnipotence and to live creatively in relation to others.

In Mr G's case, his mother was not present to reinforce his aliveness – she was forbidden by her husband from being so. Her existence thus appears to have been insubstantial: she shadowed her husband rather than mirrored her son. And Mr G's father ignored what was alive in his son. As a result, Mr G was unable either to avoid death or relinquish his omnipotence. Thus, during the course of the therapy, he ceaselessly annihilated and revivified me according to how alive he himself felt. My obstinate survival, and my reflecting back not of the deadness but of his destructiveness and omnipotence, enabled him to move eventually towards a position in which his true and creative self could be exposed. At which point, it became clear that this true self had had a surreptitious relationship with me all along.

Finally, a few words about technique.

Orenland and Windholz have pointed out that in the analysis of narcissistic patients a common pitfall is for the analyst to mistake interaction between him and the patient for an inter-personal relationship. In other words, for a Kohutian mirror transference to be taken for a true object relationship. On the whole, I feel this pitfall has been avoided.

However, a different type of error, described by Kohut – that of succumbing to the temptation to moralise and to 'teach' the patient how he *ought* to be living – has to be acknowledged!

Perhaps this desire to offer Mr G a different model of existing was bound up with 'countertransference' feelings, i.e. the feeling that Mr G was desperate for a mother who would provide a point of reference different from that of his father.

Finally, it seems curious – perhaps suspicious – that I should succeed in feeling myself to be Mr G's mother in the transference precisely at the point when my training period was over – as if I too had felt afraid that too much intimacy with Mr G might result in my training patient being snatched from my arms!

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WORKING WITH CLOACAL CONFUSION

HELEN MORGAN

In early embryonic development the bowel and the urinary system form a common channel, the cloaca; from this structure the genital tract also develops. There is thus a primordial relationship between these systems that may lead to an unresolved confusion about their separate functions.

Introduction – the operation dream

Soon after she started therapy, Carol brought the following dream:

> I discover I am pregnant by my lover. His wife helps me to get to my GP. and on the way, complains to me of her husband's laziness. The GP. is kind but unable to help, so directs me to the hospital where a surgeon will operate. Later I am in a waiting room and another woman points out that blood and milk are oozing from both my breasts and vagina and advises me to call for my baby to feed it. I do so and, eventually a surgeon arrives. He is cold and uncaring and informs me that, whilst I was under the anaesthetic, he operated on me but, on cutting me open, had discovered that the baby was hopelessly tangled up in my guts. Removal of the child would have meant death for either myself or the baby, so he had sewn me back up and left the baby inside.

In this paper, I will refer to this dream as an illustration of several central points in the story of Carol and of our work in therapy. It contains: a confused and inappropriate triangular relationship between Carol, lover and wife; a mix of vital fluids, blood and milk, as well as the breast/vagina, womb/intestine zonal confusions; the cold, compassionless surgeon operating on the unconscious patient; the appalling dilemma of the mother and faecal baby caught together in an endless entanglement where a move to seperate will bring death.

Background

Carol is an Argentinian woman who, at the time of our initial interview, was 33 years old. She contacted the BAP through an acquaint-

Qualifying paper for Associate Membership of the British Association of Psychotherapists. Awarded Lady Balogh Prize, 1989.

ance of hers because she had become depressed soon after her marriage eighteen months prior to this time, and felt lost and alone in this country. She reported having suffered bouts of depression before, aged 18, 26 and 30, and during these episodes had received anti-depressants and homeopathic treatment and had also attended Gestalt and Group therapies. She presented as a lively, attractive woman of rather boyish appearance, fairly dark-skinned and, given her occupation as a dress designer, surprisingly careless in her dress. She complained of sleeping and crying a lot and repeated thoughts of dying. She told me she had taken an overdose twice before, aged 26 and 30. She said she just wanted me to give her 'peace of mind'.

Whilst Carol's mother has appeared as a substantial figure throughout the therapy, I have never had a clear sense of her father. He was a doctor in General Practice in Argentina and is now retired. Until ten years ago, he was dependent on cocaine and, perhaps because of this, never stayed long in any one practice. The family, therefore, had to make frequent moves and suffered financial difficulties. The only occasions of happiness in Carol's childhood that she could recall, were focussed on the times when her father would sing and play acting games with her, take her to concerts or to the swimming pool. Despite the affection with which she spoke of him, Carol's memories pointed to an unreliable and confused relationship with him. She was sometimes taken to plead with the bank manager on his behalf and, on her fifth birthday, she was taken to visit him in a padded hospital room where he was recovering from ECT treatment. He left the discipline of his children to his wife and never intervened when she used physical punishment, yet would sometimes 'sneak out' with Carol when her mother had forbidden her to leave the house. A particular memory that serves to illustrate Carol's confusion regarding her father, was of an incident when he shot the dog after it had bitten Carol's baby brother. The dog didn't die, so her father operated on and saved it.

Carol's mother was a nurse and later became an administrator. Her alternating displays of affection and aggression towards Carol formed a central influence on her early years and was, therefore, a central theme in therapy. This will be expanded on in greater detail later. There are three brothers, one eighteen months older, and the others five and ten years younger. When Carol was about four, her mother 'adopted' a girl of two so that Carol should have a sister. This girl was pretty but of limited intelligence and came to be treated as a servant by the whole family. She was used by all the children sexually and was harshly treated by Carol's mother. She left the family when

she was fourteen and apparently has made frequent attempts to regain contact with the family which have all been refused. She is now a prostitute.

From five onwards, Carol was involved in sexual activities with her older brother and later with the younger brothers. She would also coerce this adopted sister into masturbating her. She did not experience actual intercourse till she was eighteen, but came close to it on a number of occasions with her older brother. Since the age of fourteen, she has not been without a boyfriend for longer than a month and has been involved in three major relationships. She has had three terminations of pregnancy.

Carol left home to study Fine Art at University, after which she worked in a variety of acting and teaching jobs. For some time she had successfully been making clothes for herself and her friends so, at the age of twenty-seven, she began designing professionally and set up her own business in Argentina. Her husband is English and was staying in Argentina when he met Carol. At his invitation, Carol followed him to England after his return here, and they set up a small clothes business together which has not proved very successful. They married to avoid visa problems. On her arrival in this country, Carol spoke little English and felt lost and very dependent on her husband. She now speaks English well and only occasionally do we have language difficulties.

'To kill my mother and wear her clothes'

I first saw Carol in November '85 as winter was establishing itself. The weather served to emphasise her sense that she was adrift in a cold land where she felt cut off and isolated. The English were sophisticated but as icy as the weather, amongst whom she felt herself to be a stupid, Third World subject, unable to fit in. All would be alright if she could only leave this country and return to her own primitive, but warm and loving Argentina, where she would find a forest-clearing in which to live.

The intensity of Carol's sense of alienation indicated more the characteristics of the schizoid condition as described by Guntrip, than natural feelings of being foreign in a strange land; 'feeling cut off, shut off, out of touch, feeling apart or strange... . When the schizoid state supervenes, the conscious ego appears to be in a state of suspended animation in between two worlds, internal and external, and having

no real relationship with either of them.' (Guntrip, 1983) Carol's two worlds had a geographical representation. Through a series of relationships with men, only one of whom had been Argentinian, she had struggled to free herself from an internal, annihilating Argentina-mother world, culminating in her escape to this country and marriage. Now this external world left her 'feeling apart and strange' and she yearned to be back inside the mother. I had a mental image of her suspended over the Atlantic between hard, rejecting England where she could exist as a seperate but lonely entity, and hot, engulfing Argentina into which she would lose her self.

Carol brought a lot of material to therapy about her early relationship with her mother, the central aspect of which was seemingly arbitrary fluctuations between affection and violence – both of an intense nature. Sometimes her mother would laugh at her misdemeanours and cuddle her. At other times she would slap her, pinch her or beat her with a stick. This might be for repeatedly running off into the woods to play with a local urchin boy and returning dishevelled, or for playing too excitedly with her older brother, or for accidently slipping and hurting herself. It seemed as if the mother's unconscious narcissistic need for Carol could not tolerate her becoming caught up with anyone else. For Carol, these punishments bore no relation to her actions. They were both unpredictable and reliable. When she was about eight, Carol discovered that her mother could not tolerate her silences, and that therefore, withdrawal proved a more effective form of revenge than verbal retaliation. She would refuse to speak to her mother for days on end until her mother could bear it no more and apologised.

On Sunday mornings Carol would be called into her mother's bed and she remembered her repulsion at the strong smell of her mother's body. She spoke of her mother as a small, fat, sloppy, ugly 'sergeant-major'. Yet, always was present the terror of becoming like her mother. She worried about getting old and putting on weight and complained that, however hard she tried to smarten herself up, she always seemed to be dressed in a scruffy, sloppy manner. Despite a vehement rejection of her mother, there was an internal identification with this 'sergeant-major' figure into whom she was continually being drawn back. She said, 'I want to kill my mother and wear her clothes.' The longing was to return inside the mother, but to do so she first had to kill her in order to survive.

When she was about ten, another doctor moved into the village where they were living. His wife was tall, fair and beautiful with

wardrobes full of elegant clothes – in sharp contrast to Carol's mother. It was at this time that Carol began to copy and make up designs for her dolls. I have come to see her choice of dress designer as a career in relation to this central conflict of both wanting to destroy and get inside the mother. Although she was well able to make and fit clothes for others, those she attempted for her mother were too narrow and too long. The act of designing was related to the wish to dress the beautiful mother. Then she would have succeeded in killing off the sergeant-major mother and producing the beautiful mother's dress which she could then get inside. In fact, the clothes she made for herself kept turning out as sergeant-major's clothes. The identification with the annihilating mother was too powerful.

After several months, Carol brought the following dream:

> I am in the garden up a high tree. My mother is in a hammock strung between two other trees. My tree begins to shake and, although there is no connection between my tree and my mother's, this causes her hammock to rock. The rocking of the hammock, in turn, causes my tree to sway even more and I fall out. My mother rushes to comfort me. As she cuddles me she suddenly bites me.

Here there is apparent unconnectedness between mother and daughter and yet the movement of one causes the movement of the other. The mother is unable to contain the shakiness of her child but, instead, is rocked by it and calamity occurs. The comforting mother rushes forward but converts her solace into a sadistic attack on the child. The dream is a vivid illustration of Carol's early experience of mothering. Her projections of bad feelings were not safely contained by the mother but instead were met with a sadistic form of impingement.

Glasser writes of the 'vicious circle' of the core complex where the weak ego both desires the return into the mother and fears annihilation in merger. Thus the subject has to push away the engulfing object but with this comes concomitant feelings of isolation and aloneness. He suggests that the chosen solution to this dilemma may be the employment of sado-masochism given certain traits in the subject's early experience of mothering. That; 'she is seen both to use her child as a means of gratification of her own needs and to fail to recognise his own emotional needs. She is both over-attentive and neglectful and thus disturbs his psychic homeostasis in both ways. Her narcissistic over-attentiveness in treating him as part of herself, reinforces his annihilatory anxieties and intensifies his aggression towards her.' Glasser stresses that it is the teasing nature of the mother's inconsistency which 'promotes both the anxiety of uncertainty and aggression

and can be seen as an important determinant of the subsequent need to control the object.' He suggests that there develops a sexualisation of the relationship in an attempt to resolve the dilemma of the wish to destroy and the longing to return inside: 'aggression is converted into sadism. The immediate consequence of this is the preservation of the mother who is no longer threatened by total destruction, and the ensuring of the viability of the relationship to her. The intention to destroy is converted into the wish to hurt and control' (Glasser, 1979).

In many of her dreams, Carol appeared as either a victim or the aggressor in violent rape scenes. In intercourse she would often fantasise about such scenes in order to achieve orgasm. She had a hammock in her flat into which she would retreat to masturbate to such fantasies, usually after having completed a garment. In the light of the dream where it is the mother in the hammock, and the connection between making clothes and the wish to return into the mother, I have seen this activity as an illustration of Glasser's proposition. For Carol, the completion of a garment and the getting into the hammock was a return into the mother's body. This act of merger, however, threatens the existence of her as a seperate self. To kill the mother who may annihilate her would leave her bereft. Instead she controls the mother through a process of sexualisation in the sado-masochistic fantasies while she masturbates inside the hammock. Thus she manages to hold onto the relationship with the mother whilst maintaining control over it.

With her husband, this sado-masochistic means of relating was much in evidence. They fluctuated between a fused closeness and heated attempts to seperate with each trying to gain power over the other. They could get into terrible rows where they would inflict intense hurt on each other – usually verbally and occasionally physically – which were then followed by loving reconciliations and intercourse. In his work on the mother-complex of the daughter, Jung describes the woman where resistence to the mother is the strongest feature: 'all her instincts are concentrated on the mother in the negative form of resistence and are therefore no use to her in building her own life. Should she get as far as marrying, either the marriage will be used for the sole purpose of escaping from the mother, or else a diabolical fate will present her with a husband who shares all the essential traits of her mother's character' (Jung, 1954). The Englishness of her husband made him a suitable vehicle for Carol to escape from her mother. Her mother disapproved strongly of sex outside of marriage and so, for Carol, the very act of escaping was a form of capitulation, part of the

inevitable draw back into identification with her mother. She also met her 'diabolical fate' in opting for a man who seems to share many of her mother's characteristics in his inconsistent alternation between neglect and impingement.

Many of their rows centred round the business they ran together. Roles, responsibilities and tasks were all undifferentiated and confused. Work was either done by both or left undone, leading to recrimination and attack. The business and the entanglement around it clearly carried an important function in their relationship. Carol related an Argentinian folk-tale about a boy and his grandfather going to market with their donkey. First the boy rode until passers-by began to jeer at the boy for making the old man walk. They swapped and then the man was criticised for riding while the boy walked. When they both got on the donkey they were attacked for mistreating the animal. They finished the journey carrying the donkey. In the relationship between Carol and her husband, the business was like the donkey towards which they were unable to establish a mutually satisfactory partnership. It became like a third partner with which one would join to attack the other. They needed this third to keep each linked with the other but through which they could attack each other sadistically. For Carol it meant that the viability of their relationship was always maintained, but was also a way of controlling him, of keeping him at a safe distance when merger threatened.

The first fifteen months of therapy

During this period I was aligned with the cold, unfeeling English aspect who sneered at her stupidity and could at any time attack her punitively. She wept frequently in sessions and complained that I didn't respond. What she wanted was for me to hold her, wrap her up, stroke her, sing to her. Nothing I said was sufficient. My words as well as my silences were, at best, useless and, at worst, cruel. She compared me to her previous therapist who would hold her or massage her when she was distressed. Carol had told me that the reason she had suddenly left this therapist was because she felt smothered by her. When I reminded her of this and said that she both wanted me to wrap her up and was also frightened that I would, Carol reacted as if I was punishing her for her wish. Verbally she called out for me to hold and envelop her. In fact, she would always sit on the couch facing me. I felt this wary watching was to keep an eye on me in case I made a

move to attack her, but also in case I moved to do as she begged. I was to stay firmly in my chair and the eye contact could be returned to whenever danger threatened. It kept us linked, but also apart.

Although at this stage, Carol accepted reconstructive and interpretive work regarding her family and marriage, she would refuse anything that implied a relationship with me. Even her complaints were about 'therapy' and not me. She insisted that the witholding of physical contact was due to the rules of therapy and not mine, and would generally take great pains to seperate me from this 'bad' therapy. She would tell me that I was clever, professional, good at my job etc., it was just that 'this sort of therapy' was wrong for her. All attempts to explore with her an understanding of any lateness, cancelled sessions and her expressed reluctance in transference terms, were shrugged off as being part of my wearisome insistence on making myself important to her. Implied was a sense that I was cold, cruel and very powerful. She imagined that I posessed a machine that could see into her mind. If only I would confess to this she would no longer have to struggle to explain things to me. Or I could give her a 'Magic Pill' that would make everything alright. Thus she would be able to retreat into an early, pre-verbal abdication of responsibility for herself that required no relating. In Guntrip's terms she was 'abolishing the relationship' as a way of managing my presence (Guntrip, 1983). Within a few months of starting therapy she registered with a homeopath who gave her pills that, in Carol's mind, worked magically.

Given the prominence of sadism and masochism in her early relationship with her mother and now with her husband, I was rather puzzled by the mildness of my feelings towards Carol. I would occasionally notice a wish to 'get her' with an interpretation, but this was usually fleeting and (I think) fairly easily controlled. It was frustrating to be perpetually in this no-win position where neither my silences nor my words would do, but when she reacted I rarely felt personally attacked. When she cried I was only mildly moved by her tears. The hardest work was to stop thinking 'about' her in the sessions but to be there with her. In contrast, her relationship with her husband seemed to be becoming even more extreme, both in the fury and the violence and in the sexual activity. It seemed that the dangerous, exciting feelings were being split off into that relationship, leaving us safe but blank.

I thought again about the problem for the surgeon in the operation dream. If this cold, indifferent professional was me, then the knife was the 'therapy'. It was the third between us which kept us linked but

apart. It was the means through which I might penetrate and attack her and it was the object of her attack, avoiding direct feelings towards me. It's 'rules' kept me fixed in my chair which was vital in keeping out dangerous, exciting intimacy and ensuring that I could not merge with, and annihilate her, but which also was felt to be a sadistic punishment. A safe triangle had been established with this therapy as the third edge. The problem was that, whilst this held, nothing could move. I stayed clever but unfeeling, she stayed unconscious, and the baby stayed tangled up inside. Within the parameters set by the dream there could only be this unfruitful conclusion. Somehow we needed to find a way of relating other than through this hard, metallic 'therapy'. The surgeon needed to discover his humanity and the patient needed to wake up. We needed to find a way of working on this birth together.

In the summer as the weather became warmer, Carol moved into a fairly elated state. She developed rather grand business plans and also began to think about having a baby. She said she felt more positively about therapy, but now the situation was that there was no need to continue as she was feeling so much better. Whereas she had expressed only relief at my absence during the previous two breaks, she was disturbed to find that she had missed me during the longer summer one.

