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FURTHER THOUGHTS ON SYMBOLISM

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In having further thoughts on symbolism, I not unnaturally re-read the first thing I had ever written on the subject, a paper entitled 'Symbolism and its Relationship to the Primary and Secondary Processes', which appeared in the *International Journal of Psychoanalysis* in 1956 but which I must in fact have written two or three years earlier.

I was at that time giving seminars on dreams to first year students at the Institute of Psychoanalysis and when it came to giving one on symbolism I found to my surprise that I disagreed with, and indeed disapproved of, the then standard analytical text on symbolism, Ernest Jones's 'The Theory of Symbolism' (1916). So, instead of dutifully going through Jones's paper with the students, I had to concoct, or construct, my own view of symbolism; and from this *ad hoc* production my 1956 paper eventually emerged. Someone must, I imagine, have encouraged or bullied me into transforming my initial seminar notes into a full-blown Scientific Paper, but I have no recollection as to who it was, though I surmise that it must have been either Sylvia Payne or Marion Milner. Nor indeed do I have any recollection of writing the paper, and when I re-read it now I cannot hear my own voice in it.

However, I find that I still agree with its general thesis. The classical Freudian, Jonesian theory of symbolism must, I still think, be misguided on at least two points; first in maintaining that the only 'true' symbols are those occurring in dreams, where, according to classical theory, they stand predominantly for sexual organs and processes; and secondly, in maintaining that the modes of unconscious and conscious mental activity, the primary and secondary processes, are qualitatively *absolutely* different – from which it followed that there are 'true' symbols formed by condensation and displacement in the Unconscious, but only verbal images, mere 'symbols in the widest sense' formed by similes, metaphors and other figures of speech in the Conscious.

Both of these ideas struck me, when I found I had to teach them, as erroneous and misleading, and I argued instead that symbolization is a general capacity which is used by both the primary and the secondary processes, and that the so-called 'primary processes' – displacement and condensation – are *examples* of the various figures of

speech, such as metaphor, synecdoche, metonymy on which language is founded and not different sorts of processes which just happen to resemble figures of speech. Late in the paper I quote with approval Lawrence Kubie's statement: 'There are no such discontinuities in nature as those who put the symbolism of dreams in a category of its own would seem to imply' (Kubie 1953).

I have remarked that I not only disagreed with Jones's paper but also disapproved of it. My reason for disapproving of it was that Jones had adopted a terminology that offended against common usage and thereby created well-nigh insuperable barriers between psychoanalysis and other disciplines, notably anthropology, which concerned themselves with symbols and their meaning. The first generation of analysts seem to have had little or no awareness that psychoanalysis might have anything to *learn* from other disciplines, and that they ought to adopt a terminology that kept open lines of communication with uninitiated, benighted outsiders.

It so happens that I know what Jones thought of my 1956 paper. He agreed with most of it, and told me that his 1916 paper had been largely polemical. He had been concerned above all things to demonstrate how dissimilar and incompatible Freud's and Jung's views on symbolism were.

Although, as I said earlier, I still agree with much of what I wrote on symbolism in my 1956 paper, I would *not* recommend anyone to try to read it now. I say this partly because I have made the same points better and more clearly in later writings, but also because there is something stuffy and dated about it.

For instance, I seem to have written it without any awareness of the need to postulate a self or an agent, or a self as agent (Schafer 1976), who initiates and sustains activity, and instead write as though the primary and secondary processes, etc, are functions of a mechanical apparatus in which quanta of energy, cathexes, shift around, buzz about, from one part of the psyche to another, without any central point from which desire and creative life-forces emerge and unfold.

There is also something politically wary about the paper, a too careful steering my way between the various Scyllas and Charybdises that confronted younger analysts in the 1950s, when Anna Freud, Melanie Klein and D.W. Winnicott were dancing an undignified *mélange à trois* of mutual incomprehension, and anything any younger analyst said was being anxiously, eagerly scrutinized on the basis of the principle 'He who is not for me is against me.' It was, as I read

recently, 'one of the most dreadful, shameful and regrettable chapters in the history of psychoanalysis' (Grotstein 1985).

But I must turn to what I think about symbolism now. First I shall recount a dream I was told many, many years ago by a patient who possessed an intuitive understanding of the symbols occurring in his dreams, and who belonged to a category of patients, or rather persons, whom Freud viewed with deep suspicion; those who possess 'a peculiar gift for the direct understanding' of their dreams, based on intuition, a capacity which in his opinion was not to be trusted since, I quote, 'its effectiveness is exempt from all criticism and consequently its findings have no claim to credibility.' This remark was in fact a crack at Wilhelm Stekel, the analyst who compelled Freud to take symbolism seriously. The first edition of the *Interpretation of Dreams* just mentions symbolism, but a whole section on it only appeared in the fourth edition, which was published in 1914, three years after Stekel had published his *Die Sprache des Traumes* (*The Language of Dreams*). (See Freud *SE* Vol 5). Then, after discussing this patient's dream, I shall go on to state my present views on the connections between imagination, symbolism and something I like to call biological destiny, leaning heavily on the texts of things I have written in the not too distant past (Rycroft 1979, 1984).

The dream. A man who was an only child and whose father had deserted home early in his childhood, opened his therapy by telling me a dream. He was swimming alone in the sea and saw a large sailing ship bearing down upon him. This ship was in full sail, its mainsails billowing and its bowsprit jutting threateningly forwards. After telling me the dream he remarked immediately and without prompting that, *of course*, the ship stood for his mother, the mainsails for her breasts, and the bowsprit for the penis that he had always imagined her to possess. This dream, then, represents not the hallucinatory fulfilment of any sexual wish, but the dreamer's conception of his relationship with his mother, and does so by a set of interlocking metaphors. *She* is likened to a ship, large, overbearing and powerful; being possessed of both maternal and paternal, feminine and masculine attributes. *He*, in contrast, is presented as small, in comparison with both the ship and the sea, and as at sea, this last being a dead metaphor borrowed from speech. The representation of his mother as a sailing ship – she was, he said, either a tea-clipper or a windjammer – is a live metaphor, since overbearing women are usually spoken of as battleships or battle-axes (It occurs to me now that she may well have been a windbag, all talk but with little inner strength of her own). The use of a bowsprit

to represent her imagined penis and her appropriation of paternal authority is synecdoche, the part, the penis, standing for the whole, the father.