Then her birthday arrived. She had told me beforehand how important this day was for her, and I decided to wish her Happy Birthday. The session became increasingly desolatory and she fell silent. She eventually told me that she had expected me to put flowers in my room for her. My words were insufficient, she wanted a present and, when she didn't get one, she fell silent to punish me, 'like I did my mother'. It was the first time she herself had made a direct link between me and her mother. The next session she came late and told me how well her homeopath's pill was working and that she was thinking of returning to Argentina. She accepted that she was trying to punish me by asserting a lack of need for me and then complained of a stiffness in her joints, constipation and a tendency to hold her breath before speaking to me. When I spoke of her need for control she became angry saying it didn't work. She couldn't make me put flowers in my room and she couldn't even attack me for it. I was like a brick wall who could never be tricked into an eye-for-an-eye, revengeful attack.

This led to a period in which Carol expressed more feelings directly towards me. She told me that she feared I might attack her having made her vulnerable, or abandon her, or swallow her up. She imagined me having conversations with colleagues where I mocked her for her

stupidity. I could see right through her – she could hide nothing from me – and thus I'ld gain complete control of her. From a position of cold, sneering boredom, I would devour, penetrate and then abandon her.

Before Christmas she discovered she was pregnant. Although she had not been using contraceptives for some time, she was convinced her husband was infertile and the news was both shocking and frightening to her. The foetus was perceived as a monster which would grow and devour her from the inside. Her own body would swell and become like her mother's. She was being engulfed both by the child inside and by her identification with the mother. As the pregnancy progressed she increasingly yearned to return to Argentina and to her mother where she could 'curl up inside her lap'. Slowly her perception of the child changed from it being a monster to being her ally. She was convinced the child was male – the only time she considered the possibility of it being female was when she thought of it as damaged. It was as if the thought of a girl inside her was intolerable as the potential for merger and identification was too extreme. In order to perceive of the foetus as good, it had to have a penis. The feminine contained all that was damaged and ugly. The stronger the sense of having this good male inside of her grew, the more proud she became of her pregnant state. At the same time, her negative feelings towards me became more extreme. The fear was that I would come between her and her child. I would steal him from her – either because I would disapprove of her mothering, or as a result of my envy of her.

In February Carol decided to end her therapy and return to Argentina. I had been seeing her for fifteen months – three months short of the training requirements – and my own anxiety was high. In her 'last' session she rejected everything I said, but did agree to leave it a week and then return for a final session. It was a difficult week for me. I was convinced of her need to continue, but I was also aware that it wasn't only her needs in question at this point. She had no conscious awareness of my trainee status or of my training requirements. Yet I was struck by the amount of power she was holding over me.

She returned a week later in a state of considerable distress. She'd had a 'terrible week' culminating in a frightening dream the previous night. She was being chased by a rapist, a man with glasses. She ran into a courtroom expecting help and found she had run into her own trial. The lawyer was attacking her for not having the body of a woman.

Carol's understanding of this dream was that the man represented the fear she had been running from all her life. The man was also me, with eyes that could penetrate her. The fact that it was her own trial and not his, was saying that the problem was hers and her own confusion, especially sexually. She said she had come to understand what I had said about wanting to flee from me, the cold, attacking mother, into the idealised, loving mother, and knew that, however much she longed for this, it would not work and she must stay in therapy. She curled up on the couch and wept, saying 'I just want to get inside my mother'. Besides an enormous relief, I also felt a great sense of sadness for her.

Looking back, I believe that the fact of the actual foetus inside of her had provoked a crisis in the stasis she had achieved internally, and in the solution to the problem of my presence. This real object inside was identified as both the child penetrating the mother, and the mother penetrating the child. Whereas in earlier years, the only possibility had been abortion. Carol was now sufficiently contained by the therapy to go through with this pregnancy. However, in order to do so, she had to split off the sadistic, attacking feelings onto me, preserving the loving, merged feelings for this other mother-baby relationship.

But the crisis was not hers alone. The point at which this threat to leave occurred meant that I could not remain personally detached. Without being conscious of it, Carol had made a very effective attack. Unknowingly, she had found my most vulnerable point in terms of my investment in her, and she wielded considerable power. As with her mother, she had threatened withdrawal from me at a time when it was almost unbearable and when I most needed her to 'speak to me' again. In terms of the operation dream, this threat to end therapy had shocked her awake and me, the surgeon, into feeling.

The development of thinking

After this the tone of the sessions changed. There was a sense of collapse in her and she would lie, crying and wrapped in the blanket. She was like a defenceless bundle of raw nerves with whom I felt I needed to take great care. She would accept all I said, but could easily receive my comments as punitive or rejecting. At times she almost visibly winced. I was now 'The Good Woman', a righteous figure who cannot be defied and of whose power she was a victim. I might offer comfort, but at any moment I might pinch or bite her. Her attempt

to retaliate and break away had failed as I could inflict the greatest punishment of all – black depression and death. My own feelings switched rapidly between extremes of warmth, concern, frustration, guilt and anxiety, a sense that I was either rushing her too fast or abandoning her by not saying enough. I seemed to be either holding her too tightly or letting her fail.

Before this, Carol's main function for perceiving the world was sensation. She would describe at length the colours and textures of the fabrics she was using with an impressive sense of intensity and life. Occasionally I had experienced envy of her ease in this area, whereas I seemed to be left with a monopoly on thinking. Whilst she had shown an evident capacity for thought in sessions, she did little thinking between. She might return to the subject of a previous session, but as if what had been said had been held in suspension rather than thought about and worked with.

Edinger, in his work on alchemy, elaborates on the concept of the 'Logos-Cutter'; 'Logos is the great agent of seperatio that brings consciousness and power over nature – both within and without – by its capacity to divide, name and categorise. One of its major symbols is the cutting edge that can dissect and differentiate on the one hand and can kill on the other' (Edinger, 1985).

Up to this point, mine had been the world of the mind and Carol's the world of the body. I wielded the differentiating 'Logos-Cutter' from which she retreated into a more unconscious, one-with-mother state. Now, gradually, she began to bring her thinking function into effect. She would think about matters between sessions and often return in a state of some excitement, eager to bring me a new understanding or insight. At first she was very uncertain and, if she felt I was insufficiently approving, would become deflated and undermined. As it became increasingly possible to explore this as part of the powerfulness she put into me, her confidence steadily grew. Before the Easter break, she was worried that, without me, she would stop thinking and fall into a desperation about her pregnancy or excited aggression with her husband. She needed to know that she could ring me if necessary but in fact, she managed the two-week break without doing so. She returned with a new confidence in her capacity to have her own thoughts and to use this thinking to seperate out the mass of feelings when they threatened to engulf, and thus to maintain a sense of seperate identity. At times she had used an internal image of me with whom she could converse. Once, for example, when she was beginning to get into a furious row with her husband, 'I' had reminded

her that she and her husband were not the same person and, on that occasion, she had managed the situation without fighting. She had internalised my seperating words and used them to seperate herself from her husband.

Carol's development of the capacity to think has, I believe, been an important factor in the process of the therapy, which I have understood in relation to the idea of the 'third' between. To illustrate this I wish to return to a dream Carol brought after about six months of therapy. The first part involves her presence at a party after which she leaves with her husband to catch a bus home:

> 'We are standing in the dark at the bus stop. I have a baby son who is so tiny he can fit into the palm of my hand. I put him to my breast and, as he feeds, he begins to grow, as does his penis. While my husband watches, the boy penetrates me and, still sucking at my breast, he reaches orgasm and I am covered in semen and milk. I feel ashamed but excited'.

This could be seen as an essentially oedipal scenario where the child has usurped the father and achieved penetration of the mother. It is, apparently, a three-person drama within which incest occurs. However, given Carol's history and the evidence within the transference, I believe this dream to be a statement of an earlier, pre-oedipal state. Carol's perception of her own father, and his lack of 'substance' for me, implied a man who was often 'absent' through his drug taking and also as a partner to his wife who complained to her children of his lack of potency both sexually and as a provider. Glasser suggests that 'Another way in which the ego attempts to deal with the aggression is to split the internal representation of the object, so that it retains the loving relationship with one part of the object and is aggressive to the other part... . It requires later development to sustain this position – for example, by displacing the aggressive feelings onto the father' (Glasser, 1979). In Carol's case, I believe that her idealisation of her father was due to a displacement of loving feelings onto him. The good object was split off into him and kept 'safe' there, whilst the aggressive feelings were directed towards the bad object mother.

Over the time I have been seeing Carol, we have often returned to this dream, and her associations to it has led me to see the central image to be a pre-oedipal, triangular one, formed by the mother, the suckling child and the penis. Carol remembered how, when she saw her parents kiss, she would go and stand between them with her back to her father and facing her mother. She thought of herself as having her mouth at her mother's breast and her anus at her father's genitals. It was as if she was the penis, the third aspect that both united them

and kept them apart. In the context of this parental couple carrying the split aspects of the mother, her body formed the controlling function of both keeping the two part-objects viable and connected, and also prevented them from merging into each other. Thus is a situation that is more differentiated than the Uroboric state and less differentiated than incest.

Jung describes the Uroborus as 'the tail-eater which is said to beget, kill and devour itself' (Jung, 1946). In the dream, the child, albeit a product of the mother's body, is nevertheless distinguishable as an entity in itself. It is not an image of one, tail-eating serpent, but of two connected by mouth/breast and penis/vagina. It fits more the description of Uroboric Incest described by Neumann as: 'a form of entry into the mother, of union with her, and it stands in sharp contrast to other and later forms of incest. In Uroboric Incest, emphasis upon pleasure and love is in no sense active, it is more a desire to be dissolved and absorbed... . The Great Mother takes the little child back into herself' (Neumann, 1954). In the dream, the excitement to orgasm and the shame experienced within the mother-child couple indicates the controlling function of the sexualisation within the core complex dilemma, as described by Glasser.

I believe that the problem presented to Carol of my existence was originally 'managed' by denying the relationship. The therapy was the third between us, the knife held by me which kept us linked while she remained asleep, unconscious. The attempt to leave had proved a crisis where we both felt in the power and control of the other. Following this, Carol began to develop her own 'Logos-Cutter' as she began to think for herself. Now we could think together. A new third element or connection was created that served the necessary function of holding us in a relationship and, at the same time, ensuring our seperateness.

The baby

Most importantly, Carol was now able to acknowledge and think about her relationship both with me and with the real child inside, and to understand something of her projection of feelings of aggression, impingement and wish to control onto myself and/or the child. She began to seperate the real child inside from the internal child-object and a warm preoccupation developed. The tenuous nature of this could be noted in my counter-transference feelings. At times I could enjoy and feel warm towards this pregnancy. At others, I would

find myself worrying about what I should do if Carol were to mistreat this child and wondering about procedures for contacting Social Workers etc. My concern seemed to be a benign, professional translation of her fear that I would disapprove, take control and come between her and her baby.

The baby was born in August. It was a healthy boy born after a long and difficult labour requiring, eventually, a Caesarian section. At the point of actual birth, Carol was unconscious!

Carol brought the baby to several sessions over the next few months. There were practical reasons for this as her husband refused to look after him while Carol came to therapy. However, there were other implications. At first she seemed to need to show me what a good thing she had produced, with some expectation that this would arouse envy but also pride in me – as if we had made this baby together. There was also the sense expressed by Carol that only with me would the baby be safe, that 'at least he'll get three hours of good mothering a week', as I would be there to protect him from her attacks. I also became aware of the baby coming between us. During one session Carol fed him and then walked around the room trying to get him to sleep. My attention became fixed on his head which seemed to be lolling about and my anxiety was sufficiently acute to fantasise taking the baby from her, or at least to advise her to hold him more firmly. However, I realised that it was Carol who needed holding and that her needs and therefore my attention were being displaced onto the baby. The attention that was being paid to his feeding and containment rather than to her's meant he had been allowed to intrude into our relationship. When I spoke of this, she expressed considerable resentment that her time with me was becoming lost to him, and recognised that she was allowing him to take the feed that should be her's. She understood that she was envious of his greed and that she had dealt with this envy by depriving herself. Acknowledging her own greed allowed her to set boundaries around her own feed and she has not brought the child since.

In the year since his birth, Carol has shown evidence of a healthy preoccupation with, and attachment to her son and he seems to be thriving. The fluctuating, narcissistically-based mothering she herself received seemed to find its central echo in the series of baby-minders Carol employed who carried the projections of the two poles of smothering, over-involvement or of emotional distance. She would complain that one was too cold and unengaged, whereas another was over-active and over-stimulating. All responded from their own needs rather than

the baby's and all were eventually dismissed. This procession of substitute carers alternated in acting out the opposite aspects of the internal mother and, in so doing, freed her to struggle with a more consistent form of mothering herself. The effect for the baby, however, was a continually fluctuating environment. Gradually Carol was able to recognise these projections as such and the latest baby-minder has been kept on for some time.

For Carol, the baby could become both the abandoned child who cannot be consoled, and the intrusive mother from whom she must take flight. She reported that, when unable to discover the source of his discomfort and ease his crying, she herself became anguished to the point of banging her own head against the wall. The inconsolable distress and abandonment fears had become activated in her. At the same time, his distress threatened to penetrate and swallow her up and she had fantasies of dropping him out of the window to rid herself of this intruder into her life. It was as if she had to direct the aggression at herself rather than attack him. As in 'the hammock dream', she could not at such times contain his swaying, and is rocked herself. She turns herself out of the hammock to prevent him from falling.

The father

At this point in therapy Carol began to express anger towards her father for the first time, an anger which increasingly focussed around a fear that incest had occurred.

A patchwork of images, fantasies and memories emerged revealing a confusion of penetration events and objects:

i) Her father used syringes as a doctor to save life.
ii) He used syringes in his drug taking.
iii) He used to take her temperature anally when she was ill.
iv) He shot and then saved the dog after it bit his son.
v) She once stole a syringe and injected the chickens. They all died.
vi) Her older brother used to excite her anally and vaginally with syringes.
vii) When pregnant with Carol's middle brother, her mother became very ill. To save her, Carol's father operated by cutting a blood vessel.

The syringe, thermometer and knife were hard, nipple-penis objects which brought life, death and excitement and penetrated all parts of

the body. Carol had been frequently penetrated anally in intercourse, both by her husband and by previous partners – a practice which she found both degrading and exciting.

Carol's experience of her father was of a man who was frequently absent through his drug-taking and through his abdication of his responsibilities within the family. He stood by while his wife punished the children and would defy her only by colluding with Carol in their 'sneaking out' together. The image is of a passive, depressed man, unable to form a strong parental couple with his wife. Nevertheless, Carol experienced happy times with him and he became the recipient of the split off, loving feelings, while the hatred remained with the mother.

Previously, then, the crucial internal relationship was to a split-object pair of good, soft breast (father) and hard, penetrating nipple-penis (mother) where each had to be held together but apart from the other. A movement towards the depressive position required the acknowledgement of ambivalent feelings for two whole objects forming a combined-object parental couple.

Now a fear of the dangerous father-penis emerged. When she first suspected that she had been abused sexually by her father Carol proposed ringing her mother to find out for certain. Now the previous splitting process was being reversed so the mother became the soft loving one and the father the hard penetrator. The proposed phone call would have been an intervention between two, reversed, but still split, part-objects.

In one session during this time, Carol was talking a lot about her father. I was unable to concentrate on an image of him and, instead, my mind kept wandering back towards her mother, and the session felt increasingly flat and stuck. I told her, rather sharply, that I kept thinking about her mother and she reacted by becoming angry with her baby-minder who was too stimulating and penetrating. In his work on 'Perversion in the Transference', Meltzer describes the situation where: 'the dissolution of the combined-object attitude towards the patient favours vulnerability to the seduction for mutual idealisation of the maternal counter-transference (Meltzer, 1979). For Carol, I had altered from being cold, hard and penetrating to a good and caring mother whose feed was acknowledged and loved. A move from the indifferent surgeon to the kindly GP. But, in the operation dream, the GP. is of no more use than the surgeon. He is kind, but lacks the expertise to handle the necessary cutting edge. As her doctor-father had been kind but unable to act to cut the over-merged mother-child pair.

I realised I was in danger of being seduced into a mother-daughter collusion against a sadistic, penetrating father. The productive potential of the cutting edge, of 'the sharp side of my tongue' was becoming lost. The wife in me was losing her spouse. A 'sharp' comment from me was provoked and brought back into focus the over-stimulating, intrusive aspect of the mother. Subsequent work led Carol to understand the confusion of penetration events, conclude that actual incest had not occurred and decide not to phone her mother. She also began to reject the degradation and excitement of anal intercourse with her husband.

The return to Argentina

This summer Carol decided to return to visit her family in Argentina and began to make plans after the Easter break. During the two and a half years I had known her, she had proposed making such a visit a number of times which I had always understood as a flight from me into the mother. Each time she had cancelled the trip. This time, there felt to be a realistic wish to face these important external figures and to discover how much they matched the internal representations. In the months prior to the visit she became anxious and depressed. She feared five weeks away from me in 'dangerous territory' and that she might become sucked into an intense hatred and a destruction of her ties with them, or an intense loving out of which she would never return. She talked of an acute sense of ugliness – both her's and her family's, which seemed to focus around two main aspects: a) the level of consistent sexual activity amongst all the siblings throughout their childhood, and b) the treatment of the adopted sister by the whole family. She expressed a painful empathy for this girl, anger at her parents for their treatment of her, guilt at her own part in this and shame for the entire family.

Carol returned from the trip relieved that she had managed the time there. On the whole, she had discovered that she did not particularly like her family members, but had maintained a sense of detachment and acceptance where she had neither attempted to change or to please them. As she expected, she had been criticised for her 'over-indulgence' of her son but had insisted she must manage her child in her own way. She was most struck by the level of physical punishment inflicted on her nephews and nieces. When anger theatened, she would withdraw

for a while to 'converse' with me as a way of understanding what was happening.

Soon after her return Carol brought a series of dreams:

> 1) I am at my cousin's communion in church which my mother has arranged. It is a beautiful, elaborate ceremony in contrast to my own which was plain and simple. I complain to my mother who apologies. She had thought that was what I had wanted.
> 2) Outside of the church the family is discussing who should replace my father who is old and dying. It is clear it must be my middle brother.
> 3) The Royal Family are visiting my home in Argentina. The Queen is English but without a husband. The Prince and Princess arrive. They are Asian.
> 4) My husband's genitals are cut off and in a basket. They are old, withered, dead. I pick them up and rub them with cream but find the task distasteful and pointless so return them to the basket.
> 5) I come to therapy but you have gone and instead I find a male actor, a wise, kindly and attractive man. I am confused and embarassed because of my attraction to him. You are outside in the woods. After the session I tell you I miss you but I'm also looking forward to this new relationship.

These dreams indicate some of the features of the depressive position. Together, Carol and her mother acknowledge her envy and distress and her mother's misunderstanding of her. Reparation is possible. There is also a sense of loss and change. The father is old and dying and must be replaced by a younger, previously envied brother. Her husband's genitals wither and I have gone into the woods to be replaced by a man. In other dreams, new male figures have appeared indicating a differentiation between masculine and feminine and subsequent conjunctio. The old, single Queen is joined by the Prince and Princess from the East.

Conclusion

In *'Psychoanalysis, The Impossible Profession'* by Janet Malcolm, the analyst described refers to the operation as an appropriate analogy for therapy where 'something is done on the analytical patient the way an operation is performed on a surgical patient' (Malcolm, 1982). I would agree with this image in his use of it as an argument against the breaking of the rules of therapy, but it is, in my view, a denial of the importance of interaction and relationship in therapy. A different standpoint is taken by Jung; 'In any effective psychological treatment the doctor is bound to influence the patient; but this influence can

only take place if the patient has a reciprocal influence on the doctor. You can exert no influence if you are not susceptible to influence' (Jung, 1946). Redfearn too points out that 'much that is written seems to imply that the therapist calmly maintains his pristine and impregnable boundaries while enabling the patient gradually to feel that his shitty, dangerous, chaotic and overwhelming feelings are more and more acceptable... . I think it is not a sufficient principle on which to base effective therapy which involves a two-person interaction' (Redfearn, 1979). Both Jung and Redfearn are stressing the importance of mutuality of affect, of a two-way process of influence, of conjunctio.

The potential for health in Carol brought her to a point where she sought out a therapist. Once found, however, my presence presented a problem which she managed by constructing a triangle of cold surgeon and anaesthetised patient joined by the knife of therapy. She needed to establish that I would not allow this knife to become blunted by any bending of the rules. However insistently she called for it, it was important that physical contact, lengthening of sessions etc. were not allowed. Even if my words were received as cutting or useless, they had to remain the essential tool of the trade. Annihilatory fears required that care and concern were denied me within the transference for, as long as I remained inhuman, I had no guts into which she might disappear. Nevertheless, if mother and baby were ever to be retrieved from an endless union, we needed to waken into a relationship within which we could work together. My Eros and her Logos had to be recognised and acknowledged.

An analogy for therapy could be seen in the poem East Coker by T.S. Eliot from which I take the following passage:

> The wounded surgeon plies the steel
> That questions the distempered part;
> Beneath the bleeding hands we feel
> The sharp compassion of the healer's art
> Resolving the enigma of the fever chart.

From the beginning, the 'sharpness' of my art was insisted on by Carol. There could be no doubt about my professional cleverness and skill. My compassion, however, was not permitted within the transference and, consequently, only mildly in the counter-transference. As Eliot implies, compassion is a function of one's own woundedness. As long as I remained a person without wounds I would neither have a need to devour or attack her, nor would I be vulnerable to her attempts to devour and attack me. The problem was that that I was also not susceptible to her influence or to my own compassion, and both were

required for the development of a relationship within which Carol could be influenced towards health.

Given her experience of a narcissistic form of mothering, Carol is, I believe, acutely sensitive to where she is needed by others. She found a therapist who needed her as a training patient, and then needed her to stay in therapy for at least eighteen months. Her threat to leave three months before this time brought into acute focus for me the fact that I was not a detached, indifferent observer of her process but, as a trainee, someone with considerable investment in her remaining with me that was at least as much to do with my own needs as hers. The dream that brought her back concerned a rapist, a figure who uses his victim for his own ends. A dream is a metaphor for an internal reality, and the characteristics of external figures who appear are, presumably, those of relevance to this internal state of affairs. My compassionate, relationship-seeking motives were denied in the transference and, instead, Carol picked up on those that were using her to my own ends – not so much a personal wound perhaps, but a 'trainee' one. Paradoxically, it would seem that the activation of this 'wound' had an important effect in the development of relating. It was after this that compassion could be added to sharpness.

Another paradox now arises in the very fact of the writing of this paper. To do so I have had to work alone, needing to cut, disect, unravel, select, categorise and name the 'guts spilled' over three years of therapy. It is a paper written, not from Carol's needs, but from my own – to fulfill requirements in order to qualify.

A few weeks after I had begun writing this paper, Carol brought a dream. Again she was being chased by a rapist from whom she managed to escape. Later they met and sat down to talk together. Carol was surprised to think of this rapist as me. She could not understand why, as it had been a long time since she had thought of me as a sadistic attacker, and she was relieved to note, when associations with the outer rapist dream were made, that this time it ended in talk rather than a harsh, attacking trial. I was aware that I had been struggling with a sense of guilt, a concern that the 'baby' that is Carol was not lost in this writing operation. I felt rather like a rapist, intruding into Carol, using her story in order to meet my own needs. This guilt may be an aspect of a present counter-transference state – that of a parent of a child now at an oedipal stage, who knows that something does indeed occur behind the bedroom door to which the child cannot be party. It may also be an aspect of a central paradox inherent in the writing of any case paper.

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COUNSELLING, PSYCHOTHERAPY, PSYCHOANALYSIS: A PERSONAL PERSPECTIVE

JAN HARVIE-CLARK

I wrote and gave this paper a few months after reading my qualifying paper as a kind of marker for myself; to test and record where I felt myself to be at this particular point in my time, as an associate member inordinately proud of my new qualification. I also wanted to share some doubts difficulties and excitements about myself and my work and raise some questions which often seem to me to be infuriatingly just beyond possible discussion with colleagues; and yet that I need to think about.

The big question for me is : what am I doing? 20 years ago and more I was doing social work as a Child Care Officer and I lived most uncomfortably for a few years working on behalf of a society which did not seem much concerned with the best interests of my clients but rather with getting its dirty washing done somewhere safely out of sight. I struggled to get families to pay their bills and keep their houses just clean enough so that they did not get evicted or their power cut off or their children taken into care – it was an enlightened rural authority where there was time and encouragement to undertake preventative work. But I was enormously relieved to give up society's laundry for counselling; I was relieved to be unambiguous about my clients' best interests. 10 years ago we enjoyed a six month induction course, one evening a week, and after passing a selection test before and after the course we became counsellors. Now the course is 2½ years long and like a watered-down B.A.P. training without as yet a requirement for personal therapy; at the end of the course you are still a counsellor, i.e. you see a client once a week, face-to-face, at a set time for 50 minutes. At Highgate Counselling Centre, my 'nursery', the expectation is that you will work with a client for an unspecified length of time but somewhere around 2 years. The client will pay according to his means and the counsellor will be in supervision with a psychotherapeutically qualified person.

I remain involved with and feel indebted to Highgate and have only recently stopped seeing clients there; but I no longer see myself as doing counselling, at least not for a whole session! Highgate has not changed, except that its standards of training and expected practice

are amongst the highest in the country, as they have always aimed to be. But I have changed. I can no longer sit with clients, sharing their feelings as I used to, listening, encouraging, supporting, perhaps suggesting an additional or alternative way of looking at something; without knowing what I now know about unconscious wishes and impulses, repression, denial, projection, the infinite variety of defense mechanisms: without looking out for the part I am playing in my client's life as an echo of past object relationships and being aware and considering how to use the feelings aroused in me by my client. When you know about these mental processes, through your own therapy and training, you can't un-know them though you can choose not to use your knowledge. An analogy would be knowledge of nuclear fission and fusion: scientists know about these processes, they won't ever forget their knowledge, but for the sake of us all they have to decide what to do with their knowledge; as I have to decide, more mundanely thank goodness, for the sake of my patients.

Technically I may be frowned upon, but I would still occasionally make a suggestion to a patient, suggest an alternative course of action or way of dealing with a problem, and spend time concentrating on a problem current to a patient's life. I find this especially with 'young' patients who are not necessarily chronologically young, but in whose lives the most exciting and demanding action is in their present lives as they face and tackle major decisions. Some counselling seems essential, even if it is to say in some way or other: 'Hold on a minute'! The pressure for discharge can be intense. Patients as indeed clients soon get used to this way of working as they get used to regular sessions and can begin the thinking process for themselves, but in the early stages of a therapy it is sometimes necessary to intervene to prevent an acting-out which would perhaps have far-reaching consequence.

Maybe this is playing God, or a Victorian father, but sometimes I find it is essential to use my privileged position to intervene, and then of course it is equally if not more important to try to help ones patient to understand why he/she was on a suicide mission, and what function his/her therapist has been attempting to fulfill; not so easy for a counsellor, partly because the long gap between sessions means that more can fall into the time chasm, partly because of the counsellor's lack of understanding of the unconscious processes. Several years ago a male client presented me with a bottle of champagne one Christmas time; I was very flattered – and flummoxed; and relieved when he decided before the end of January that counselling was not giving him

what he wanted. More recently when a patient gave me a piece of his work I was able to accept it gratefully and look with him at the hopes and expectations which accompanied his gift, understand with him that he was offering to make up his low fees in a way which seemed open to him and that he was imploring me to recognise his productions as valuable; and we were able to continue to work beyond that immediate understanding as, his self-esteem intact, we could see together that he wished me, his transference mother, to hold his work to be precious beyond price and to value him for his production. At the next break he talked of his wish to make a present to me and we could see that now a gift should shut up my expected demands for more effort/change from him. The potential meaning of a patient's gift is infinite, but in order to explore it you have to be able to appreciate it and allow the space to unravel it. You have to have experienced such a wish yourself and explored its meaning within the appropriate stage of development in order to hear what a patient is presenting.

So now, with the help of my shiny new training, I am better equipped to hear, however many times a week I am listening to a patient. At Highgate we call our customers 'clients' and think of ourselves as counsellors but at UCH we call them 'patients' and believe we are psychotherapists. I have worked in the Department of Psychological Medicine's outpatient section, as a voluntary clinical associate, for two years and seen three patients, each once a week, under the supervision of a psychoanalyst. My fantasy was that I would be able to see patients who were so ill that I would not see them at Highgate or in my private practice. I did not know of the piece of research work undertaken by Guy's outpatients department and the Westminster Pastoral Foundation which showed that there is no discernible difference in terms of degrees of illness between the two client populations. Maybe counsellors, just like psychotherapists, believe that the *really* difficult, skilled work is done by the other 'clever' people.

Although I was working at Highgate and at UCH simultaneously, I did find it easier to work with the transference with supervision that supported that way of working. And I did discover that I could work with very disturbed people by allowing myself to become the disturbing object. One of my patients was a self-cutter; she cut her arms and feet when she felt particularly bad about herself, after she had been drinking heavily and when she was alone. Although the cutting provided her with an immediate relief from the tension which had been building up inside her, she felt terrible a few hours later. She had had some outpatient therapy and worked hard to get herself taken on for more.

I think that she saw herself as a hospital case, and would never have considered approaching a counselling centre or private therapy. I really can not say that I 'cured' her but by becoming, by her allowing me to become, the transference mother and father who abused this little girl and whom she was trying to cut out and drown, we effected a marked shift in her self-destructive behaviour. Perhaps inevitably, now that the exciting and relieving behaviour has changed, she is left experiencing a profound depression from time to time, so that I can not say her future is in any way assured at this stage. But as a result of once-a-week treatment over two years, I am sure that this could not have happened before my BAP training. I could not have stood an atmosphere which could have been cut by the blade which she kept for such use; it is not easy to stand it now; how can it be easy to partake in a life-or-death situation? No wonder few people want to get into such work. Yet she also values our work greatly, needs and uses it well, which must have been part of the original parental situation; the positive balance, often impossible to discern, is essential for a positive, even a more positive, outcome. I could expand and did contemplate writing this whole paper on my understanding of this patient; because I find the dynamics of her treatment so utterly fascinating: there is obviously a whole lot for me in the danger being revealed and played out on another stage. But Murray Jackson's warning, when he turned down this patient a few years ago for treatment at the Maudsley, comes back to me: that such patients do well in treatment but tend to regress after the finish.

This work is quite obviously, I think everyone would agree, not counselling; nor is it psychoanalysis – or is it? We are trying to analyse her state of mind when she cuts herself, the unconscious fantasy, the conflictual desires, the projective identification; I am working with the transference and paying close attention to my counter-transference in order to reconstruct her childhood scenes and fantasies and her present state of mind. In Hannah Segal's paper 'The curative factors in psychoanalysis' she writes that 'the thesis of my paper is that insight is a precondition of any lasting personality change achieved in the analysis and all other factors are related to it...that is, the acquiring of knowledge about ones unconscious through experiencing consciously and, in most cases, being able to acknowledge explicitly and verbally, previously unconscious processes. To be of therapeutic value, it must be correct and it must be deep enough. It must reach to the deep layers of the unconscious and illuminate those early processes in which the pattern of internal and

external relationships is laid down and in which the ego is structured. The deeper the layers of unconscious reached, the richer and the more stable will be the therapeutic result.'

Here I think is one reason why this treatment is not psychoanalysis. Though I continue in hope that we will reach deep enough into her unconscious to restructure the pattern of destructive relationships, I do question to myself how rich and stable the result can be. I think to myself, if only we had more time...will we ever be able to achieve a less persecutory inner core which can withstand not only my absence but also the future dangers of life events? So maybe one of the differences between psychoanalysis and any kind of psychoanalytic psychotherapy is in time, and I believe it is something that we therapists are not able to face honestly. If we are able to continue our work together, this patient and I, we may be able to help her to a greater or lesser extent. She wants to feel better, I am trying to help her to feel better about herself by working with and through the bad feelings. We are not setting out on an adventure, an exploration of the unknown, so much as attempting a rescue mission. So we have a therapeutic intention in the forefront of our minds, and it is very unlikely that she would want to go further than achieve a life which she feels is more worth while than that she has so far experienced. More time, more sessions either more frequently now or for a longer period, or even both, would undoubtedly help her more than we have so far achieved; but I don't think her treatment would ever turn into an analysis. She does not want to find out about her psyche; only to achieve a more satisfactory experience of life.

There are many elements of this debate that I believe counsellors, therapists and analysts shirk. Part of the fuel for the debate is professional jealousy; counsellors want to be therapists, therapists want to be analysts, everyone wants to claim the one true religion and no-one finds it easy to admit that anyone else can do it better than he/she can. In the accepted hierarchy, those on the steps above are seen as having the desirable goodies and keeping them all to themselves, whether it is the better patients or the better brains or the better premises. I can not be alone in having seen marvellous results from a sensitive patient caring counsellor and dubious results from a prominent analyst; but it is difficult not to believe that someone must be better, have something better, if the someone is considered to be of higher status. It is difficult to see the wood from the trees, to see the value of the quick-growing pine tree alongside the mighty slow-to-mature oak...let alone these wretched sycamore psychotherapy saplings

which spring up ubiquitiously from every crevice to grow, many of them, into...perhaps you could follow that one as you will!

Maybe this analogy is useful to illustrate another point in my search to differentiate between counselling, psychotherapy and psychoanalysis. A pine-sycamore-oak seed always turns into a pine-sycamore-oak sapling and finally, given adequate nutrients and space, a fully grown tree of that species. The unfortunate trees do not have the opportunity to change their classification in the bi-nomial system. The biological definition of a species is a group which has the same number of chromosomes and can interbreed. To borrow this analogy, our three species of the 'talking treatment' are differentiated several steps higher up the system, and interesting though I would find it to continue this research, I do not know enough biology; but I do know that pines, sycamores, and oaks can not interbreed. However, we can sometimes change our species, transform ourselves from one to another – by taking an additional training. If we do not change our species by further training, does this mean that we do not share any of the characteristics of the other species? We are after all, all members of the helping professions, all engaged in treatment through talking, and we share some of our tools; our interest in the feelings, thoughts and actions of our fellow human beings, a non-judgemental attitude, a reliance on ourselves and the relationship between ourselves and our client/patient as the medium of our work. To go back to my tree analogy, we are all trees; we may be found in different habitats or we may be found happily existing in the same woodland, provided there is room for us all. BUT; we can look very different, and be used for very different purposes. There are many things for which only trees can be used though it does not matter much what kind of tree: sometimes it does matter and sometimes it matters very much indeed.

So I am suggesting that we have to define ourselves by our training and that is immutable unless we undertake another course of training: but that what we do with our training, how we use our training, is a different matter. So my next question is: I can understand at this point in my professional development, when I am doing counselling and when I am doing psychotherapy – but could I possibly be engaged in analysis sometimes? Is this any different from intensive psychoanalytic psychotherapy? And if it is, how is it different? I have already suggested that time has at least something to do with a difference, and intention too. Although I expect this to be controversial (it would be good to get a debate on this), it seems to me that the more time you allow and the further you want to get, the greater chance you are going to have

of an analysis rather than a therapy; the more chance you are going to have of finding out about the unconscious. The unconscious is not a finite quantity; after 10 years of my own analysis, I am sure of that!

So just what is psychoanalysis? Is it the discovery of the unconscious, is it an explorative, investigative research process? Freud's famous statement from the Budapest Congress of 1918, which was quoted recently by Professor Sandler in his paper 'Psychoanalysis and psychotherapy, problems of differentiation', really sets the cat among the pigeons. Freud said: 'It is very probable, too, that the large scale application of our therapy will compel us to alloy the pure gold of analysis freely with the copper of direct suggestion...'.