If one compares this dream with the interpretation that I would have had to have made of it if he had not made it for himself, they differ in the way they use symbols. The dream uses visual imagery and is, in Freud's terminology, a product of primary process thinking displaying condensation and displacement, or, in Susanne Langer's (1951) terminology, which I prefer, a product of non-discursive symbolic thinking, in which the symbols are presented simultaneously (i.e. like a picture not a text) and derive their meanings from their context. The interpretation, on the other hand, uses verbal symbols, words, whose meanings are defined by general usage and by dictionaries, presented in an order determined by syntax to form a discourse, which reveals by its use of little words like 'like' which elements are to be understood literally and which metaphorically. The word 'mother' in the interpretation refers literally to his mother (or to his internal image of her), while the ship with its sails and bowsprit are patently metaphors describing how he imagines her, what he feels about her.

The advantages and disadvantages of these two types of symbolic statement are obvious. The dream is vivid and evokes clearly the emotions of a small boy who is frightened of his mother, but it gives no indication as to *why* a man in his thirties can still feel like a small boy who is frightened of his mother, while the interpretation is matter of fact but opens up the possibility of continued discourse which could eventually discover why he sometimes still feels that way.

I now turn to what I presently think about symbolism and its connection with the imagination and biological destiny.

As Marion Milner (1952) in particular has pointed out, there seems to be a general, innate tendency, need or drive to apprehend all objects, all processes that are perceived but are *not* one's self by likening them to bodily processes, organs and sensations that *are* one's self, a process that enables us to assimilate the originally alien outside world into the inevitably familiar world of one's own body, its movements, its activities and its sensations. This assimilation provides us with a growing stock of images which we can liken to our body and its activities and to which, reciprocally, our own body and its activities can be likened. As a result imagery derived from our own body is available for making metaphorical, symbolic statements about the outside world – and also about our own mental processes – and imagery derived from the outside world becomes available for making metaphorical, symbolic

statements about ourselves and our physical and mental processes. In other words a two-way imaginative traffic develops between ourselves and the world external to ourselves, so that each can provide metaphors to describe the other. This is why, as language shows, we endow countless inanimate objects with heads, necks, shoulders, eyes, waists, breasts and so on, and can conceive of winds whistling, rivers running, brooks babbling. Language is, indeed, full of, constructed of, metaphors which must have arisen and survived because of the ease with which our minds can liken non-human objects to parts of ourselves. Furthermore, our mental processes would remain ineffable, undescribable, if we could not describe them by metaphors derived from our bodies or from the outside world. It is, incidentally, no accident that all psychoanalytical theories are based on models derived from other sciences and are therefore metaphorical systems.

Man, then, is a symbolizing animal who constructs on the foundations of his elementary bodily experiences a network of images which embraces and orders his perceptions. This network, or rather the activity of this network, is, I conceive, what we call imagination. It enables us to do not only what all animals can do, that is react adaptively to the immediate present, but also to anticipate and rehearse the future, to relive and remember the past, to conceive what it might be like to be someone else, to imagine how things could be other than they are, and to construct fictive alternative worlds.

This insight that our imagination, our way of perceiving ourselves and the world around us, is constructed on the foundations of our elemental bodily experiences is, I believe, the germ of fundamental truth that lies buried in the piece of classical analytical theory which asserts that the symbols occurring in dreams are predominantly sexual; an assertion that has been popularized and vulgarized in the journalistic concept of the Freudian symbol.

Now, Freud really did say that the symbols in dreams are predominantly sexual. In his Tenth Introductory Lecture (1916) he said, I quote, 'The range of things which are given symbolic representation in dreams is not wide: the human body as a whole, parents, children, brothers and sisters, birth, death, nakedness – and something else besides.' The 'something else besides' turns out to be, I quote again, 'This field is that of sexual life – the genitals, sexual processes, sexual intercourse. The very great majority of symbols in dreams are sexual symbols. And here a strange disproportion is revealed. The topics I have mentioned are few, but the symbols for them are extremely numerous'. Freud then goes on to list over thirty symbols for the male

genitals and over twenty for the female. Reading this paper in full one is indeed left with the over-powering impression that in Freud's view dream symbolism is predominantly sexual, but I must confess that I think he reached this conclusion by a mixture of logical error and intellectual sleight of hand.

The logical error consists in failing to appreciate that the topics he designates 'few' and the symbols he designates 'numerous' are not of the same logical type, and cannot therefore be compared numerically with one another. The topics; birth, death, parents, sex, etc, are general categories arrived at by abstraction, the symbols mentioned are specific objects. It is, therefore, no more surprising that there are more symbols than topics symbolized than that there are more animals in the world than there are species of animals classified by biologists, or that there are more words in use than parts of speech defined by philologists. And in any case, there is really no point in listing sexual symbols. Nothing actually *is* a symbol but anything may be used as one. There is no reason to suppose that there are any objects that someone sometime somewhere might not use to construct a sexual metaphor.

The sleight of hand consists in asserting, first, that the range of things given symbolic representation in dreams is 'not wide' and then going on to give a list of things; the body, parents, children, birth, death, etc, which covers an extremely wide range of emotionally significant experiences, and then, secondly, asserting that 'the field of sexual life' is 'something else besides', when in fact it is precisely what binds the other topics together. After all, to go through Freud's list: we only have a body because our parents had intercourse, at least once; we only have children because (or if) we have had intercourse; we only have brothers and sisters because (or if) our parents had sexual intercourse more than once; birth and death are the first and last members of the series birth, copulation and death; and nakedness has obvious connections with sex, birth and death. One cannot help wondering whether in 1916 Freud, like Jones, was being polemical and concerned to demonstrate how dissimilar and incompatible his and Jung's views on symbolism were.

So, if one refuses to follow Freud in his categorization of sex as 'something else besides', it becomes possible to restate his ideas about symbolism in more general, inclusive terms without, incidentally, bowdlerizing them. It becomes possible to say that the range of things symbolized in dreams embraces all aspects of man's life-cycle, and that the psychoanalytical study of dreams reveals that human beings are more preoccupied than they mostly realize with their biological destiny,

to use the widest possible term to encompass the whole life-cycle of birth, maturation, love, reproduction, aging and death. And this life-cycle has to be called destiny, however portentous the word sounds, because it is only marginally determined by conscious choices and decisions but mainly by biological patterns that are inborn and ineluctable (e.g. one's innate vitality, temperament, aptitudes, age of onset of puberty and ageing) and by social factors over which we have had no choice. We did not choose our parents or select which genes they should pass on to us, nor the culture into which we were born, nor the impact upon us of the various social, economic and intellectual movements at work within that culture.