From this point, I think we may all be involved in a gigantic self-protective cover-up job. It would be far more simple and perhaps honest to take this view; that psychoanalysis is the pure gold, is the research into the unconscious; that psychotherapy is the alloy, the attempt to cure which may include direct suggestion. Greenson put it a little differently in his chapter on Transference and Technique in 'The practice of psychoanalysis' published in 1985: 'Interpretations alone, pure analysis, is a non-therapeutic procedure, a research tool...it is the proper blending of analytic and non analytic techniques which makes for the art of psychotherapy.' Greenson also suggests that is only years after the ending of an analyst's training that he can be confident enough to deviate from the methods he has been taught to try to fit them to his particular patient; suggesting surely that the art of psychotherapy is a great deal more difficult to practise than that of psychoanalysis.

Greenson is suggesting that interpretations alone are pure analysis, a pure investigation of the unconscious as hidden by the various defence mechanisms. Is this what we psychotherapists are aiming to do in our work? Harold Stewart, in a recent paper he gave to the B.A.P. (March 1990) and is now published, lists the agents necessary to produce psychic change as: 1. Various types of transference interpretations: 2. Extra transference interpretations: 3. Reconstructions: 4. Therapeutic regression: 5. Techniques other than interpretations to overcome analytic impasse.

I can not find it stated anywhere in BAP literature, but I assume we are working with a patient to try to help him/her feel better...we try to do that by helping our patients to understand their unconscious mental processes and defences so that some investigation is an essential part of our work; but our primary intention is to help alleviate by making possible psychic change. As regards the kind of change, we

have to remain impartial and absent ourselves as far as possible to allow space for our patients to find themselves and their own unique solutions and adjustments. We are not, however, merely aiming to investigate and explore, we are primarily aiming to allow for change which will be improvement. But it seems to me that we might employ all five of Harold Stewart's 'agents' in much the same way as he suggests.

All my patients have sought treatment because they have come to recognise that they need help to understand and sort out the painful areas of their lives, and this is so whether they are able to come once or four times a week. It is true that I will try to persuade them to come as frequently as they are able to afford, in terms of time, money and resistance of a psychic nature. That is because I find that the possibilities of insight and so change are enormously increased if we can do more work together. I have worked for 10 years as a counsellor, seeing patients once a week, and I know that it is quite possible to do excellent and usework work this way. But it is limited. Limited both by time available and by the counsellor's own understanding and insight which he/she has therefore available for the patient. It may be that such limited treatment is more appropriate for some patients, although I feel that it is more appropriate for the counsellor or therapist rather than the patient. The time question is a troublesome one in every setting, but I do feel we should be as honest about it as we ourselves can afford to be. There is our training which holds out an optimum of three times a week, but in our own therapy we may have found that we enjoyed or needed or benefitted by more frequent attendence: or we may not have had the option because we could not afford it for whatever reason, or our therapist may not have been able to offer it, again for whatever reason. So our own experience is coloured before we see a patient, and our work with patients is built on that foundation. Not at all what is in the best interests of the patient.... The argument so often used is that some patients can go as far in once or twice a week as others need more frequent sessions, seems to me to be specious. Maybe that is what they can afford and they will make the best of the time available to them – but if they could afford more, they could make better use of their treatment? If their therapist could afford to allow them more time, could he/she work with them more effectively? The answers may, and I believe, should change as therapy progresses and resistances decline. Maybe there will be room for some of Harold Stewart's agents for psychic change – but could we really say there is space for all of them?

So it is no good, in fact dishonest, for us to hold that less frequent treatment is ever as good as more frequent. It may be all that is available, and it may well be that something is better than nothing. I have worked for two years seeing patients for a brief period. I experimented with 6, 10 or 12 sessions, fuelled by anxiety of ever-increasing waiting lists wherever the centre I was working for was offering low-cost or free treatment. I found it was extremely hard work to see someone under the pressure of a time limit, that I wanted to get to know the patient, his history and his current situation as well as I could and work with the transference as directly as he could allow. There are other ways of approaching short-term work which would maybe be less demanding on worker (and on patient) but I was doing what I usually do in a condensed form. I found it was often amazing how clients responded and that it was quite possible to build a very strong therapeutic alliance in a very short time and that dramatic changes could be seen. I wonder how permanent or useful our work would be...and I was also very much aware of how exhausting I found such work. It may well be that small changes effected in this way have wide-spread effects, and that this is all some people want and look for in treatment.

As work with my training patients progressed I was able to see the effect of psychic change and find that I enjoyed this slow rich multi-faceted process a great deal more. I now find that working face-to-face far more difficult, tiring, and trying than being able to concentrate solely on the unseen joint activity; as Freud said in his technical paper 'On Beginning Treatment' 'I can not put up with being stared at by other people for...hours a day' and I would add that I can not put up with holding in my head all the minutiae of so many peoples' lives; obviously if I see patients more often I see less people. For me, the evidence of my eyes is more overwhelming, and confusing, than the evidence of my ears. I trust the perception and understanding of aural and unconscious senses more than that of my sight sense. So that while a frightened confused disturbed patient sits and watches me intently I find it hard to get beyond the visual contact and I find the encounter exhausting. A patient who has sat nervously and talked incessantly for several months has justed started to lie on the couch and the whole pace and tenor of the work has changed. Another patient has spent most of two years sitting opposite me and refusing to use anything I say to relieve her crippling depression, so attempting, I feel, to cripple us both. She attends regularly and promptly while I struggle to interprete her donkey-like obstinacy and keep faith with

the procedure. Another patient has been attending therapy for a year now, three and now four times a week, to understand why he is unhappy; he can afford more, in terms of time money and motivation and wants to use his treatment to improve and understand himself. He said recently that what he felt he had to do was to find out all about me – and so I think begin to be able to differentiate himself, which is what he has come to do. I have to 'do' very little, he does the bulk of the work, I have to offer an interpretation when he gets stuck; what a relief this is in comparison to the previously described patient.

This patient, who is not a complete stranger to the analytic world, thinks of himself as being in analysis with me. He has certainly come for help, but I think he would understand that help is obtained, as Hannah Segal said, as 'Insight leads to therapeutic changes when the acquiring of knowledge about ones unconscious are experienced consciously'; and that cure 'means restoring to the patient access to the resources of his own personality, including the capacity to assess correctly internal and external reality'.

The most useful paper I have found in trying to assess what it is that I might be doing is Nina Coltart's 1982 paper entitled 'Slouching towards Bethlehem'. She is attempting to explore the difference between psychotherapy and psychoanalysis and says that 'It may be constructive and ego-supportive for a patient who comes once or twice a week to get onto a track indicated by one of the signposts of the sessions; in analysis we can afford to ignore them in the slow attentive working towards a deeper nexus of feelings, fantasy and wordless experience that is slouching along in a yet unthinkable form'. She continues: 'There is a delicate balance between our reliance on our theories and on our knowledge of human nature...and our willingness to be continually open to the emergence of the unexpected.' Could it be, I ask, that sometimes we psychotherapists have a greater or wider knowledge of human nature by the time we come to our training, which is usually later than psychoanalysts, than some analysts? And that a psychoanalytic training allows for more theoretical knowledge and understanding than ours does? Could it be that sometimes intensive psychoanalytic psychotherapy is indistinguishable from psychoanalysis except that the therapist has trained elsewhere? And that the converse is also true? But that a critical difference between psychoanalysis and psychoanalytic psychotherapy is in 'the slow attentive working towards a deeper nexus' which requires the time and space of psychanalysis?

This discussion really comes alive for us when we consider who can be a therapist for our students and although after the furore of a few years ago we have now got new guide lines, I am sure that this debate will – and should – come up again and again. We want the very best for our students, for our patients and for the future of our organisation. Students need to understand their own unconscious mental processes so that they can use their unique tool to understand their patients, but they must too have discovered, even if they were not aware of their original motivation, that they were searching for self knowledge, to help themselves primarily, even when they applied for training. They should have access to the most and the best; what constitutes the most and the best is what I have tried to address here.

To end I want again to quote Dr Coltart, to fall back on her experience, although I would have to change her discussion of an analyst to that of a therapist and I hope she would think this would still hold.

> 'The day that one qualifies as an analyst, the analyst that one is going to be is a mystery. Ten years later we may just about be able to look back and discern the shape of the rough beast – ourselves as analysts in embryo – as it slouched along under the months and years until, its hour come round at last, there is some clearer sense of ourselves as analysts...the process of doing analysis has slowly given birth to an identity which we more or less recognise as an analyst, or at least the identity which we have become and are still becoming which for us approximates to the notion of "being an analyst". This may be very different from that which we long ago had visualised or hoped for.'

Is it so very different, or indeed slightly different, to practise psychoanalysis or psychoanalytic psychotherapy? I believe I use the same tools, although with a different emphasis as my training has emphasised clinical work and experience rather than the theoretical; so I shall probably continue to work with more patients whom I shall see less frequently (but continuing to encourage them to attend more frequently) than a psychoanalyst, and possibly see more damaged patients. However some analysts, as therapists, work mainly within the N.H.S. seeing very many patients, and some analysts do see very ill patients indeed. So...although I think there must be a difference between psychoanalytic psychotherapy and psychoanalysis in terms of training, of motivation, of frequency of sessions, and of intensity of treatment, I do not find it easy to make this a clear differential and I hope others will continue this debate; perhaps through the pages of the newsletter?

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SOME TECHNICAL PROBLEMS IN WORKING WITH DREAMS

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Dreams have always been allocated a unique status in psychoanalytic thought and have been regarded as a cornerstone of psychoanalytic work. Freud, at the end of his life, believed his 'Interpretation of Dreams' (1900), in which he famously stated that 'the interpretation of dreams is a royal road to a knowledge of the unconscious', to be his most important contribution to the science of psychoanalysis. The capacity to recall and report dreams has been described as an 'ego achievement' (Blum, 1976), and indeed one might extend this notion to the very capacity to dream: we are all familiar with how this fundamental mental activity is disturbed or nonexistent in seriously ill patients. Dreams have also been seen as an essential part of the psychic work of working through (Segal, 1981). Despite this unique status, little has been written about the technical issues involved in working with and interpreting dreams in clinical practice. This paper is an attempt to address that deficit, by focusing attention on the complex and important factors which surround and determine both the presence of a dream in a session, and what is then done with it, by therapist and patient.

One area of difficulty, I believe, has to do with this notion of the unique position that dreams are afforded in our work. Should we regard a dream as a special class of material, or as a clinical communication like any other? Freud, interestingly, was quite clear about this:

> Dream interpretation...should be subject to those technical rules that govern the conduct of the treatment as a whole. (1911).
> It is only too easy to forget that a dream is as a rule merely a thought like any other, made possible by a relaxation of the censorship and by unconscious reinforcement...(1923).

Despite this, I suspect that we are often inclined, unknowingly, to subscribe to the 'royal road' position, and to think about and respond to a dream in a different way to how we might respond to our patients' other utterances or behaviour – as a rare opportunity for more direct access to the patient's unconscious mind, say, or as a chance to prove to the patient that he does indeed have an unconscious mind, or simply as an opportunity to display our cleverness. The context of surrounding

material in the session, in both its form and content, is then in danger of fading into the background. Stewart (1981) gives an example of a 'defensive dream' whose true meaning is only comprehensible with reference to the session in which it occured. The following clinical vignette further illustrates this: a female patient lay on the couch and began a session with these words:

> I went into a chemist to buy shampoo. I picked up a bottle and looked at it carefully to make sure it was the right one. When I got home I discovered I'd bought a bottle of conditioner instead.

She was then silent for some minutes, seemingly awaiting my response. Her words were intoned in a rather emotionally detached manner. I was unclear whether she was telling me about a dream or a real event. As her story unfolded, it became clear that it was a real event, but would I have responded differently – or even thought about it differently – had she begun by saying 'I had a dream in which...'? In fact, it can be seen how my confusion about what she was telling me mirrors her confusion (of shampoo and conditioner) in her story, and it may be that this enactment in the transference is the important communication. Perhaps also, the way in which this anecdote was related, inducing some sense of dislocation and confusion in me, was a way of 'conditioning' me to provide her with the wrong interpretation. Had my attitude been one of 'now this is a dream, and I must think about it as a dream', then this level of the communication might have been missed.

Related to this issue of the dream as communication, which, as with all communication is many-layered, is the question of the function of the communication. Segal (1981) has remarked how dreams in borderline and psychotic patients are often experienced as real events, such that there is no sense of symbolization in the dreamer's mind, only of a concretely experienced event. In such cases, the analyst can only usefully pay attention to the function of the dream for the patient; interpretation of the content of the dream is of little use, as it assumes a capacity for working with symbols which is not present. The function of such dreams, according to Segal, is evacuative: it allows the patient to get rid of an intolerable affect of thought. This can be seen in the following clinical example: a male patient, in his third year of treatment, had only recently begun to report dreams. His sessions were generally remarkable for a flood of material, in that he spoke volubly, with very little time or space for reflection. He spoke with a sense of inner pressure, as though to get rid of what was in his mind and disown it. Only rarely could the material he

brought be worked with, in the sense of mutual discussion or investigation. Towards the end of one session, in which we are able to look at how he uses his therapy to get rid of intolerable states of mind, and also at the difficulty he has in taking in what I say, he reported the following dream:

> He was at a dinner party, and realized that he had a growth in his ear canal. He surreptitiously pulled it out and inspected it – it was horrible. Then immediately another growth formed in his ear to take it's place.

He understood the dream to describe how there will always be something in him which gets in the way of our communication. This felt right to me, but I was also aware as he reported the dream that the dream itself, not only the growth, was experienced as something horrible, and was to be gotten rid of; he wanted no investigation, no inspection, of the dream by us. It was felt to be something that blocks, rather than aids, our communication, and it's evacuation was seen as essential but futile, as another growth/dream would quickly take it's place. This example demonstrates Joseph's (1985) point, that a dream can reveal its meaning by being lived out in the session.

Hobson (1985) has described dreams such as this as 'self-representing', in that the events in the dream correspond to events in the session in which the dream is told; the dream thus represents the session and features a representation of itself. He recommends that in order to best apprehend the significance and function of such a dream, it is helpful to scan the contents for a representation of the dream itself. The nature and role of how the dream is represented within the dream may betray what the dream represents within the session. This can be demonstrated by clinical material from a female patient, whose therapy had been locked for a long time into a static, defensive, erotised transference, which served to conceal anxieties of a probably psychotic quality. This pattern was especially prominent after a break in treatment. In the first session after a weekend, she reported this dream:

> She was looking at a vulva, and was obliged to touch it, in order to stimulate it. She felt horrified and disgusted. An older woman was advising her. When she asked the older woman what to do, she replied dismissively 'You should know.'

The patient had no associations to her dream, and awaited my response with an atmosphere of quiet but excited anticipation. It seemed to me that the dream was both represented by itself and enacted in the session, in that I was presented with something that I was required to look at, probably with interest and excitement, and to

touch and stimulate, but if I asked for my patient's help in knowing what to do with it, then I was firmly told 'you should know'. The sense I had of the dream presented divorced from the patient's own thoughts and associations reflected the picture of a disembodied vulva, oddly detached from a human being. When I took up this aspect of the dream as enacted in the transference, the atmosphere of quiet excitement dissipated, and she was then able to link the dream with her lonely masturbation over the weekend, and with how cut off and detached she had felt. The interaction between us then acquired some quality of emotional richness and depth, which had been so singularly lacking up until then. Had I become interested in the content of the dream rather than its representation within the session, then I believe it would have only served to accelerate the patient's excitement and join in with her in an activity which would have felt at best meaningless, and at worse probably intrusive. It would, in fact, have borne the same relationship to genuine psychoanalytic work as masturbation does to intercourse.

This notion of the dream's function within the session is also related to the experience of the dream for the dreamer, and is a dimension of dream work often irgnored or overlooked in clinical practice. Stewart (1973) has described how a 'fixed' experience of dreaming, such as watching a dream as though watching a film, as a passive onlooker, is often an indication of splitting and fragmentation of the ego. As integration occurs, the dreaming experience becomes more fluid, so that dreams can be experienced as important events that the dreamer is involved in and part of, rather than watching in a detached fashion.

It is my experience that interpretation of the content of such 'ego-distancing' dreams, as Stewart describes them, is rarely helpful. The patient mentioned previously who reported the 'vulva dream', would often, in her first year of treatment, tell me a series of dreams in a session which she had 'watched' during the night. These dreams were generally told to me, not as something for us to work with, from which to arrive at understanding, but rather like a small child – myself – being read a series of stories, in which wild, amazing, fantastical events occured. I was meant to be gripped and fascinated in this infantalized way, but also placated and lulled into a false sense of security, that 'psychotherapy' was taking place. It was false because defensive, in that it functioned to keep me at a manageable distance from the patient and in a somewhat infantalized state, as otherwise I was experienced as dangerously persecutory. I was expected to do whatever psychother-

apists do with dreams, but this activity of 'interpretation', when it occured, held little interest for the patient. When I realized this, and tried to talk to her about the similarity between her experience of her dreams as stories she watched or read and the function they served in the transference of keeping me safe and controlled, she felt criticised and rebuked, and reported no dreams for the next year. What this illustrates, I think, is again the concreteness of the dream experience, and the technical difficulty of how to address this with such seriously disturbed patients.

One could say that one basic question exists in our minds when we are presented with a dream, as with any other material in a session: what to interpret? How can this be best used to help the patient towards understanding? The clinical examples described previously suggest the clinical usefulness of attending to the form and function of the dream and to how it is experienced by the patient, and how these factors resonate within the transference relationship. This notion of the dream as enactment is, of course, not new. Heimann (1956) describes the dynamics of this process vividly:

> The communication of an idea, or a memory, or a dream not only forms part of the patient's emotional relation with his analyst; it is also prompted by it. Here, as so often in our work, we encounter a two-way traffic. The patient tells a dream not because it just happened to come into his mind. It came into his mind because to tell it to his analyst is a suitable way of expressing his impulses towards him, which he then acts upon by telling the dream.

This image of 'two-way traffic' helpfully directs our attention not only to how what we do might influence why or how a dream is reported to us at a given moment in a session; it also raises the question of how to make use of our countertransference in working with dreams. This, as always, can be a very sensitive arena for detecting the most important anxiety communicated by the dream. It is often a matter of being attuned to the atmosphere of the dream, rather than its specific elements.

For example, a young borderline woman in twice-weekly psychotherapy, who often functioned in a provocative and argumentative manner in sessions, brought a dream in the second session of the week:

> She was summoned into the office of a young, handsome security guard, who suspected her of stealing something, and who demanded that she empty the contents of her handbag. She felt very anxious, hoping that she had nothing incriminating. She turned out a botle of pills, a bag of used and infected needles, and an insect buzzing in a bottle. The security guard seized on the pills as evidence that she is ill.

She was initially puzzled by the dream, but said that she felt in the dream as she does in sessions – that the dream portrayed how attacked she felt by me, and was evidence of how unhelpful I am. Feeling unsure of what to interpret, and under pressure from the patient to enact the dream, I responded too quickly, and seized on the used, infected needles as evidence of her needling, provocative behaviour which so often infects the sessions, and to which she seemed so addicted. This was not a fresh insight – just as the needles are 'used' – and in fact only served to promote a further argument between us. Had I thought for longer, and had I been more sensitive to the emotional atmosphere of the dream as detected in my countertransference, which was a quality of vague sexual tension about being alone in an office with this young guard, then I might have usefully avoided functioning as the security guard does in the dream – seizing triumphantly on an element from her emptied handbag/dream to use against her. What I did do only increased her feeling of persecutory guilt and the vague sense of unease in the dream was converted into sterile and repetitive argument. Had I also been more attuned to my countertransference feelings of being attacked by the patient when she spoke about her own understanding of her dream, then I might have understood how she was using her dream as evidence against me – to unmask me as an attacking and unhelpful psychotherapist.

Attention to the 'narrative shape' of a dream can also be a useful way of apprehending crucial anxieties that are embedded in the dream but may not be rendered explicit in it's content. For example, with reference to the dream just described, had I listened to the dream narrative, which progresses from the unease at being in close contact with someone who threatens to expose something shameful to a scene of triumphant accusation, then I may have been warned about how to avoid being drawn into exactly this movement within the session – a movement from a fear of shameful exposure to a situation of (mutual) angry accusation and argument.

To conclude: there can be no doubt that the dreams which our patients tell us do offer us a potentially rich opportunity to help to guide them towards insight; the technical problems in doing so, however, as this paper attempts to demonstrate, are very important. In the last act of Shakespeare's 'Cymbeline', the character Posthumous (so called because both parents died when he was born) has a remarkable dream which portrays to him the events of his birth and his parent's death. On waking, of unsure what to make of this strange experience, he says:

> Tis still a dream; or else such stuff as madmen
> Tongue and brain out; either both, or nothing:
> Or senseless speaking, or a speaking such
> As sense cannot untie. Be what it is,
> The action of my life is like it, which
> I'll keep, if but for sympathy.
> (V,iv,146–151)

If we are to work with our patient's dreams in such a way as to offer speaking which can untie sense, then attention to the complex technical difficulties detailed here is crucial. When this can be achieved, then it becomes possible for our patients to think in a serious and meaningful way about their dreams – for they can then appreciate that, as for Posthumous, 'the action of my life is like it'.

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PRIMAL SCENE DREAMS

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Psychoanalysis provides a diversity of conceptual and technical tools to employ in the therapeutic work of uncovering the patient's central conflicts and anxieties, interventive tools which are designed to loosen defences and allow an emotional flow in the transference which can be analyzed and ultimately resolved. There are many patients, however, with whom analytic work in the transference meets consistently with resistance. Among the determinates for this resistance are characterological defences that are too strong and/or split-off traumatic material that is pre-verbal and thus unavailable. It is fortunate when such patients are able to communicate through dreams what is otherwise unconveyable. In this paper, I will briefly review the dream literature as background for a case in which dream communication and interpretation are the principal interactions in the analytic work with a female bisexual patient who could not bring her dilemma more directly into the transference. The clinical presentation will include a series of the patient's vivid dreams which altered over the course of the therapy, eventually making work in the transference possible. The analysis of these, I will maintain, has brought about structural change in the early primal scene trauma.

In 'The Interpretation of Dreams' (1900), Freud extensively examined dream life and put forward his theories about the unconscious significance of dreams as primary process symbols of neuroses. Repressed early memories or forbidden thoughts evade censorship during sleep and appear in dreams, disguised by the dreamwork.

Leon Altman in his book 'The Dream in Psychoanalysis' (1969) points out that with the rise of ego psychology within American psychoanalysis along with its predominant interest in ego functions, and the influence of ego psychology in England as a legacy of the Viennese analysts, dream interpretation had fallen for a period into relative disuse as a primary clinical instrument. The belief that the dream is suspect has been due, in part, to the recognition that it can be used as a defensive manoeuvre to distract the analyst from more important present-day psychopathology and also to the idea that its prima facie significance is that of a gift to analysts who show interest in them, both objections which may indeed be true but do nothing to

vitiate the dream's unconscious significance. Altman re-emphasized the importance of the dream, calling attention to 'dreams from above', having to do with day residue and present-day preoccupations, and, particularly, 'dreams from below' issuing from early life which can vitally illuminate resistance, defences, transference, counter-transference and psychic conflict in general.

In an important re-evaluation of dream interpretation from within the position of modern ego psychology, Blum (1976), at an international symposium, stated that the dream remains the keystone of clinical practice in the uncovering of infantile experience and in aiding reconstruction, the changes in its usage since Freud being toward more transference interpretation of dream material.

From the perspective of the British independent tradition which has developed since Freud along lines that emphasize the experiential aspects of the analytic situation, object relations, the self, the emergent unconscious and play, there have been contributions by Khan (1976) that stress the importance of the dream space and dreaming experience in actualizing the self, and Milner (1976), who sees the dream as an attempt to symbolize life experience. Rycroft (1979), has spoken of the dream as a 'private, reflexive self-to-self communing' that can be used to communicate with the analyst, involving disowned and repressed parts of the self or past experience, and employing defences and symbolic disguises. Rycroft states that 'imagination is a normal, universal function or faculty, that dreaming is its sleeping form, and that, if people have neurotic conflicts these will manifest themselves in their dreams'.

Investigations of the form and function of the dream as a reflection of the structure of the personality have been made by Segal (1986), who also notes that 'the forbidden wish can find fulfillment without disturbing the repressing agencies'. Segal gives importance to dream work in the psychic process of working through, taking the 'good' dreams that appear in the course of analysis as a sign of this process. Meltzer (1984) has reworked dream theory in the light of the ideas of Klein and Bion, maintaining that the dream is 'thinking about emotional experience' and that it displays 'narrative continuity' spread over the months and years of the analytic process. Moreover, it is a 'theatre for the generating of meaning' as well as an attempt to solve a conflict. Earlier, Ella Sharpe (1937) wrote eloquently of the metaphor and symbol of the dream as 'poetic diction' in the language of the unconscious.

The capacity to play with the contents of the mind is characteristic

of dreaming and creative work. Padel (1987) has emphasized that 'dreams from below' constitute real psychic work, the alteration of symbolic meanings in unconscious phantasy. The essential clarifying point has been made by Fairbairn (1943) and Guntrip (1961), who affirm that phantasy and structure are identical as psychic entities. As Guntrip states, 'phantasy is primarily a revelation of endopsychic structure'. If it is granted that dreams are composed of unconscious phantasy triggered by day residue, it can be taken as true that consistent changes in dream symbolism are equivalent to the alteration of unconscious phantasy and thus are indicative of inner structural change.

The patient whose dreams I wish to consider, Mrs R, was 44 when she decided to seek treatment 3½ years ago to help with an acutely distressing situation: she, a married woman for 22 years in a partnership that was stable and companionable, seemingly happy enough although childless, a model marriage in their friends' eyes, had allowed herself to be pursued and seduced by a young Lesbian actress. A large, warm and charming person, the actress, unfortunately, was a trophy-collector of 'straight' women who loved then abandoned them. Mrs R was heart-broken. Never having had an inkling before this intense affair that she might have been homosexual and, moreover, that it could be possible to be so emotionally tortured as when the affair was breaking up and so totally bereft afterward, she wanted therapy to help her to understand what had happened to her and why she had caused so many around her to suffer through her anguish.

In regard to the patient's background, I will give a brief summary. Mrs R was the only child of a fussy, volatile, controlling father who worked as an accountant and a mother who was of fragile health, emotionally very tense and fearful. Her mother had eating difficulties, was often anorexic, and had frequent fainting spells during the patient's adolescence. Because of her mother's fragility, Mrs R could never go out to play during childhood without returning regularly to ascertain that her mother was alright.

Mrs R's birth was marked by her mother's subsequent illness with peritonitis and jaundice which required that she be confined in a convalescent home for three months. Mrs R remained in the hospital nursery where she was looked after by a hospital nurse. Interestingly, years later when Mrs R's wedding announcement appeared in the newspaper, this woman wrote to her out of the blue to congratulate her, mentioning the early connection. When she was finally brought home, her mother was still unwell and most of her early care was

accomplished by her maternal grandmother, who would disappear when father returned home at five every evening. This routine went on until the patient was nearly a year old, forming a picture of maternal disruption and loss.

Entirely relevant to issues in the patient's psychopathology was the fact that the family lived in a small, 3-room suburban flat and Mrs R slept in the parental bedroom until she was 12 years old. There were strict routines and rules for everything in the home, particularly around bedtime. She does not ever remember seeing her parents undressed, nor in any sort of sexual embrace, and she particularly remembers a bedtime fantasy that when she closed her eyes at night it meant she would disappear. Sex was never mentioned, the night-time set-up never discussed, and Mrs R remembers insisting with childhood friends that her parents never engaged in sexual intercourse.

In adolescence, her keen interest in school-work ceased, and she poured her energies into theatrical performance and modern dance, which were practiced obsessively. She went out with boys only because it was the thing one was supposed to do, but stopped seeing them as soon as they wanted her to become romantically or sexually involved. Denying any knowledge of sexuality, she maintained a virginal image in her dress and demeanor, and in one of her sessions became aware that she had always idealized the image of herself as a pure, innocent four-year-old, untouched by corrupting knowledge of the world.

Her first sexual experience was with her husband-to-be, whom she met at college. She determined to take the plunge for the sake of marriage and said that she found it pleasant enough, even exciting, which continued for some years. Her husband is a benign, upright person, successful in a creative field and respected by his peers. Mrs R's work has included professional dancing and acting. She has never wanted children, having always been haunted by the guilty feeling that she had damaged her mother by her birth.

When Mrs R began three-times weekly psychoanalytic psychotherapy, it became apparent that her personality was basically obsessional, characterized by defences of orderliness, tidiness and control that manifest in her style in the session as well as life habits. She is of medium height, attractive and slim, with dark hair trimmed in a boyish style, dresses always in trousers and clever boyish clothes and has large dark eyes. She comes into the consulting room and places herself very precisely on the couch. After an initial silence of a minute or so, she begins to speak in a calm and careful manner. After completing her thought she stops speaking, allows a silence while awaiting her next

thought, and then, gathering and organizing herself, speaks again. The content includes current activities, many memories of her childhood, adolescence and adult life, and detailed portraits of her friends and family, always presented tidied up and without emotion as the good, quiet little girl she was brought up to be, the day-time version of her life which omits the unspeakable night-time spectres. In various ways I have interpreted her defences against affect, her fear of strong emotion, as well as pointing out her compliant false self as a repetition of her compliance with the regime in her parental home. I have also commented on how she protects me from her difficulties and emotions as she protected her fragile mother in childhood and comes to the sessions to make sure I am all right. Transference interpretations produce a surprised response and denial, with the exception of work around holiday separations. She uses me transferentially as a witness to her performance in the sessions, which she avers is a time she uses to relate to and to explore herself, in a manner similar to the way she was made to witness events in the parental bedroom. None of my interventions nor their variations has altered her basic modus operandi in the session. It is only through her vivid dream life that she began to communicate to me her striking inner dilemma. In a sequence of dreams she has revealed a network of anxiety-laden phantasy, expressed symbolically, that derives from the primal scene.

The first such dream occurred about a year after beginning therapy. It was as follows:

> This dream is like a story with a beginning, a middle and an end. In a quiet Victorian house by the sea there is a mother, father and two children. I looked out onto the bay and saw two enormous animals slowly splashing in the water, lifting their feet: one like a rhinocerus, turned away, I couldn't see its head; and the other like a mammoth without a trunk. I was holding the mother in my arms like a Victorian doll, when there was a disturbance on the beach. People were alarmed and gathering around. Swimmers were being pulled out of the sea, sick and dying from something poisonous in the water. The rotting corpses were heaped under the window of the house and they began to bloat and grow larger, a foetid mound. The mother said that it was time to go to bed, and began reading a bedtime story. The story book began with the sentence 'And then there were no more flowers, flowers, flowers', with the word 'flowers' repeated to the bottom of the page. On the next page was 'And then there were no more trees...'; the next, 'And then there were no more animals ...' Then I knew everyone would die of this plague and it would be the end of the world.

The dream has been called by Greenson (1970) 'the freest of the free associations', since it evades internal censorship and control. When Mrs R brought dreams to the sessions they were followed by associ-

ations to its parts and the whole, triggered off by its reportage, so that the whole session was made up of a network of associations with the dream as its focus. Her associations to this dream were to her childhood, her anxious, strait-laced mother, to bed-time stories read to her, to details of the shared bedroom, the arrangement of its furniture and to the appearance of her parents as mounds in their bed as seen from her position in the bedroom. There were also associations to her husband, who would often make up stories to tell her before they went to sleep. I said that the two huge animals represented her parents in bed at night when she was little and that, far from closing her eyes and not looking at them, she had watched them intensely. I made further comments that the dream was about her fear that her parents sexual activities in bed were dangerous and poisonous to her, even catastrophic, that the missing parts of the animals represented her mother's missing penis and her father's penis disappearing into her mother, and that the people dying in the water represented dead babies produced by her parents' intercourse.

In the very next session a dream was reported, apparently linked to my statement in the previous session about looking intensely at her parents in bed. The dream was remarkable for its similarity to the dream of the 'Wolf-Man' recorded by Freud (1972), in which there were several white wolves sitting in a tree looking into the house with large, staring eyes. Freud believed this dream heralded the uncovering of the roots of the Wolf-Man's childhood obsessional neurosis in which the witnessing of parental intercourse at age $1\frac{1}{2}$ was the main aetiological factor. Mrs R's dream was as follows:

> I was walking down the suburban street of my childhood when out of a house came a beautiful black ocelot. It was staring at me with enormous glowing eyes that emanated colour, changing from red to blue to green, both separately and together. I felt frightened until a man came along who was the porter who lived in the basement flat of my home. He said, 'this is the way to tame wild animals', at which he lay on the ground, pulled up his shirt and let the animal smell his sweat. I thought this was very clever. The scene then became one in which a woman held a baby ocelot draped in her arms.

Her associations to this dream were to an occasion in her childhood when her father returned home tipsy from an office party, bringing with him into the bedroom a tiny kitten as a gift for her. Her mother, one of whose phobias was about cats, was horrified and angry, insisting that the kitten be taken out of the flat and given to the porter. Mrs R was terribly upset by this, as she had longed for a kitten. Other occasions when her father had been drinking came to mind, times

when he would become playful and affectionate, causing her mother to become annoyed and rejecting. Based on her associations to her childhood bedroom, I said that the ocelot in the dream symbolized her child self watching fearfully, while pretending to be asleep, her father's attempts to make love to her mother. And I said that the porter represented me, who was revisiting her childhood with her to tame her fears and to help her with the anxiety that had been aroused in her. I further interpreted in the transference that in looking at her early experience together with me, she can now feel safe, held like the baby ocelot in my arms. Her associations to this dream linked with her constant anxiety as a child that she was in her parent's home on sufferance, that she would be thrown out like the kitten if she broke the rules, including the tacit one that she 'disappear' at night.

Rycroft (1979) suggests that dreams be studied in sequence, with earlier dreams remembered by both patient and analyst and providing the context within which later dreams are interpreted, thus developing a familiarity with the patient's imagination, dream language and symbolism. Modifications in the patient's unconscious can then be monitored over time. Five weeks after the ocelot dream Mrs R reported a dream with primal scene content which was less disguised, as follows:

> I went outside and saw a parade of floats going by. On the first was a Queen who was holding a briar wand in order to fend off the King, who was, something in Greek with a name like 'orgiastic paedophile', I wasn't sure about the words but I knew that it meant orgies with children. There was a voice-over, which was announcing the parade. The Queen got off the float and began to dance but not very well, and I thought that I could do it better than she could. The voice-over then said, 'On the next float is the King and he has gone over the top', and I saw that it had nude children on it. And then I woke up.

In this dream, she associated the voice-over with me and the Queen's dance with her desire to be a dancer but never feeling that she could dance well enough. I interpreted the King and Queen in terms of the bedroom scene, saying that she had felt implicated in her parents' sexual activities, afraid that her father would make sexual advances toward her and at the same time wishing that he would, feeling that she would be able to do it better than her mother.

Although Freud warns in *The Interpretation of Dreams* that associations to dreams cannot be altogether dispensed with, he says '... with the help of a knowledge of dream-symbolism it is possible to understand the meaning of separate elements of the content of a dream or separate pieces of a dream or in some cases even whole dreams, without having to ask the dreamer for his associations'. Mrs R's dream langu-

age had begun to form regularities providing a dream short-hand which could be immediately apprehended on some occasions without associations, as Freud indicated. Violent men would invade her road, break into her flat, threaten her with dangerous electrical material, point guns at her, and men would lose control, vomit and make a mess, expressing her unconscious equation of masculine sexuality with violence and disgusting loss of self-control, phantasies that originated in the parental bedroom. Mrs R has accepted all the primal scene dream interpretations with a mild sense of wonder and agreement.

Desire for and fear of heterosexuality was further illustrated in a dream five weeks later of a college tutor, a teacher of 'Creative Expression', who was having sex with a fellow student and Mrs R felt jealous. However, when he began to try to seduce her she kicked him in the stomach and hurt him. He kissed her and his head turned into a skull with a light inside and she knew that he was the devil. She awoke with severe menstrual pains, which was unusual for her. In the session the associations led to feminity and her feelings about being a woman which meant being the victim of men.