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PROJECTIVE IDENTIFICATION FROM A JUNGIAN PERSPECTIVE

GORDON HARRIS

The title of this paper might more properly read: 'Projective Identification from the perspective of a Jungian', meaning the writer, insofar as what is offered here is a very personal mixture from a variety of sources, belonging to more than one theoretical orientation.

'Projective Identification' as a term derives, as is well known, from the theory of Melanie Klein. But it has become a term in common use by Jungians, particularly of the developmental school. Jungians of this type have, on the whole, found the theories of Melanie Klein extremely valuable, especially as they have a lot in common with much that Jung himself put forward to account for some of the most puzzling and often disturbing aspects of the relationship between therapist and patient. For myself, I find that problems to do with projective identification are perhaps the most prevalent of all in my work with patients, and it is only now after many years of practice that I am beginning to get the measure of them. In this I have been very much helped by Rosemary Gordon's paper 'The concept of projective identification' (Gordon, 1965).

But here is a definition of projective identification written by Klein herself in 1952 in her paper 'The emotional life of the infant' (quoted in Gordon's paper). In it she describes how:

> The ego takes possession by projection of an external object – first of all the mother – and makes it into an extension of the self. The object becomes to some extent a representative of the ego, and these processes are in my view the basis for identification by projection or 'projective identification'. Identification by introjection and identification by projection appear to be complementary processes. It seems that the processes underlying projective identification operate already in the earliest relation to the breast. The 'vampire-like' sucking, the scooping out of the breast, develop in the infant's phantasy into making his way into the breast and further into the mother's body (Klein, 1952).

Let me put alongside that what Jung has to say about the identical phenomenon, although he uses other terms such as *participation mystique*, *primitive identity*, *psychic infection*, *loss of soul*, *feeling into*, to name just some of them. For example, in *Two Essays on Analytical Psychology* he writes of a patient:

> a naturally quiet and rather sentimental youth (who) had fallen in love with a girl, and as so often happens, had failed to ascertain whether his love was requited. His primitive *participation mystique* took it for granted that his agitations were plainly the agitations of the other, which on the lower levels of psychology is naturally very often the case. Thus he built up a sentimental love-fantasy which precipitately collapsed when he discovered that the girl would have none of him (Jung, 1928) (quoted Gordon, 1965).

There is a particularly striking definition by Jung of the process he calls 'feeling into' (Ger. Einfühlung) in his 'Psychological types'. In the following English translation the term 'empathy' is used to translate 'Einfühlung'.

> Empathy is ... a kind of perceptive process characterised by the fact that, through feeling, some essential psychic content is projected into the object, so that the object is assimilated to the subject and coalesces with him to such an extent that he feels himself, as it were, into the object. This happens when the projected content is associated to a higher degree with the subject than with the object. He does not, however, feel himself projected into the object; rather, the 'empathised' object appears animated to him, as though it were speaking to him of its own accord. ... As a rule, the projection transfers unconscious contents *into* (my emphasis) the object, for which reason empathy is also termed 'transference' (Freud) in analytical psychology (Jung, 1921) (quoted Gordon, 1965).

This quotation comes from Jung's volume on Psychological types, and in particular from a paper concerned with aesthetic experience. As Nathan Schwarz-Salant points out, Jung's statement refers to positive aspects of projective identification that lead to an aesthetic awareness, and a deep imaginal search for processes in the object. Schwarz-Salant comments on Jung's statement that [the subject] does not feel himself projected into the object by pointing out how this refers to a subject 'who already has an ego-self differentiation. But in other instances of projective identification, the subject (or at least certain ego functions of the subject, as Klein emphasised) does project psychic material into the object, and this can lead to a state of confusion and to a weakening of consciousness that leads to emotional flooding by unconscious processes' (Schwarz-Salant, 1989).

In 'The psychology of the transference' Jung writes of the psychic infection of the therapist by the patient:

> The transference alters the psychological stature of the doctor, though this is at first imperceptible to him. He too becomes affected, and has as much difficulty in distinguishing between the patient and what has taken possession of him as has the patient himself. This leads both of them to a direct confrontation with the daemonic forces lurking in the darkness. The resultant paradoxical blend of positive and negative, of trust and

> fear, of hope and doubt, of attraction and repulsion, is characteristic of the initial relationship. It is the hate and love of the elements, which the alchemists likened to the primeval chaos (Jung, 1946).

Jung, of course, does not link up his concept of 'feeling into' with a theory of early infantile development as does Klein with the concept of projective identification. But his concept of transference is based very much upon the experience in analysis of two people interacting with each other and in the process actually changing each other, both analyst and patient, in a way that Jung described with the help of imagery derived from the ancient art of alchemy, to which I refer below.

Rosemary Gordon makes a useful distinction in her paper when she speaks of the three mental mechanisms of identification, projection and projective identification:

> We might say that identification is the psychic equivalent of ingestion, projection is the psychic equivalent of excretion, and projective identification is the psychic equivalent of fusion, which is experienced postnatally, first of all, in relation to the mother and her breast in the feeding situation and later on in the union of male and female in coitus (Gordon, 1965).

For me, the experience of fusion and the dissolving of psychical boundaries between myself and the patient constitute perhaps the most challenging aspect of the work. Such fusion carries both negative and positive connotations. In its positive aspect it is the basis of empathy, enabling me to put myself in that other person's shoes, to mention just one possibility. But in its negative form it has me very often trying to hold tight to my analytical seat to avoid my psyche being totally hi-jacked by the patient, not only feeling myself to be, but also feeling myself to be *acting* in terms of being a character within or part of the patient's inner world. One of Jung's particular contributions in this field has been at least to make clear to me how fusion states between two or more psyches are in fact endemic in the very situation of people interacting with each other. His concept of the collective unconscious, for example, describes a state of affairs in which everyone is linked at a deep psychical level, just as the sea-bed links the islands and continents of this globe.

Nathan Field, another Jungian-trained psychotherapist, has published a paper on 'Projective identification – mechanism or mystery?' In it he addresses the question of how exactly feelings and feeling-states can be put into the analyst by the patient. He asks:

> How is it possible that an unwanted bit of one person's psyche can lodge itself in the psyche of another? How does that bit get across the intervening

> space? How can the recipient acquire the conviction that the feeling is his rather like a deluded hen bird into whose nest a cuckoo's egg has been deposited? And once the introject has been neutralised, how does it make its way back to its rightful owner (Field, 1991)?

He quotes two psycho-analysts (Carpy and Money-Kyrle) who suggest that a process of psychical induction is involved, rather like, to use my own analogy, the way a current in one electrical coil can induce a current in another electrical coil without physically being connected, as in a transformer. He also quotes Freud's observation that 'it is a very remarkable thing that the unconscious of one human being can react upon that of another without passing through the conscious' (Freud, 1915).

Such attempts to think in terms of psychic contents leaping a gap are, Field suggests, based upon an inadequate model of the mind. He says:

> We are faced with the problem of transmission only if the two parties involved are deemed separate entities to begin with. If, at the unconscious level, they are already merged, no transfer is required, in so far as in the state of merger what happens to the one happens to the other (Field, 1991).

Later in his paper Nathan Field refers to Jung's use of the symbols of alchemy as a way of clarifying the merged states that analyst and patient get into.

> (Jung) emphasised that the crucial interactions did not take place between the conscious personalities of analyst and patient but in the area of a shared unconscious. The alchemical states of *nigredo* (blackening) and *massa confusa* (confused mass) are remarkably reminiscent of Bion's 'darkness and formlessness', out of which meaning evolves (Field, 1991).

With regard to this area of a shared unconscious, both Nathan Schwarz-Salant and Andrew Samuels have from their different backgrounds adopted the concept of a *mundus imaginalis* in order to define more closely what this area is (Samuels, 1985; Schwarz-Salant, 1989). The *mundus imaginalis*, the imaginal world, is a concept that was developed by Henry Corbin, the French philosopher and scholar. This *mundus imaginalis* is an in-between state, an intermediate dimension, in his original French *entre-deux*, which may even have the meaning of 'neither one thing nor another'. Samuels says:

> It is possible to see ... how the *mundus imaginalis* acquired a relevance for countertransference phenomena. They too are intermediate, in between patient and analyst, and also in between the analyst's conscious and unconscious. My use of Corbin's idea involves the suggestion that two persons, in a certain kind of relationship, may constitute or gain

> access to or be linked by that level of reality known as the *mundus imaginalis*. For the patient the analyst *is* a person in-between, a real person and also a transference projection. For the analyst, the world he shares with the patient is also the patient's own imaginal world (Samuels, 1985).

Samuels is most gripped by Corbin's equation of the *mundus imaginalis* with visionary states. Certain experiences in the counter-transference can be regarded as visions, i.e. no direct sensory input is involved, nor is the experience of an intellectual nature; neither are they the result of a deliberate act of imagination. He quotes Jung when he refers to visions as 'disturbing spectacles of some tremendous process that in every way transcends our human feeling and understanding' (Jung, 1930). Jung goes on to ask: 'Is it a vision of other worlds, or of the darknesses of the spirit, or of the primal beginnings of the human psyche?' Samuels says we may add to the list: or visions of another's psyche, empathic visions, analytical visions? Corbin, in a passage of his translated and published in *Spring* refers to the imagination as being 'in mystics and prophets ... the organ of visionary knowledge' (Corbin, 1983). For an analyst, when he or she is doing analysis, that organ is the counter-transference.

Samuels introduces his paper with a brief illustration of the phenomena with which he deals in this paper. He quotes the words of one of the therapists who collaborated on the project:

> Veronica is 20 and single. She is depressed and lives at home with her parents: she works for a bank. At school she was a model pupil and head girl. She started drinking heavily in her late teens and turned down several offers of university places at the last moment. After my third session with her, as I was getting into my car, I experienced a sharp moment of anxiety, an image of a car crash came to me, and I found myself thinking, 'What'll happen to Veronica if I have a car crash?'

Samuels says: 'The therapist knew she was not going mad and that what had happened related to the patient. She was an experienced worker and able to manage her shaken feelings. Her conclusion was that she was being affected by her patient's massive feelings of destructiveness towards her and that her worry about the patient's well-being was representative of the patient's own guilt. The therapist regarded her countertransference reactions as having been stimulated by communications from the patient' (Samuels, 1985).

I wish to offer here an experience of my own which I regard as belonging to the same order of countertransference phenomena as Samuels quotes. I refer to the occasional experience I have had of dozing momentarily during a session and having a dream which pro-

vides the crucial image for understanding what is happening within the patient. I have sometimes quoted such dreams to patients and found that they directly relate to the patient. In one case where I was working with a scientist I dozed off during a long silence and had a dream. In it I was travelling on a bus to Hull, and then, once arrived at my destination, I found the bus taking me away from Hull towards the south-west. I woke up immediately after the dream (my total dozing time was probably not much longer than the dream), and decided to tell my patient what I had dreamt. I asked him whether this dream meant anything to him. He said 'yes' immediately and told me that when he left school he had very clear and fixed ideas about becoming a research scientist, and applied to Hull university for a place. He did not like the interview however, nor the interviewer, who he felt was too anxious to have him do research for him before even getting his first degree (I suspect some homosexual fears and wishes in my patient were triggered off by the interview). Although he was offered a place he altered his plans and decided to go to Exeter University in the south-west, where he followed a much less goal-directed path. The connection of all this with his therapy lay in the fact that he was at a loss to know where his therapy was taking him next. My dream was, I believe, a form of communication from the patient directed towards me when I was in a literally unconscious state. I shall say something more about the phenomenon of therapist sleepiness later in this paper.

To return to the *mundus imaginalis* I note that both Schwarz-Salant and Andrew Samuels draw a connection between the *mundus imaginalis* and what Winnicott called the 'third area', sometimes the 'area of experience', sometimes the 'area of illusion' (Winnicott, 1991). Schwarz-Salant draws a parallel between Winnicott's idea of transitional space and the ancient concept of the subtle body. He writes that 'this concept is a mainstay of alchemical thinking and refers to experiences that can be neither physical nor mental but partake of both realms. Moreover, the subtle body is a realm through which projections pass and transform; while its processes can be perceived by the imagination they are not usually available for discovery by the rational mode' (Schwarz-Salant, 1989).