Four nights later Mrs R dreamed of a wonderful necklace given to her in the dream by her grandmother, whom she associated with me. It was made of tiny carved and painted ivory animals on a braided gold chain, which she associated with the therapy sessions. She put it on with another necklace that her husband had given her, made of rough rafia, which she associated with male sexuality. The two became tangled together, causing her distress. The dream changed to a scene in which she was having her long hair chopped off and she was left with thin red hair like a friend of hers who was in analytic therapy and who had broken down. This I interpreted as her fear that therapeutic change would mean break-down because of the involvement of her therapy with male sexuality, with the increasing awareness of herself as a woman, and with her night-time fears as a child. The fear of breaking down has recurred from time to time and seems to indicate the intensity of her early anxiety and the shifts that were taking place in her defences against it.

The evolution that dreams undergo as a result of analytic therapy show that they are far from being random productions, but rather display the 'narrative continuity' observed by Meltzer (1984). A variety of themes repeat and interweave in the ongoing dialogue with the unconscious. One was the theme of theft, which appeared three months later with a dream about a punk couple who were robbing neighbors in her childhood home. Mrs R confronted them, saying, 'Don't try it,

people are watching'. In this dream, the theme of watching links with the ocelot dream, her stolen looks at the parents, and her unconscious awareness of her role as a sentinal in the bedroom to protect her mother from her father's sexual advances. There is the implication that sexual intercourse = robbery: the phantasy that her mother was robbed by her father of vitality, rendered ill and unable to give physically or emotionally to her daughter.

Blum (1976) has pointed out that, as analysis advances, the underlying conflict in a series of dreams may appear with increasingly less disguise in the manifest content. Nearly two months later my patient had an overtly erotic dream about her parents:

> I was with my parents and my father was making my mother put on a black corset with needles that stuck inwards. My mother had her clothes on. Then I realized that my father was beginning to press up against me, starting with his pelvis. I had my eyes closed and felt like a column of darkness. I decided to go along with it, relaxed completely and experienced a wave of sexual pleasure. Then I stopped and felt very guilty, as if I had done something terrible and nothing would ever be the same.

The sado-masochistic excitement present in this dream upset her, along with its day residue, which was to do with a play she had seen the night before about a man who had sexually and violently abused his wife. I said that she had become sexually aroused as a child by what she believed to be sexual sadism between her parents together with erotic feelings about her father, and that she felt very guilty about this.

Not only was the dream content altering in the direction of more direct sexual material, but dreams around the beginning of the third year of therapy began to alter in another way in that I began to appear in them undisguised. This was due, I believe, to changes in unconscious phantasy resulting from the previous interpretive work, indicating that the trauma of the primal scene was becoming clarified and was beginning to be worked through and replaced by the oedipal transference as I have begun to play a role in the internal drama. In my first undisguised appearance in her dreams, four days after the erotic dream about her father, she came to visit me but encountered an unfriendly husband who set up a dangerous obstacle. I interpreted this dream in a straightforward way as anxiety about being close to me as my partner might not like it and would threaten her.

Several weeks later there was what she called a 'paranoid' dream about me: we were together in her childhood bedroom, both in pyjamas and going to bed. I asked her for a special drink which she didn't have

and I became annoyed, threatening to leave if she didn't go out to obtain it. She felt very anxious about this. I pointed out that in her mind I had taken her parents' place in the bedroom, moreover she felt unless she complied with what I wanted, nourished me, I would reject her and break off our relationship. In the transference, I had become her needy, demanding mother and the demand to be nourished also indicated her own wish to suck the breast.

A third dream in which I appear undisguised occurred four months later. She came to a session where I met her, saying goodbye to my husband, and led her to an incredibly messy bedroom, asking her to lie down on my husband's side of the bed, which she didn't want to do. She sat at the end of the bed feeling inexpressible sadness and I rubbed her chest in a gentle, soothing non-erotic way, which she wanted me to go on doing forever. I interpreted that the mess symbolized early primal scene emotions, that she sees me as a soothing mother and that she both wants and fears a seduction by me. In these dreams transference and its interpretation appear to take place at the dream level.

Recent dreams show not only an overall reduction of anxiety in her dream life, but changes in symbolism that indicate that release from repression, integration and working through are taking place. Toward the end of the third year of therapy, she reported a dream in which the night-time scene of her childhood appeared undistorted. The dream, almost like a memory, was of waking up in her childhood bedroom and hearing her parents in bed arguing. This dream indicates, to me, that the primal parental figures have become less saturated with terrifying phantasy and much more realistic as a result of interpretive work.

A pleasant dream of the seaside occurred at the beginning of the fourth year, which contrasts markedly in its benignity with the first seaside dream reported in this paper. She was watching two men and a woman playing in the shallow water. The men were swinging the woman up into the air and letting her go, enabling her to fly. She would soar above the water, occasionally splashing into it and pushing off again. Mrs R was watching this scene with breathless fascination, urging the woman on. I pointed out that flying can be a metaphor for the feelings evoked by sexual intercourse and that her dream is telling us that what men and women do together sexually now seems much less frightening.

Although on balance her dreams are less frightening, a recent one shows a continuation of the working through of the sado-masochistic

theme: a flirtatious girl waitress is seduced by an older man, after which she sticks a knife into his eye. This scene is observed by a prim, Victorian older sister figure. By putting herself into the role of observer, she distances herself from unacceptable parts of herself, in this case the flirtatious, sadistic adolescent girl that she repressed and defended against when a teen-ager.

Discussion

The view that a primitive internal world begins at birth and contains instinctual drives, anxieties and defences in relation to primal objects was first put forward by Melanie Klein (1932). As the human organism matures, the primitive phantasy system is modified by experience, by contact with the external environment, and undergoes various phases of psychic reorganization and development. Mrs R's early internal world, conditioned by passions and frustrations in regard to maternal loss entangled with tumultuous phantasies of parental coupling, had become split off and repressed, rendered unavailable to later development. The primal scene was so imbued with violence and sado-masochistic excitement springing from her own phantasy attacks on the parental couple who excluded her, that the resultant images of a damaged, victimized mother and degraded, violent father prevented her from having children of her own. The early phantasies began to take symbolic form in the patient's dream material, giving access to unconscious anxiety that was not present or available in the session material due to strong pre-conscious obsessional controls.

With the presentation of this series of dreams I have shown the way in which Mrs R's dreams evolved over the course of analytic therapy, appearing disguised at first as 'the return of the repressed trauma', then changing as they emerged from repression into overt pre-oedipal and oedipal content. Dream analysis has allowed working through and integration into the personality to take place, both at a conscious and unconscious level and in the transference, bringing about structural change.

Without attempting here a complete discussion of the patient's sexual development, there are three points about her bisexuality that I shall mention.

Firstly: Unresolved longings for maternal love: the irruption of homosexual libido in the patient's passionate affair appeared to be a rediscovery of and reunion with early idealized maternal objects, the lost

nurse and grandmother of infancy who had provided the warm, safe physical intimacy denied to her by her anxious mother. The emphasis on early mother–daughter relations in female homosexuality is in agreement with the views of Deutch (1932); additionally, Chasseguet-Smirgel (1978) writes about the idealization of pre-genital sexuality in the perversions.

Secondly: Early oedipal phantasies, split off and repressed, were laden with excessive anxiety and guilt, but there was not a complete flight from the oedipal father, nor the identification with the father and the appropriation of the phallus, that characterizes true homosexual female development, i.e., the primal scene exposure in this patient excited fantasies to be in the mother's place as well as the father's, a passionate desire to have the penis as well as the breast.

Thirdly: The sadistic components in homosexuality have been widely recognized by writers such as Chasseguet-Smirgel (1978), MacDougall (1972) and Glasser (1979). This patient's affair, masochistically suffered, was also a sadistic attack on her husband, family and friends, who were all made to suffer through her anguish, representing an outbreak of the sado-masochistic excitement of the primal scene phantasies.

Through making use of the device of dream communication, Mrs R has been able to communicate ego-dystonic phantasies for which she can feel less responsible, bypassing the conscious part of the personality. The present direction of the work is toward owning the phantasies, assessing their contribution to the lesbian seduction and understanding how they tend to operate still in her present life.

There are three consequences of the patient's repression of primal scene phantasies that have hampered her development which should be mentioned. The first is the effect on her creativity of not being able to make a mess, to go into a creative regression in which reorganization takes place and something new emerges. Mess or confusion was associated with the primal scene and activated her obsessional defences. The second is linked with the first: the patient's defences against sexuality and aggression, first erected in the parental bedroom, prevented her passions from flowing into her work as a performer, enfusing and enlivening her performance. Excessive control prevented her from reaching the higher level of artistic achievement that she wanted. The third is the inhibition of curiosity that affected her intellectual development, preventing her from looking freely and curiously at the world and learning for herself. Although the therapy is not completed, she has taken on new intellectual interests, there is evidence that she has

become less anxious in many areas of her life, can better tolerate strong feelings in herself in the sessions, and is finding excitement in new understanding and insight, a new view of the world through her own eyes.

Summary

A brief review of the literature on dream interpretation is offered, with an emphasis on the importance of the dream as a valuable tool for the illumination of early experience, particularly with a patient who is unable to convey early trauma in any other way. It is argued that split off unconscious phantasy can be symbolized in dream material, that it can be affected through interpretative intervention, and that changes in dream content over time is indicative of inner structural change. A clinical account of the effects of exposure to the primal scene is presented through a series of dreams from the treatment of a bisexual woman with an obsessional personality who slept in the parental bedroom until the age of 12. The evolution of the dream material is shown, moving from a phase of initial disguise into one of overt primal scene content, then into one in which dreams indicate modification and working through of early traumata. A discussion of the implications of exposure to the primal scene in regard to the patient's bisexuality and overall development is included.

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OBITUARY

Masud Khan 1924–1989

The controversial psychoanalyst and analytic writer, Masud Khan died on 7th June in London at the age of 64. His life had aroused a lot of comment and criticism particularly amongst his English colleagues. He had a more wholehearted following in both France and America.

Born in 1924 into a devout Muslim family in the Punjab, he grew up on his father's vast feudal estates. He was born in his father's old age: the middle child of his father's third marriage at 76. His mother was then 17. Khan grew up in an isolated, privileged world; a world of polarities as to his parents' ages, education and demarcated sexual roles; a world where he was taught by a governess with an Oxford degree and where his leisure time was spent with horses and playing polo. He came to England in 1945 as a young man with impressive looks and stature.

In England, Khan was due to start at Balliol, Oxford having already obtained his MA in Lahore, but was accepted for training at the Institute of Psycho-Analysis. He was one of the youngest analysts ever to qualify and was in his twenties. His analysts had been Ella Sharpe, John Rickman and after they had both died, Donald Winnicott. Khan was supervised by both Anna Freud and Melanie Klein.

Khan was a maverick in the analytic world. An omnivorous reader with an impressive library, he had a distinctive style and literary flair. He evolved his own terminology in which 'incapacity', 'resourcelessness' and 'psychic pain' had more validity than 'neurosis' or 'psychosis'. He had an aristocratic hauteur and displayed a contemptuous disregard for many of his colleagues but sponsored several new analysts in his successful term as editor of the *International Psycho-Analytical Library* and also in his role as associate editor of both the *International Journal of Psycho-Analysis* and the *International Review of Psycho-Analysis*. He was particularly active in editing Winnicott's work and was instrumental in publishing it and making him available to a wider public.

Khan published papers extensively in the States, France and England. He had four books published: *The Privacy of the Self* (1974), *Alienation in Perversions* (1979), *Hidden Selves* (1983) and finally and unhappily his controversial book *When Spring Comes* (1988). He, more than any other clinical writer since Freud, poignantly managed to

convey the very texture and quality of what a true analytic encounter could achieve; the relief of being understood, of feeling knowable and experiencing one's 'true self' within the 'holding' potential of Freud's therapeutic framework and setting.

Khan was larger than life. Everything about him was theatrical and fascinating and his second marriage was to the prima ballerina Svetlana Beriozova. His life in his last thirteen years was no less dramatic. Since the mid 1970s he had been dogged by cancer and severe ill health which had gradually forced him to give up his thriving private practice and concentrate on writing.

Khan had numerous operations, on his eyes and for the removal of various cancers. He never complained and never feared death but increasingly he confined himself to his large London flat, recognising how dislocated he felt in the three-person world. I think it was this limitation which held the key to his sensitivity and success as a psychoanalytic clinician. For him there was no pretence of being a 'blank screen' analyst. Although he claimed that he modelled himself on Freud and Winnicott, in actuality he used *himself*, more than any other analyst, as the main therapeutic agent.

I think it would be true to say that Khan's whole style of being, both private and professional, was based on his father. No one could ever deny that he was both brilliant and learned but he remained in essence, from first to last, an Eastern potentate, capable of both nurturing care and sadistic punishment. I am sure that this was the very same style of feudal rule that Khan's father exerted on his family and retainers.

JUDY COOPER

BOOK REVIEWS

The Plural Psyche

By Andrew Samuels. Routledge, London. 1989. pp. 253. Pb.

The Plural Psyche is as much a philosophical book as psychological. It is intelligent, penetrating and thought provoking, but not particularly easy to review. It was born out of papers which appeared in various journals since 1981 and this may be a reason why in some ways it comes across as being slightly contrived – a collection of papers linked together into a book. I do respect Samuels the pioneer, but I wonder if he is frustrated at there being so little unexplored territory left in depth psychology and needs to find new frontiers. He says that 'there was a golden age that is now past' – the age of the two original pioneers and their followers. Those revolutionary thinkers had to be single-minded in order to carve their way. Their followers had to be loyally unbending in order to consolidate their position. The next generation could be more flexible in evolution and could cross-fertilise. Samuels suggests that *our* generation can now be reflexive, can explore inwards rather than push outwards. The vehicle for this is pluralism, which he defines as: 'an attitude to conflict that tries to reconcile differences without imposing a false resolution on them or losing sight of the unique value of each position.... it seeks to hold unity and diversity in balance'. It is a tall order.

Through the book it is possible to perceive two threads – the arguments for a pluralistic approach to depth psychology and examples of how this might work in practice. Many of the chapters dealing with practice were extremely interesting – they made me look at familiar subjects from a different angle – but I was not persuaded that here were especially new approaches. Perhaps Samuels is not expecting revolutions in practice; perhaps I already personally have more pluralistic leanings than I was aware.

The four chapters contained by the theme of Father led to interesting discussions of gender, the feminine principle, aggression and borderline. Samuels makes a good case for more consideration of the father's importance and role in a child's development. Father can help the eros principle develop in his children, particularly the daughter; he can facilitate the positive transformation of aggression, particularly in his son. Incestuous feelings are psychic fact; there can be much that is

positive in them, in different ways, for both girl child and boy. He introduces the interesting idea of 'unconscious gender certainty' and demonstrates its undesirability. His argument follows satisfyingly and convincingly through attitudes to and of masculine and feminine, to the roots of aggression and to borderline states. He elegantly uses gender as a metaphor for 'otherness' and, in advocating the concept of gender uncertainty, he leads the reader to consider states of 'not-knowing' – and holding the tension therein. This is so relevant when we encounter bleak, unfathomable places in a patient's process, but Samuels also takes us further, to the way we view 'otherness' – in schools, trainings and theories. Too much certainty brings notions of orthodoxy and heresy, which in their defensiveness restrict evolution.

The primal scene chapter develops the theme of 'otherness' into discussion of conjunctions, opposites and what is undifferentiated – always asking which is metaphor and what is literal. He had earlier presented the idea of plural interpretations. The single-strand, incisive interpretation is not the only way, he suggests, and he asks that the more tolerant, many-layered interpretation be given fair consideration. This I saw as pluralism in practice, but I found the arguments unconvincing – it would be too easy to label a wooly intervention complacently as a plural interpretation, (a danger Samuels acknowledges).

He draws on modern philosophy to introduce, in the *mundus imaginalis*, additional understanding of countertransference. I was quite comfortable with the idea of 'a space in-between', where the psychic reality of countertransference, and indeed projective identification, might be said to occur. More pragmatic readers may find it unpalatable, but I commend them, in pluralistic spirit, to read and give it thought. The author introduces the idea of 'reflective and embodied countertransference' – but do we need more differentiations? I found the definitions tenuous – but applying them in one's practice is a better test and usage will be a matter of personal taste.

On the subject of our depressed culture, I found Samuels the philosopher less persuasive. He presents 'depression as a philosophy of our day, dedicated to the condemnation and suppression of aggression'. The fear of nuclear war in the collective psyche is less relevant now than when his manuscript presumably went to press, such rapid changes having occurred in Eastern Europe. But his argument does seem to lean quite heavily on this as he discusses aspects of morality and he ignores the perhaps more important, but very different, global threat of religious fanaticism. Certainly patients have difficulties in being in touch with aggressive feelings and fantasy, but healthy

depression as an acceptance of life's conflicts in the reality of a difficult world is not really acknowledged. There is a 'coda', a sort of afterthought, at the end of the chapter which does touch on the positive aspects of depression.

The chapter on alchemy reached and spoke to me in a completely different way. Up to that point I felt I had been reading Samuels the earnest persuader, the prosleytiser. This chapter seems to have a more peaceful style, a certain mellow thoughtfulness – offered rather than thrust. Admittedly I am particularly drawn to alchemy, but even allowing for this I felt his use of the subject to argue the importance of eros and agape in the consulting room entirely convincing (although I would have liked at that point a containing mention of boundaries). The chapter is a commendably clear commentary on alchemy and particularly on Jung's paper: 'The Psychology of the Transference'. Anyone who finds the subject unapproachable – or even dismisses it – is urged to reconsider. For it is a rich metaphor.

The Plural Psyche is a demanding book. Samuels says that it 'largely depends on a dialogue with the reader' and there is 'a good deal of argumentativeness'. It provoked strong reactions in me; it challenged assumptions, sometimes uncomfortably, and therefore made me think. I am sure that this is what the author intended. At many points I found myself asking: Why should I be reading this? Why did he need to write it? How is it going to help me in my daily work in the consulting room?

This last question addresses the second of my two perceived threads. The author once said to me: 'Alchemy is a fascinating subject of course, but it's of no use when you have a "disturbed person" [my version of his words] sitting in front of you.' (Samuels c.1979; personal communication). I recalled this comment as I wondered if one could say the same about pluralism.

I also have mixed feelings about the pluralistic approach in the breadth of depth psychology. I would dearly love followers of the different schools to be able to talk intelligently together, with both passion and tolerance. We would be in danger of stagnating if we did not attempt to push our frontiers – and The Plural Psyche pushes. But such pluralistic debate demands a lot in the practical world. Most psychotherapists work to the best of their abilities within their known orientation, enhancing skills over time. Absorbing different methods is a major task. It is not surprising that we huddle together in our orthodoxies. Outsiders become heretics and trainings can turn a blind eye to regression in students and allow stagnant obedience cults to

develop. Pluralistic debate will challenge this process. Samuels is more at home than most in the active debate, verbally as well as written, but it behoves all psychotherapists at the very least to think pluralistically.

At various points in the book Samuels introduces the thought that diversity need not be a basis for schism. What I feel he ignores is the desirability, even necessity, in certain circumstances for separateness. His pluralist philosophy can seem unrealistically idealistic. He wishes it were possible to combine Fordham's technique with Hillman's vision, but perhaps we must accept that depth psychology inevitably contains its oils and its waters. He distinguishes pluralism from eclecticism – the latter ignores the contradictions between systems of thought, the former celebrates them. Eclecticism blandly satisfies everyone, pluralism stimulates with piquancy. Perhaps the problem comes when too many strong flavours are combined and the dish becomes impossibly unpalatable.

A specific desire of the author is for more discussion and cross-fertilisation between Jungian analytical psychology and psycho-analysis. In the chapter on alchemy he states that he wants 'to present Jung as more in the mainstream of analytical thinking than is usually considered to be the case'. Jungians probably know more about psycho-analysis than psycho-analysts (in public at any rate) know about analytical psychology; this assymetry is a pity. Pluralistic debate would create a more even balance, but I suspect that many psycho-analysts react smugly to Jungians' interest, whilst remaining to be convinced that they themselves should consider absorbing some Jungian thought. Those of them with some latent pluralism might reconsider.

I had to work at this book in order to review; it was a good experience. I might have been lazier had I been reading it just for me. I found it irritating at times, I disagreed strongly in places and then found myself moving back from that extreme position; I chuckled, I felt warm, I was exasperated; I thought first one thing and then another. Sometimes I nodded sympathetically and at others I shook my head abrasively..... I suspect it is exactly what the author wanted.

MARTIN FREEMAN

Psychic Equilibrium and Psychic Change. Selected Papers by Betty Joseph

Edited by Elizabeth Bott Spillius and Michael Feldman.
New Library of Psychoanalysis, 1989. pp. 230. £14-95p.

Each of the papers in this book is by itself very substantial but the collection is made manageable by the Editors' division of it into four different parts and by their very helpful introductions to each part. The parts are arranged in chronological order to show the development of Betty Joseph's thinking. They are also organised around four major themes in Joseph's work and although, as the editors state, they are so closely related that it is difficult to describe them separately, attention to these themes may provide the best way of conveying an idea of what the book offers. The themes are: 1) The patient's need to maintain psychic equilibrium. 2) Psychic change. 3) The patient acting out in the transference and trying unconsciously to get the analyst to do so too. 4) Avoidance of 'knowledge about' in favour of 'experiencing in'.

The first theme is about the patient's need to maintain his psychic equilibrium. Joseph believes that all our patients have a system of defences employed to maintain a familiar status quo and that any threat to change the equilibrium thus established will be met with resistance. Piecemeal interpretations which might shift one part of the defensive structure are intolerable because other parts may shift as well. The analyst must therefore reveal the whole defensive system as discovered through the transference. Throughout the book the author stresses the importance of deciding whether the patient is operating at a depressive level or from a paranoid schizoid position (terms which she defines). This point is illustrated by an example of a patient at the paranoid schizoid level who tells her about his nastiness to his wife. If the guilt had been addressed as though the patient had reached the depressive position, it would have played into the patient's masochism as criticism from the analyst who would thus have been acting out in the transference to maintain the patient's defences.

Patients do, of course, move to and fro between these two levels. The need to maintain psychic equilibrium exists for patients on the depressive level but it is more urgent for those in the paranoid schizoid position where the patients may be defending against psychosis. Patients with a compulsion to repeat are described by the author as sticking to a half dead state in an endless attempt to keep a balance between love, which gives rise to envy and greed and the destructiveness

in turn arising from these. When the envy is confronted in the transference, progress may be made, but at this point the patient may get so anxious that he leaves; hence the avoidance of a close relationship is repeated and the equilibrium maintained. The psychopathic personality has a different structure of defences and Joseph shows by example how the analyst's attempts to upset this structure can lead to fear of psychotic breakdown.

In many of Joseph's examples the psychic equilibrium maintained by schizoid defences is necessitated by the patient's fear of his own envy and there is an interesting chapter devoted to this subject. The author defines envy as opposed to jealousy or greed and finds its origins in the unavailability of enough warmth and gratitude to counteract what she regards as an ubiquitous feeling with which we all have to deal. I think it would be helpful to readers to hear more about the difficulties (and perhaps ways of surmounting them) of holding on to patients confronted by the intolerable pain arising from fear and recognition of their envy.

The second theme is psychic change. Betty Joseph writes in her paper on this subject 'I do not think that long term psychic change is ever an achieved absolute state but rather a better and more healthy balance of forces within the personality always to some extent in a state of flux and movement and conflict.' We all have ideas about desirable long term change which Joseph broadly describes in terms of the patient taking responsibility for his own impulses and being able to face the separateness and reality of objects. She sees the analyst's job, however, as helping patients to observe, tolerate and understand their own habitual ways of dealing with anxiety and relationships; the analyst must follow moment to moment changes without being concerned about whether they are positive; she is, in other words, a facilitator and not a judge.

Fundamental to achieving change is the need to find the part of the ego which can stand outside and help to investigate what is going on inside the patient and to take responsibility for it. Joseph is here talking about a therapeutic alliance but she has no illusions about the reliability of the ally. The patient at first may be no ally at all being against, rather than for, understanding, wanting at all costs to maintain his psychic balance and doing all he can to distort the work of the analyst to this end.

Psychic change brings psychic pain and Joseph describes a particular sort of pain which occurs when patients begin to enter the depressive position. It is acute and indefinable. Sometimes it is this pain which leads people into analysis, sometimes it occurs during the analytic

experience. It is felt in a concrete way as a physical pulling or forcing out and initially may bring feelings of profound loss. Joseph's debt to Bion is acknowledged here, as in other parts of her writing and she describes the enrichment following the pain of this sort of separation in terms of his observation that a patient who can suffer pain can also now suffer pleasure. She also quotes Bion's view of this kind of pain as a growing pain which is often accompanied by confusion resulting from the normal stages of development never having been worked out.

I found the chapters about patients acting out in the transference and trying to get the analyst to do so too, the most helpful part of this book. Betty Joseph is not only sympathetic to her patients but she also stands by the therapist who is made to feel insensitive and blundering; whose interpretations of the symbolic content of the material fall flat or who finds herself collaborating in the conduct of a therapy in a way which has nothing to do with her own ideas of what analysis is about. She tells us how important it is to tolerate the patient's projections and that often some of the most acute anxieties emerge attached to doubts and criticisms. When she is bored, Joseph says, she assumes she is talking about material and not addressing the patient: analysis, she reiterates, is an experience and not an explanation. In her paper on 'The Patient who is Difficult to Reach', Joseph describes the patient whose ego is split between the needy parts and the observing parts. Here the analyst may find herself talking about rather than to, the real patient. The patient is acting and especially in speech; co-operation is too easy. The patient aims at getting understanding, sometimes bringing specific problems, rather than at being understood. Often, says Joseph, it is the way these patients speak which is important, rather than what they say. There may be constant attempts to misunderstand interpretations, to take words out of context and to disturb and arouse the analyst.

Although Joseph does not advocate that interpretations should focus exclusively on the transference, she emphasises throughout her papers that it is only through the experience in the transference that any real change can take place and often the therapist's counter-transference is the sole means of getting in touch with infantile worlds. It is through the transference that we can see the kinds of defences being used and the level of psychic organisation operating. Using the transference in this way determines the nature of the analyst's interpretations. It is only the patient in the depressive position who hears interpretations as we mean them; others will hear or use them differently. For instance they may hear them as criticism or having heard them correctly, use

them as some kind of attack. Links with the past are considered by the writer as very important to help to build the patient's sense of continuity and individuality, to achieve detachment and to help to free him from a distorted sense of the past; the past, however, can only be viewed in the light of the transference which informs us about the infant's phantasies and ways of operating.

All Betty Joseph's papers are illustrated by clinical examples which make the reader pay the close attention to the analytic process that the writer advocates. Some of them are complicated and difficult to understand on first reading but once fathomed out, they are very illuminating. Most of these illustrations help to clarify, in one way or another, the use of projective identification which is a concept Joseph clearly explains and which is central to this book. The most advanced of patients, says Joseph, never give this up entirely and it becomes the basis for empathy. At the opposite end of the scale, however, it is the patient's attempt to get back into the object and to avoid all separateness and pain; as in the case of her patient with a rubber fetish. This sexualised entering into the analyst, which Joseph believes is only partly understood, is very different from the identification which a healthier patient might make.

The theme about avoiding 'knowledge about' in favour of 'experiencing in', has much to do with projective identification. Joseph gives an example of how members of a supervision seminar struggled to make sense of the patient's material but then realised they were acting out (as the analyst had done) the patient's defensive attempts to make sense of her mother who could not make sense of her. It was necessary to bear the misunderstanding of the material in order to gain this awareness.

This book has helped me towards a better understanding of some of my most difficult patients and I think anyone who reads it will find it useful not only as an explanation but also as a lasting experience.

ANNE TYNDALE

Between Feminism and Psychoanalysis

Edited by Teresa Brennan, pub. Routledge, 1989

This book is based on a series of seminars, organised by the book's editor Teresa Brennan, and given in King's College, Cambridge during

1987. It is a highly intelligent collection of articles which address questions of the utmost importance not only to feminism, but also to psychoanalysis and its institutions. It intervenes in a debate initiated by Freud about differences between the sexes when he published 'The Dissolution of the Oedipus Complex' in 1924. Since then we have been arguing intermittently, with much passion, about whether or not the differences are innate. In 1973 Juliet Mitchell's book, 'Psychoanalysis and Feminism' was published, marking, with hindsight, an important moment in these discussions. Not only did it herald a 'return to Freud' in this country, but it also contributed to a wider feminist movement that paved the way for a return to psychoanalysis. In the mid to late 60's psychoanalysis was at a low ebb; the Institute of Psychoanalysis even having difficulty in finding patients for the low-cost clinic it runs on behalf of its training programme. Psychoanalysis had come under heavy criticism from feminists in the early years of the Women's Movement and its increased popularity has co-incided with feminism's increasing expertise in this area. This book both in its title and its pages pays its respects and debt to Mitchell's book while moving the discussions forward.

The book takes as its starting point the writings of Jacques Lacan. What is common to all the writers is that whether or not they are in agreement with Lacan's works, they take it to be of the utmost importance to engage with them. Lacan's theories give an account of how the unconscious subject is constructed through its engagements not only with others, but also with what he considers to be the very fabric of society-language. He takes as a theoretical problem Freud's discovery of the 'talking cure', and studies the effects of language upon the human subject.

Teresa Brennan is to be congratulated for bringing together such an interesting collection of papers. Her introduction situates the book very clearly and provides a helpful guide to its contents. Had there been a paper that addressed itself to the writings of Melanie Klein, I think the book would have been even better. It is a small grouse but an important one in that Klein's work is the dominant influence in British psychoanalysis today.

The first section of the book entitled 'The story so far' contain two articles. The first is an article by Jane Gallop, in which she highlights a conflict in Juliet Mitchell's work between her use of psychoanalytic and Marxist theories. Gallop uses this conflict to raise questions about the status of scientific enquiry in relation to psychoanalysis and feminism. The second by Rachel Bowlby explores historical coincidences

between psychoanalysis and feminism. Through an exemplary examination of Freud's theory of feminity and its reworking by Lacan she explores some of the conflicts that feminism confronts today. Her questions are pertinent to psychoanalysis for they relate to the questions of aims and ends which any analysis must confront, and which any theory of psychoanalysis must also confront. These themes explicit in these two articles run implicitly through many of the other papers in the book.

In Part 2 'The story framed by an institutional context' Lisa Jardine and Alice Jardine in two different articles discuss questions of politics and tactics for feminism within an institutional setting. It is a nice coincidence of names, for these writers are apparently unrelated and live in different countries. Lisa Jardine discusses problems confronting women academics whose work is used only in so far as it can be assimilated by the prevailing patriarchal, symbolic structures. She tackles this through a commentary and critique of Lacan's paper 'God and the Jouissance of The (crossed) Woman'. This involves thinking about tactics and the ethics of tactics for change. She links this with the transmission of psychoanalysis on the couch, which has implications for technique in the practice of psychoanalysis and raises questions about the ethics of psychoanalysis and what a feminist's ethics would look like. Alice Jardine, in an article, which also has bearings on the transmission of knowledge, discusses the relation of past to present through an examination of feminist generational differences. That is to say, the question of what is taken up and how, both within institutions and in the relation between the analyst and analysand; this must also involve the analysand's relation to her own history.

From prevailing symbolic structures exemplified in institutions such as the university and psychoanalytic organisations, the third and fourth sections of the book discuss the possibilities of 'towards another symbolic'. Rosi Bradiotti also is concerned with what is involved in the transmission of knowledge from one generation to another: for her, changes in understanding are prompted by the historically differing problems that different generations find confronting them.

For herself, and her generation ('those women of 35 and under') she thinks it is 'the achievement of equality and the assertion of difference'. She argues that the support of essentialist arguments made by some feminists in relation to the difference between the sexes is a necessary tactic for change, and that these arguments represent an attempt to grasp something of the truth which needs closer examination. She makes the important point that it is insufficient to reject an argument

on the grounds of ideology. It is necessary to engage with difference, grasp the disagreements and analyse the theoretical assumptions behind them. She joins Luce Irigary in searching for an alternative, female symbolic. Margaret Whitford takes Luce Irigary's project as the theme of her article and gives us a re-reading of Irigary, which I highly recommend. For Irigary, patriarchy is exemplified in Western metaphysics, which Whitford tells us Irigary wants to dismantle. She hopes to do this from within western metaphysics, by analysing the points at which the patriarchal symbolic traps women in imaginary positions which deny them the status of existence, other than in relation to men. The mother–daughter relationship is unsymbolised by the patriarchal symbolic and urgently requires symbolic representation if women are not to remain trapped by patriarchal representations of them. Irigary doubts that this can be achieved without the forging of a new female symbolic 'to represent the other against the omnipresent effects of the male imaginary'. For myself I prefer Whitford's article to the one that follows by Irigary, and which but for her article would have bemused me as to why it was there. Irigary argues that the agents of change can be found in the gestures outside of speech; that these need analysing within the cultural context of the individual and also of its sex. As things stand men and women are trapped both by their fear of difference and by their denial of feminine representations. Irigary is the only practising analyst amongst the contributors. The book would have benefited, I think, from just one or two more clinicians offering some perspectives other than Irigary's, and particularly by a Lacanian one. Irigary is taking up the plea that Lacan –somewhat hysterically – makes to women in 'God and the Jouissance of the (crossed) Woman': 'to tell us (men) something of feminine jouissance'.

The three articles in the fourth section carry on the search for a female symbolic through discussing the place of psychoanalysis and feminism in literary criticism. I think this section is probably of least interest theoretically, although some may find the literary examples of interest.

The last two sections are entitled 'sexual difference'. Where Jane Gallop was concerned about the scientific status of feminism Toril Moi investigates feminist critiques of science. This broaches the question of what does and what does not constitute a science and by what criteria. She approaches this through a critique of Nancy Chodorow (who is also discussed by Margaret Whitford) and some American writers who have been much influenced by her. Chodorow has been very influential in certain sections of the feminist movement in this country who draw

heavily on non-Kleinian object relations theory. It is this particular alliance of feminism and psychoanalysis, which has been most heavily assimilated into some of the psychoanalytically based training programmes in this country. It goes along with a current emphasis on what are thought to be 'the female virtues of empathy and understanding'. (It has also supported the current vogue for analysis by countertransference, which currently holds such powerful sway that it is very difficult to question it.) Moi's critique is useful here. She goes on to discuss the work of Freud and Lacan on theories of sublimation via a French feminist philosopher, Michelle Le Doeff, in an endeavour to combat patriarchal ideology in science. Gayatri Chakravorty Spivak wants to give an analysis of the word 'woman' that can not only take account of class and cultural differences, but also of such contradictions as the way in which an imperialised people – particularly their elite –can partially identify with their oppressors. This paper comes out of her experience of teaching in Delhi and Calcutta for six months, which was the first time she had taught in her country of citizenship.

The last two papers in the book, which also form the final section are, for me, perhaps the most exciting. The first by Joan Copjec is a very erudite paper, which offers a radically different way of construing questions about the social order and psychic existence. In it she says that contemporary analyses which present the psyche and social as a closed unit have forgotten a third term – the real. Through her articulation of the real she is able to make the causal argument that although 'the subject and the unconscious are effects of the social order' the subject is not determined by it; rather that the subject is constructed through its inability to conform to social limits. Her account of the real is derived from Lacan and very closely linked to his reworking of Freud's death drive. This is not the death drive of Melanie Klein which is founded on a dualism of opposites – life and death. The Lacanian death drive, which is to be found in Freud, functions according to a contradictory position: the aim of life is death.