Schwarz-Salant goes on to expound projective identification in terms of Jung's work on the 'Psychology of the transference' (Jung, 1946) and the woodcuts Jung took from the *Rosarium*. He writes:

> In alchemy the existence of what we call projective identification was crucial for the initiation of the alchemical *opus*. Apprehending it was

synonymous with the *fixing* of Mercurius, and could result in finding the *prima materia* or the *massa confusa* or in arriving at the stage called the *nigredo* (Schwarz-Salant, 1989).

Schwarz-Salant declares his practice of openly disclosing the images in his mind to his patient in pursuit of what he refers to as 'interactive analysis'. He describes his work with a woman patient where they were acting like a couple who did not want union.

> When this anxiety-provoking dynamic was active, I would withdraw when she contacted me. Conversely, when I contacted her she would withdraw. We seemed to be ruled by an interactive couple whose roles we enacted. By approaching our interaction this way we submitted to a third element that was having its way with us.

Schwarz-Salant calls this third element 'Mercurius', described by Jung as an 'elusive, deceptive, ever-changing content that possesses the patient like a demon' (Jung, 1946). Schwarz-Salant says: 'We were able to sense this presence through an imaginal act, a metaphorical way of viewing our interaction ... an interaction that can best be conveyed by the image of two couples simultaneously present: the patient and an unconscious dyad'.

Schwarz-Salant goes on to take issue with the Kleinian concept of projective identification:

> As long as I was dealing with 'the parts put into me' by the patient, or 'parts I put into her' in counterprojective identification, I was approaching our interaction through a Kleinian metaphor. That is, I was dealing with projected parts and attempting to understand them through a spatial model that had a clear inside and outside. But when my patient and I were able to perceive the interactive couple in mutable states of fusion, union, or radical non-union, we began to enter a different kind of space, one composed of couples and their relationships rather than projected parts (Schwarz-Salant, 1989).

Andrew Samuels similarly expresses the thought that projective identification, while undoubtedly playing a part in the formation of transference and counter-transference, lacks something as an explanatory theory.

> The *mundus imaginalis* concept can be used to flesh out the concept of projective identification by postulating on what projective identification is based and then what it is that enables its operation to take place. Using words from other disciplines, the search is, respectively for the 'rhizome' which nurtures projective identification and for the 'ether' which facilitates its transmission (Samuels, 1985).

The answer, he suggests, is the *mundus imaginalis* which provides a pre-existent environment, ready, as it were, to facilitate psychological processes. He quotes Hamilton, who criticises the concept of projective

identification for its lack of any reference to any pre-existing 'primary mutuality' between mother and child (Hamilton, 1982). The *mundus imaginalis* is, for Samuels, an attempt to express the psychical basis of that mutuality, at least as it appears in analysis. He also acknowledges his intention in his fascinating paper to be a matchmaker for two world views, one empirical, the other poetic, one in which counter-transference becomes the root of interpretation and one in which such a clinical confine is anathema. He asks: 'Fordham's technique with Hillman's vision? ... It follows that to divorce work on the apparently imaginal and work on the apparently interpersonal is conceptually in error and practically limiting.'

I wish now to leave the concept of the *mundus imaginalis* and return to the concept of projective identification, with which I began. Where Jung, and many analysts today (including Rosemary Gordon), would differ from Melanie Klein is in not treating projective identification 'as if it existed merely as an unconscious phantasy and in the psyche of the patient only.'

> Rather, it is probably a process which, if it is sufficiently primitive and elemental, may really break down the boundaries and separateness between persons and lead to truly shared experiences (Gordon, 1965).

In this paper I reserve the term projective identification for those primitive fusion states in which the sense of the otherness of the analyst is annihilated and, as Klein says, 'the ego takes possession ... of an external object ... and makes it into an extension of the self'. Much analysis over possibly many years may need to take place before what began as projective identification becomes, if it ever does become, the experience of mutuality, at both the conscious and the unconscious levels for which Jung used the alchemical term 'the coniunctio' i.e., a kind of psychical marriage in which the two partners are both two persons in their respective otherness as well as one flesh metaphorically speaking. Few, perhaps, are the analyses which end that way.

Let us turn now to the *clinical implications* of all this. I have left out of account in this brief introduction the question of the kinds of unconscious contents that the patient projects into the therapist in terms of which the therapist finds himself or herself willy-nilly responding and acting. Rosemary Gordon's paper treats that very thoroughly and I refer you to it. I want to speak rather from my own experience, and say how much I agree with Nathan Field when he points out the importance of the therapist taking some real risks with the patient instead of reacting in a rigid fashion in the manner of the stonewall batsman determined not in anywise to be lured away from

the crease. I believe it is important for the therapist to let himself or herself into the waters of the patient's unconscious sufficiently to become vulnerable to the effect of those waters upon him. This is particularly true, I find, with the so-called borderline patients. They are extremely sensitive to the ways in which the therapist refuses to go anywhere near their border. How often have I said to myself about a patient due to arrive at the next session, 'I'm not going to let myself be goaded this time.' So I sit rigid and tense, trying to avoid being caught up and goaded yet again. Of course, the patient says to me, 'You seem to be far away today' and, of course, she is right. Eventually I am drawn in and I am within reach, although I have to watch it in case I capitulate totally to the workings of the patient's projective identification. Nathan Field says:

> The situation may be compared to trying to save someone who has fallen through a hole in the ice. If he is too far down to grasp the hand you reach out to him, there may be no alternative but to go into the water with him. ... (The analyst) needs to demonstrate to the patient that, even when plunged into the same element as himself, it is possible to remain afloat without panic (Field, 1991).

Denis Carpy, in a very interesting paper on 'Tolerating the countertransference: a mutative process' (Carpy, 1989), makes a very similar point. He writes of a session with a patient whom he found particularly irritating generally:

> The patient got under my skin in a way, causing me to act out slightly by making comments which were critical and involved my trying to make her feel something she was unable to feel. What I took to be her triumph at the end resulted, I believe, from her having been able to observe that she had got to me and affected me this way ... The analysts's partial acting out allows the patient to see, consciously or unconsciously, that she is affecting the analyst and inducing strong feelings in him, and it allows her to observe him attempting to deal with those feelings (Carpy, 1989).

He goes on to refer to Brenman Pick (Pick, 1985) who suggests that the patient watches, consciously or unconsciously, to see if the analyst evades or meets difficult areas within the interaction. Carpy goes on:

> I would like to say, more specifically, that I believe that it is the *inevitable* partial acting out of the countertransference which allows the patient to see that the analyst is being affected by what is projected, is struggling to tolerate it, and, if the analysis is to be effective, is managing sufficiently to maintain his analytic stance without gross acting out. I believe that it is through this process that the patient is able gradually to re-introject the previously-intolerable aspects of himself that are involved. He is also

able to introject the capacity to tolerate them which he had observed in the analyst (Carpy, 1989).

I want to say something now about projective identification as *communication*, surely one of the key positive uses of projective identification. I see a particularly schizoid computer scientist twice a week in the early morning. He has been working with me for nearly four years. His mother committed suicide after years of mental illness, and I feel that the bonding and mirroring in the earliest months of his life between him and his mother were pretty well non-existent. He is cerebral in his conversation, studied and wooden in speech, lying rigidly on the couch with the rug over him, which is highly symbolic of the psyche of me as the therapist into which he slips with great ease. One of the ambivalent pleasures I have working with him is that, particularly in the spring when nature is beginning to wake up in the village where I live, I find myself in his presence becoming hyper-acutely aware of the sounds around me; the birds singing, the clock ticking, and a great peacefulness which is quite blissful. I am totally in the here and now like a baby open to every sensation occasioned by his environment. But he lies there, seemingly cut off from all this, desperately racking his brain in the silences because he cannot think of anything to say, as he confesses eventually. And I am feeling sad because I cannot share this experience consciously with him. Am I, perhaps, the baby in the presence of the switched-off and preoccupied mother? He politely accepts my attempt to interpret this to him, but not in an insightful fashion.

Lately I have realised it is no use interpreting this to him. When this happens I just have to stay with the experience and not interpret. For thereby I *am* sharing something with the baby in him insofar as that baby exists underneath the concrete layers of his intellectual defences. And I believe that in depth he is getting the benefit of that sharing, even though the attempt to interpret it is fielded and warded off by his conscious brain. And now, more recently, his tears have at last come to the surface, an expression of that sadness that I was feeling with him and on his behalf during my times of solitary communion with the sounds around me when in his presence.

Another example of such communication occurred with a male patient whose presenting need in therapy was to work through his unresolved mourning for his father. During a recent session the patient told me a dream, the details of which I have forgotten. I found it very difficult to understand this dream, and the session ended with my feeling very dissatisfied with my attempts to make sense of it. For a

day or two after the session I felt upset and guilty over my failure to understand it. The patient and I also seemed out of rapport with each other over this dream. At the following session the patient told me that he was 'angry' over my inability to help him with his dream. I disclosed to him that I likewise had been concerned after the session over my failure to understand. I then put it to him that maybe his relationship to his father had been one of similarly blocked communication and that he and I had been re-enacting the relationship between father and son where both were holed up inside themselves and were unable to get through to each other, while at the same time they both felt deeply about this. 'Yes', replied the patient, 'and the difference is that you and I can meet the following week and talk about this'. I believe that through projective identification the patient and I had been re-enacting the son-father relationship in a way which led to understanding of their cut-offness from each other and of the helplessness they both felt in relation to each other.

One of the biggest problems of projective identification that I find myself contending with is my tendency to suffer in the presence of certain patients from a mild narcolepsy. My wish to doze off often bears no relation to how tired I actually am. With one of these patients there is hardly a session when I don't actually find my eyelids getting heavy. I feel drugged and have to struggle to stay awake, in fact it has been a matter for comment in the session when I haven't felt so sleepy. Here again we are dealing with a form of communication between patient and therapist, although with different patients the message conveyed may equally differ. With the patient I am referring to I feel that there is more than one aspect to what is going on. I feel that as the sleeping therapist I am, in effect, the mother who 'fell asleep', as it were, on her baby and ceased to pay attention to her. She feels herself, in fact, to have been deeply ignored in her essential self by her mother. But my sleepiness is also my reaction to feeling warded off by the patient, as if I were the child trying to get close to the mother and being pushed away. Another possible meaning of my psychosomatic reaction is that I am experiencing the negative mother within her trying to penetrate and disable me psychically so that I cannot get near the daughter. Furthermore, as this patient bristles most of the time with considerable aggression, I feel that she, under the influence of her negative mother-complex, is trying actually to kill me off as the embodiment of the masculine principle with its fertilising function, metaphorically speaking. Yet another meaning I have discovered has to do with this patient's profound sense of shame which somehow

causes her to become veiled from me by my falling asleep. Another meaning has occurred to me of late, and in fact, when I interpreted this to her some weeks ago my sleepiness vanished and has not recurred. I refer to her deep wish to die and be re-absorbed into the cosmic womb of death. This is a manifestation of what Kierkegaard called 'the sickness unto death' from which this patient profoundly suffers. Finally, my plunge into unconsciousness has also taken the form of an inadvertent attempt to by-pass conscious processes of communication, insofar as I have occasionally woken up to find myself actually in the middle of voicing an interpretation and not having a clue as to what I've actually said, although it seems to have meant something to the patient. It is not a technique to be recommended, of course! All these various interpretations of my sleepiness I have made at some time or other to this patient, although I think her progress has been less due to insight gained on her part and more due to the therapist's capacity to survive from week to week despite being 'killed off' so frequently.

Over the years I have come to realise more and more in what primitive states of need and distress patients come, even the most apparently well patients. In all such cases of disturbance at the level of the 'basic fault', as Balint called it (Balint, 1968), the ability both to use and to suffer projective identification is vitally important, and it *has* to be suffered before it can be used, without a doubt.

From a Jungian standpoint that is entirely in accord with the alchemical model of the transference, where analyst and patient are both changed in the analytic process, even though the focus must be primarily upon the patient. Where projective identification can be worked through it can lead to a differentiation of the psyches of analyst and patient so that they genuinely become 'other' to each other, but in a way that does not give rise to the threat of annihilating separation but, where sufficient trust is generated in the patient, can eventually give rise to what I have already referred as the '*coniunctio*', corresponding somewhat to Freud's 'genital stage' in which mutuality is the keynote of the relationship of patient and therapist. And that ultimately is what psychotherapy is all about, perhaps!