The final paper by Parveen Adams offers an alternative for women to the search for a specifically female symbolic – a possible path out of the Oedipal maze. She examines a new form of sexual practice – lesbian sado-masochism, which she argues is not a pathological product. She analyses it by drawing on Freud's late comments on the splitting of the ego in order to review his theories of fetishism, sadism and masochism. In arguing that lesbian sado-masochism is not pathological, she is not suggesting that this is a post-oedipal position. Rather that lesbian sado-masochism is an example of non-pathological split-

ting, which may serve as a clue to what direction a feminine jouissance beyond the phallus may take. As Teresa Brennan says in her excellent introduction, this final paper challenges the prevailing orthodoxy of heterosexuality within psychoanalysis. It is a well argued and clearly written piece, which like the preceding article opens challenging perspectives.

VIVIEN BAR

Behind the Couch: Revelations of a Psychoanalyst

By Herbert S. Strean as told to Lucy Freeman. New York: John Wiley & Sons. 1988. Pp. 223. £14.95.

As therapists, few of us are really honest about what we *do* let alone what we think and feel about our patients. Perhaps this uninhibited foray will encourage a more open discussion on this neglected but important topic. Even though the subject of countertransference is in vogue, therapists' reactions are only acceptable as a mirror of patients' feelings and say little about us as human beings.

This book is extremely welcome as it shows the inner workings of a therapist's countertransference by revealing not only his thought processes but also the relevant details of his private life. It raises the seminal question should an analyst remain a blank screen or be a real person too? Strean is obviously orthodox in his approach but he reveals a lot in this book and one wonders what effect this might have on his analysands.

Repeatedly, in fraught and demanding situations with his patients, Strean gives thanks to his analyst Reuben Fine for his own successful analysis and for helping him painstakingly work through his own primitive sexuality, aggression and rivalry. Strean acknowledges that his work has improved with age and experience in that he has less need to impress and feels freer to be himself and can even accept and sponsor certain patients' surpassing him!

Strean deals with important countertransference questions rarely touched on in the literature such as his feelings as a Jewish analyst with an anti-semitic patient. He also describes how he reacts to a seductive patient and how he handles an anonymous threat to his wife. In addition, I found interesting the much under discussed minutiae of

analytical and therapeutic technique, for example, what name does one address patients by.

Not surprisingly this book has sold well. People have an intense primal scene curiosity about analysts and both their private and working lives. It is a book that is particularly accessible and easy to read. At times it is glib but on the whole it represents a fruitful collaboration between a psychoanalyst, Herbert Strean, and a professional writer, Lucy Freeman, who has herself been analysed and has written dozens of books on psychoanalysis. So much of analytic writing is dry and erudite but Freeman has brought Strean's case material to life making it readable, interesting and comprehensible to both laymen and professionals alike.

JUDY COOPER

Give Sorrow Words

Dorothy Judd

With Bettelheim we know that 'love is not enough'. The core of Dorothy Judd's book is an account by a child psychotherapist of $2\frac{1}{2}$ months of treatment with a $7\frac{1}{2}$ year old boy dying of acute myeloblastic leukaemia. In it we learn much of what it is that must be added to love in work with the mortally ill child. The account of the treatment is harrowing for the reader. Just as Dorothy Judd is shocked by the baldness of Robert as she meets him, so the reader is shocked by the ravages of Robert's illness and treatment in his last months. Through this shock the reader learns how this brave, frightened, angry, sad and life-loving boy uses the help of a child psychotherapist.

Robert was referred for psychotherapy because of the isolation of his Scottish family from their normal environment as well as the grim prognosis of his disease. With the consent of his parents, Dorothy Judd arranged to see Robert regularly twice a week. The diary account of treatment is in fine, illuminating detail. At the same time, the other dimensions of Robert's experience are held firmly in focus – the bone marrow transplant with the father as donor, the transition from active treatment to palliative care, the patient's separation from his only sibling. Through Mrs. Judd the reader shares the privilege of being in contact with this boy, his thinking, feelings and fantasy in his last months. With her we approach his death and grieve his loss. 'Perhaps

through reading this, others facing similar situations, personally or professionally, will find some useful guidelines, warning of possible pitfalls, rather than hard and fast prescriptions', writes Mrs. Judd modestly.

This account of a treatment is prefaced by an extensive overview, both of Mrs. Judd's own psychoanalytic theoretical frame, a Kleinian one, and the extensive literature and research on death, dying and their relationship to children. This overview also includes a useful account of psychosocial support services available to seriously ill children and their families, ranging from individual therapy, through family therapy, group therapy, to home care teams and the Hospice movement. The account of treatment is followed by a third section, ambitious in scope, which discusses the prolongation of life, the concept of the consent to treatment, of the impact of serious illness on those who survive it, and of bereavement following death. This structure of the book is clear but the effect is somewhat uneven. The well-maintained impetus and cohesion of the central section on the treatment seems somewhat detached from the lengthy theoretical introduction and briefer subsequent discussion.

'Give Sorrow Words' is broad in content and addressed to both the general reader and to the professional. One consequence of this approach is some lack of consistency in levels of exposition and conceptualisation. It is clearly and obviously useful to therapists working in similar fields, as it raises many or most of the essential questions in the work. It may cause therapists not now working in medical settings to think of venturing into them. It touches on the personal difficulty and pain of such work, discusses the 'burn-out' phenomenon and advances Mrs. Judd's own solution – maintaining a balance between this type of work and other work. Its accounts of psychoanalytic theory, its synopsis of relevant research, its description of leukaemia and its treatment, method and dilemmas of therapy, are all admirably lucid. One hopes it will also be of interest, for example, to oncologists, haematologists or health service managers who may hold purse strings.

The experiences of several experts in the psychosocial care of dying children is cited directly, and there is a full bibliography. It seems regrettable, given the focus of a Scottish child treated in the North, that, where quoted, experts are predominantly Londoners. What of Northern expertise? Oncologists and haematologists do figure in the account of treatment but are not given space to comment and reflect on their roles or policies, which however the author criticises in places.

For readers unfamiliar with the work of a child therapist Dorothy

Judd provides a clear explanation of their training, role and way of working. 'Therapy', she says, 'aims at restoring normal emotional development. However in a hospital setting the main focus would be on allowing the child to work through the traumatic situation that causes the child to be in hospital and the child's response to the trauma.'

As Mrs. Judd describes breaches of several of the usual parameters of psycho-therapeutic treatments, she alerts the reader. She becomes increasingly flexible, seeing the patient between his twice weekly sessions, attending to his urgent physical needs, stroking him or holding him, working directly with his parents. Importantly, she shows how none of these changes altered her capacity to work as a therapist or the patient's knowledge of her particular function for him.

For the professional reader there is much of interest. There is a particularly sensitive account of the mother's painful and difficult experience of the therapist's intervention. This is technically fascinating, for example, in consideration of the linked, parallel responses of the therapist and the mother's response to Robert's attacks on his own body. This consideration of self-damage too demonstrates the great usefulness of an interpretative approach to such well-documented behaviour in a leukaemic child. Dorothy Judd's exposition of the place of the work in the transference, which draws on Eisler's thinking, deserves much consideration.

Dorothy Judd mentions the limited availability of child therapy, and the more widely available family and group therapy. The very high instance of psychiatric morbidity in children with life threatening illnesses and their families is evidenced but there is perhaps insufficient consideration in this work of how much treatment should be available for these many thousands of patients nationwide, and of which children in particular might most benefit from individual input. Mrs. Judd's position in the institution in which she treated Robert was unclear. Although there is frequent mention of her attendance at meetings, it sometimes appears that she visited the hospital from the outside for the purpose of treating this patient. At one point, when Robert asked for her by name, the ward sister who was caring for him surprisingly asked, 'Who is Mrs. Judd?'. Mrs. Judd mentions the important potential role of the child therapist in interpreting the child and his needs to other staff and as treatment progresses she becomes increasingly active herself in negotiating changes in medical management and, for example, in arranging the visit of Robert's elder sibling. In some settings where child therapists are an integral part of a paediatric team they

may have as important a role in staff support as in individual therapy with the children and their families. Their position in the team will certainly influence their capacity to represent at all times the psychological needs of the individual patient, an important structural consideration.

There was little spoken with Robert about his impending death. Communication on this was largely non-verbal and by Robert's choice through the use of children's stories which he asked his therapist to read to him. A careful examination of counter-transference enabled her cathexis to stay steady with her patient and to remain with him to his end, an experience which is sometimes denied dying individuals, surrounded as they may be by many caring people. At one point in her narrative she wonders to herself if she is over-involved. In Dorothy Judd's work we learn much of the levels of concern, compassion and love, informed by skill, thought, knowledge and support from colleagues necessary to the undertaking of such work. The contribution this book makes to our understanding and experience, the many practical, theoretical and ethical questions it raises may over-ride reservations about the publication of such an essentially private and personal account, as they did for the therapist-author.

SANDRA RAMSDEN

Child Psychotherapy, War and the Normal Child. Selected Papers of Margaret Lowenfeld

Edited by Cathy Urwin and John Hood-Williams. London Free Association Books. 1988. Pp. 405.

Margaret Lowenfeld was a pioneer of child psychology and child psychotherapy, who developed a unique form of treatment for disturbed children and a theory of early mental functioning, which while it had elements in common with analytical psychology and psychoanalysis, remained a product of her own experience, her own route; as a paediatrician, researcher, therapist and woman 'of two nations'. This book is part selected papers, and part a life of Lowenfeld, which traces her ideas and her work from paediatrics to founding and running the Institute of Child Psychology. It describes her early life as the daughter of a Polish father and a Welsh mother, born into a materially comfortable, culturally rich and emotionally impoverished family in London

society in 1890. Cathy Urwin paints a picture of the young Lowenfeld caught between warring parents, and battling with her own frequent illnesses, her isolation and her depression. Later as a doctor she worked with relentless dedication to alleviate the suffering of children, and to understand their mental and emotional functioning through observing their play, which was, she believed, essential for healthy and creative adulthood, and for a healthy and peaceful world.

It was while in Poland between 1918 and 1921 that Lowenfeld met with experiences which were to direct her future life and work. Her elder sister, who later became well known as Dr Helena Wright, a pioneer in the field of birth control, had wanted to study medicine since childhood. For Margaret it was a later decision and encountered opposition, particularly from her father. However, she did train and subsequently began work at the Royal Free Hospital in London in November 1914. It was therefore with several years of hospital work behind her that Margaret Lowenfeld travelled to Poland in 1918. She had been asked for help by the people of her family's village who were experiencing terrible hardship caused by the war. Typhoid, dysentry, cholera, tuberculosis and influenza were rife. Lowenfeld involved herself with the children who were orphans of the Russian –Polish war. The experience which she later wrote about, and which perhaps encapsulates the process which was at work within her in this war torn environment was this: while delivering supplies, Lowenfeld visited a house which received surviving children brought there by cattle trucks, the dead being thrown out on the way. She met with a group of boys aged between ten and fourteen, who had, it seemed to her, lost everything; they had no language, no nationality, no roots, nor anyone to whom they could tell their experiences. When she saw them again some time later, a large number of these children had not only survived but had set about organising their lives. Lowenfeld asked herself what it could be within these children which enabled them not only to survive and create a new environment for themselves, but to appear 'cheerful and normal'. Later she, like Bettelheim, was to compare their misery and that of the prisoners of war to the 'depressions of infancy'.

Back in London, Lowenfeld became involved in research into illness in children, and into infant feeding. Two papers from this time, 'Organization and the Rheumatic Child', first published in the Lancet in 1927, and 'Researches into Lactation', first published in the Journal of Obstetrics and Gynaecology of the British Empire in 1928, are reproduced in this book. In their introductory notes to these papers Urwin and Hood-Williams place this work in the context of medicine at the

time, and stress the importance of Lowenfeld's background in research to her later work. In the Lactation paper her detailed research technique demonstrates that it is the relative strength of the individual infant's jaws and ability to suck which determines the fat content of the breast milk received, which has bearing on its nutritional value. At that time she appeared to draw no psychological conclusions from this evidence. Her work with sick children made her aware of how the course of an illness was different in different individuals. It was the capacity of some children to cling to life and survive against the odds which struck Lowenfeld, and which, like the experience of the orphaned boys in Poland, contributed to her later concerns with the capacities in children to overcome and make sense of their experiences.

In 1927 Lowenfeld opened her own Children's Clinic. It was at that time that the Child Guidance Movement was coming into being. It was with the Child Study movement of this time that Lowenfeld found her natural colleagues. Teachers and social workers were being trained in child development and observation. Lowenfeld and her clinic staff, who were from varied backgrounds, observed, studied and treated children with physical illness, and those who were thought to be 'nervous' or 'difficult'. Her 'holistic' approach took account of every aspect of their lives. Parents took their children and sometimes children took themselves to Lowenfeld's clinic, which she viewed always as a 'place for experiment'. It was here that children began to make 'Worlds'. They were provided with sand tray, water and chose small toys with which they constructed their 'Worlds', which were then recorded and studied by Lowenfeld and her staff. The form of therapy which emerged from the clinic provided the basis for the training of the Institute of Child Psychology, which Lowenfeld founded in 1931. It was a therapy which concentrated entirely on the meaning attributed to his play by the child himself. No emphasis was laid on the relationship between child and therapist, and no interpretation was made of transference on to the therapist. Lowenfeld, while accepting some of the ideas within the psychoanalytic movement of the time, was critical of what she saw as attempts to impose on the therapy of children, theories which had been reconstructed from, or were the conceptual extensions of the analysis of adult patients. She stressed that her aim was not to dispute the existence of the processes described by psychoanalysis, but to discover a technique which would make those processes available to scientific evaluation. Her aim was to develop a tool with which a child could demonstrate his mental state without interference from adult interpretation. For Lowenfeld the 'Worlds', constructed through the play of

children, became not solely attempts to master anxiety or to express conflicts of infantile sexuality, they were created products of mental, emotional and cultural significance. She came to formulate a theory of preverbal thinking by asking herself the following question: 'Since the parts of the brain with which one thinks are formed and active long before seven, when language is available for thought, in what way do children, before they reach this age, think, and register, and group their experience?' (p. 326). She believed that the mental concept was as important as the affect i.e. an urge or a wish was incomplete without a picture.

Lowenfeld first presented her theory in two papers: 'A Thesis Concerning the Fundamental Structure of the Mento-emotional Processes in Children' (1937), and 'The World Pictures of Children: A method of recording and studying them' (1939). The latter, presented to the Medical Section of the British Psychoanalytical Society in March 1938, is included with the discussion which followed her presentation, and in which she was roundly attacked by, among others, Mrs Klein, Dr Isaacs and Dr Winnicott. While Klein criticised Lowenfeld for 'forgetting' how she had previously acknowledged the influence of her own work on unconscious phantasy, Isaacs drew attention to the isolation in which Lowenfeld chose to work and develop her ideas. Winnicott was critical of what he saw of the limitations of the set technique of building 'Worlds', he saw the apparatus as hindering what could be learned of a child's inner world by simpler and less organised means. It was a devastating reception of Lowenfeld's work. Klein told her that 'her obvious wish to keep away from one of the fundamental principles of psychoanalysis, namely the transference, leads to a dead end'. (p. 293).

Lowenfeld's work did not come to a 'dead end'. She went on to develop her theory in two papers: 'Direct Projective Therapy' (1944) and 'The Nature of the Primary System' (1948). The latter is the most important of her works, and incidentally, the most readable. From this paper the reader gets a sense that Lowenfeld had, twenty years after the first 'Worlds' were made, integrated her theory into a way of thinking about thinking. Here she placed her theory within her own life experiences, personal, cultural and clinical. She did not use the terms 'conscious' or 'unconscious' to describe children's mental and emotional processes, rather she postulated two systems of thought: The Primary System (later called the Protosystem to avoid confusion with Freud's Primary Process) and the Secondary System, the latter being a shared logical system expressed in language. The Primary or

Protosystem she described as non-rational, pre-verbal, an inner experience of the child in which he groups his experiences firstly into what feels good and what feels bad. Complicated groupings take place which are not governed by reason or logic, but by association and identity. She referred to the works of the painter Chagall as containing examples of what she called 'clusters', complex structures, which it is not possible to express in words, and which exist without the usual rules of time, space, up, down, inside and outside. Lowenfeld saw the Protosystem, as it emerged in the 'World' play of children, as evidence of an urge toward pattern and linking.

> First of all there is much in the Primary System that is common to many different individuals and groups, and fairy-tales, folklore, myth and fable embody many of these elements. As the Jungian school of analysis has shown, through an enjoyment of these, the energy which charges the Primary clusters can find its way through the Secondary System, to expression in the outside world. Certain of the clusters even become almost tangible in solidity and form the 'introjected objects' of psychoanalysis. (p. 343)

Lowenfeld claimed that the impact of her therapeutic technique lay in the patient's discovery of his inner experience through his own work. While they concede that the Protosystem was never a theory of interpersonal relations, and that Lowenfeld's determination to find a method external to patient/therapist relationship left that area unexplored, the Editors believe that her interest in the capacity of the infant and child to create images which mediate his relations with his environment can be seen in the light of later developments in analysis. They cite the work of Post-Kleinians Bion and Meltzer. For those of us working in the London school of analytical psychology with Dr Michael Fordham's theory of the primary self and its capacity for deintegrative and reintegrative activity, this is familiar territory. Of the psychoanalysts, it was Winnicott, who having made a stinging attack on her methods in the thirties, later acknowledged Lowenfeld's contribution to the broadened understanding of symbol, and the value of her work on creativity and play.

The Institute of Child Psychology was closed in 1978, five years after Lowenfeld's death. The reason, it seems, was the lack of an emphasis within its training on the transference as the central tool of child psychotherapy. For those tempted to think that Klein's prophecy of a 'dead end' has come true, the Editors assure that the influence of Lowenfeld's work lives on in Child Guidance Clinics. They believe that her theory of development, based as it was on a broader scheme than the family

and interpersonal relations, opens areas not fully addressed by psychoanalysis. This is a big book; a life and a life's work. Cathy Urwin and John Hood-Williams have skilfully constructed a vehicle for the collected papers of Margaret Lowenfeld.

PATRICIA ALLEN

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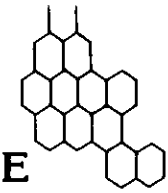

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When referring to articles include authors' names and initials, date of publication in brackets, the full title of the article, the title of the journal, the volume number and the first and last pages, e.g.

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

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

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

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