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DIFFERENT WAYS OF STRUCTURING THE FRAME: ACCORDING TO WINNICOTT, KHAN AND LANGS

JUDY COOPER

Introduction

The idea of a boundaried space is crucial to psychotherapeutic endeavour. Freud became progressively concerned with establishing 'an atmosphere of safety' in the analytic setting (Schafer, 1983) and this important concept has been taken up in different ways by many subsequent theorists. Indeed, as Hester Solomon remarked (personal communication, 1990), Jung's 'vas hermeticum', Bion's principle of container/contained and Winnicott's holding environment all pay tribute to the necessity of a safe place if one is able to trust another enough in order to bring one's deepest conflicts to awareness. Patients, families, groups, nations – all need boundaries, a protected space; without it chaos spills out.

In this paper I want to compare three different ways of structuring the analytic frame:

i) the maternal frame as implied by D. W. Winnicott
ii) the paternal frame as implied by Masud Khan
iii) the interactional frame as expressed by Robert Langs.

These three analytic styles show different ways of attempting to provide a space with an 'atmosphere of safety' and it is for the reader to judge which stance would best suit his individual need for psychic integration and growth.

Background to the emphasis on safety in the analytic setting

In the early days of psychoanalysis people were not directly concerned with frame issues, although we know that Freud began by providing a rather lax frame using touch, confiding in patients and conducting sessions while walking in the park. Schafer (1983) points out that Freud became both explicitly and implicitly aware of the pitfalls and difficulties inherent in the analytic enterprise and in his 1911–1915

'Papers on Technique' (*S.E.* 12) he is anxious to address the problems involved in making the analytic setting as safe a place as possible.

Freud was acutely aware (possibly from his own experience) that it was very easy to *use* one's analysands for gratification of one's own unresolved narcissistic, sexual and aggressive needs. In the analytic setting there is tremendous pressure from the infantile wishes of patients for magical, gratifying responses to which analysts must not yield, as short term frustration leads in the long term to building up trust and a climate of safety.

The analytic relationship requires a great deal of delicate handling. Freud was aware of this. It was not to be a personal relationship. It had to be objective, and yet, at the same time, intimate and empathic enough to create an environment in which the unconscious could express itself freely. Also, paradoxically, the setting had to feel safe without being too gratifying or reassuring which would, in the long run, only serve to bolster the patient's resistance.

In 'The Atmosphere of Safety' Schafer (1983) shows that Freud was far from being a mechanical clinician and he believed that there was no generalised version of analysis. However, he stressed that in any individualised version of analytic change, a secure atmosphere had to be built up and significant lapses from this atmosphere could lead to an experience of danger, mistrust and an intensification of resistance. Central to analytic work is the analysis of resistance and transference but for the transference neurosis to emerge, an analyst must be sure of resisting temptation (eroticism, masochism, power struggles, panic and negativity) and also feel safe enough with his own analysis to accept a patient's analytic limitations.

Schafer found that Freud was keen to promote an 'atmosphere of safety ... fostered by the well-maintained analytic attitude' (p. 32). This involves an enquiring 'finding out' attitude: welcoming, accepting, non-directive and non-judgemental. Freud gradually came to feel that it was important for patients to follow the basic format of the fundamental rule, the recumbent position and a certain frequency and regularity of sessions, but the main point of no compromise for Freud was the non-negotiable discipline required of an analyst. Freud was aware of the demands imposed by the nature of analytic work and total discipline was a necessity if analytic work was to proceed for the benefit of the patient.

So, although Freud did not deal with frame issues as such in the same detail as some much later clinicians, he outlined an analytic code of behaviour which he felt would give maximal opportunity for the

resolution of unconscious infantile conflicts on emergence of a transference neurosis. Nonetheless he felt that it was only through the diligent construction of an entirely safe place that a creative therapeutic alliance could be formed within which the freedom of doing real analytic work could, hopefully, begin.

The notion of the analytic setting as a frame

Freud's genius was that he 'created a space, time and process which potentialize that area of *illusion* where symbolic discourse can actualize' (Khan, 1974: 251–252). Freud established the analytic setting with the analyst providing his patient with the privacy of a comfortable room and a couch to lie on, a set repetitive span of time for meeting and his own alert and unintrusive presence. It is only in comparatively recent times that the idea of the setting has expanded and come in for much closer observation. Marion Milner (1952) was the first one to have identified the analytic frame with the part played by the frame of a painted picture: 'The frame marks off the different kind of reality that is within it from that which is outside it; but a temporal spatial frame also marks off the special kind of reality of a psycho-analytic session. And in psycho-analysis it is the existence of this frame that makes possible the full development of that creative illusion that analysts call the transference' (p. 183).

Analysts began to speak of the frame as a protective shell and to see a need to secure it very firmly. Frame management has come to the fore with various components of the therapeutic environment (such as the room, privacy, sound-proofing, warmth, seating, length of sessions, fees, confidentiality, touch, self-revelations and the interventions the analyst makes) coming under scrutiny.

Langs (1978) who has made a diligent exposition of the frame in psychotherapy makes the point that 'the metaphor requires, however, an appreciation of the human qualities of the frame and should not be used to develop an inanimate or overly rigid conception' (p. 696). With its concern for the explicit and implicit 'basic hold' created by the ground rules of the therapeutic interaction, the frame refers to the total analytic space and ambience that an analyst provides for his patient.

D. W. Winnicott's maternal frame

Winnicott's whole attitude and frame was very much based on the breast. Coming from paediatrics he had observed hundreds of mothers with their infants and his observations led him to centre his findings on the crucial importance of 'environmental reliability', based on caretaking by the 'good enough mother'. Consequently, the notion of a 'holding environment' became the cornerstone of both his developmental and psychoanalytic theories. If the Oedipus Complex and castration was central to Freud, then 'it was the annihilation of the core self by intrusion, a failure of the holding environment' (Phillips, 1988: 149) which was crucial for Winnicott, and illness for him could be classified in terms of environmental breakdown.

Winnicott's (1958) clinical setting was constructed with this in mind and he set out to provide a frame which gave the opportunity for extremely damaged patients to have experiences that made up for severe disruptions of holding (impingements). These corrective experiences properly belonged to infancy under conditions of extreme dependence. Winnicott describes a therapeutic approach which includes explicit nurturance and his emphasis is on need rather than greed, on hurt rather than anger.

It has been well documented that 'Winnicott modelled his clinical orientation to the patient largely on an "ordinary devoted mother's" holding care of her infant' (Khan, 1971a: 225), and the descriptions by Guntrip (1977), Little (1981, 1985) and Winnicott on Mr B (1986) of their respective experiences of Winnicott as an analyst effectively bear this out. He did not simply 'mother' his patients but he did try to do what the 'good enough' mother does, that is to provide attention and care and security so that the patient would feel free to develop on his own.

Bleger (1967) expands on Winnicott's idea of frame as mother and says that it represents all the details of management done in adaptation to an infant's needs. He explains that the silently maintained protective elements in the frame are related to those elements in environmental care which build up the ego from the primitive and undifferentiated psychic organization which is based in the early symbiosis between mother and child. Bleger sees the frame as the most primitive fusion with the mother's body and, in analysis, the frame helps re-establish the original symbiosis as a step towards modifying it: 'What Winnicott designates as "the actual physical holding of the infant" in the clinical

situation, metaphorically as well as sentiently, is represented by the role of the couch' (Khan, 1974: 204).

Of particular relevance to Winnicott's work, Viderman (1974) felt that the analytic space is defined by both its physical and psychological components and the rules that establish it, such as the fundamental rule and the analyst's evenly sustained attention; neutrality, benevolence and the silence and passivity of the analyst are altered only by his interpretations and control of his countertransference. With Winnicott's metaphor of the maternal-like holding functions of the analyst, he suggested as early as 1956 that, with certain patients, the holding environment of which the analyst is a part would have to do all the essential therapeutic work for long periods of time.

Although Winnicott wrote about the importance of the 'reliability of the setting' (Phillips, 1988: 64) he obviously meant this within a wide and flexible context. He stressed the importance of the frame in facilitating therapeutic regression and felt that the more psychotic a patient the more essential was the management of the frame and the steady maintenance of the holding environment, rather than any interpretation. However, his clinical work can be seen as being full of 'modifications in the framework' although he emphasised the overall importance of the 'therapeutic hold'. He was not unduly concerned about upholding a tight framework and talks in terms of a patient making the analyst fail him as a repetition of an earlier trauma: 'It was part of D.W.W.'s extraordinary and macabre genius that he alone (except Freud – the Wolfman proves it! And Ferenczi!?) had the explicit cognizance that what was demanded of him was *to fail* and he obliged' (Khan, 1971b: 4th Feb.).

Winnicott could afford to be somewhat idiosyncratic in his clinical practice. Perhaps this was all part of his concentrated effort towards maternal provision. In theory, he stressed that mismanagement of the ground rules could be construed by the patient as getting it wrong and could lead to a resistance that could not be overcome until the deviation was rectified. However, in his own clinical work, what could be seen as gross lapses in the framework could be viewed as Winnicott's attempt to try and meet patients' unconscious needs. He made a careful distinction between needs and wishes and stressed the point that a mother should, and indeed must, fail the id, but never the ego of her infant.

In his own clinical work Winnicott perhaps felt that the detail did not matter as long as his overall setting provided his patients with an arena for experiencing regression with the 'illusion of omnipotence',

'transitional phenomena/space' and an opportunity to 'play'. Thus, from various sources (for example: Guntrip (1977), Little (1981, 1985), Anderson (1985) and Winnicott (1986)) we see that he gave longer sessions if he felt these were indicated, he went out of his house to greet patients, he at times sat alongside patients, he served coffee at the end of sessions, he helped patients on with their coats, he arranged for Little to go to hospital and took her there while she hung on to his coat all the way, he touched and held patients, he told self-revelatory anecdotes, he gave opinions and saw and wrote to patients' families; and all this in the service of providing a holding and facilitating environment!

The only breach that seemed out of control was his habit of falling asleep in sessions. But as Khan said in an interview to James Anderson in 1981 'These two Americans are attacking Winnicott. They say he falls asleep in sessions. He does, but it doesn't matter. He delivers the goods' (Anderson, 1985).

Although Winnicott was far from rigid he was by no means undisciplined. It has been said that he pushed patients into regression but, it should be stated, not necessarily into collapse, for he certainly believed that the experience of breakdown could be momentary. His emphasis on being the facilitating mother meant that in Phillips' view, his patients were safe from adult genitality with him because in Winnicott there is a definite 'flight into infancy, [a] flight from the erotic'. (Phillips, 1988: 152) However, this was because he was chiefly concerned with treating people who had false self personalities and pre-oedipal problems. Winnicott believed that these patients would be functioning at a primitive level without an intact ego and would not be able to form a classical transference neurosis.

Masud Khan felt that after more than twenty years of an analytic relationship with Winnicott 'he [Winnicott] has changed a catastrophic threat of loss of object into separation anxiety' (Khan, 1971c: 6 Feb.). The exhaustion of doing this level of primitive work and of being attuned through a state of 'primary maternal preoccupation' to adapting to any given patients needs; in short, the provision of holding the regressed patient in the clinical setting, could not be done by rote. It made a tremendous demand on Winnicott and took a toll on his energy so that 'near the end of his life, Winnicott was talking with Khan about a troubled, depressed patient he was treating. Winnicott said, "I can't help him. If I were ten years younger I could hold him" ... he no longer had the endurance to provide a holding environment for someone so disturbed' (Anderson, 1985).

Masud Khan's paternal frame

Khan's frame and analytic style is very much based on phallus. He writes insightfully and takes up Winnicott's idea of a holding environment, expanding on the ideas of helplessness and resourcelessness. Thus, his theories cover the concept of 'cumulative trauma' and mother's role as a protective shield. However, it can be seen from his case histories, particularly his later ones (1983, 1988), that Khan's 'holding' is conducted very much in terms of his unique temperament and sensibilities. In fact, it could be said that if Winnicott's clinical setting was aimed at 'holding' the regressed patient, Khan's was aimed at 'managing' him.

Indeed, reading Khan's books is an experience, and although a charismatic analyst is a contradiction in terms and contravenes the accepted convention of strict neutrality in the analytic process, one can see how Khan takes his patients authoritatively into 'analytic care' and provides them with an 'auxillary ego' and the secure coverage of 'therapeutic management'.

He wrote 'some of the most incisive literature on the psychoanalytic settings and process' on holding, regression, incapacity and dependence. However, his aristocratic hauteur meant that he cultivated his own distinctive brand of psychoanalysis: '... an interesting setting somewhere between Lahore and London. Each analysand would be greeted at the door by a houseboy to be ushered to a waiting room; then when the analytic hour arrived the houseboy would escort the patient to the consulting room door, where "inside" this place Khan stood waiting. A handshake, and the session began. Many of his analysands understood his own unique fashioning of psychoanalysis, one that eventually necessitated surviving and using his Islamic pronouncements on the analysands' personal defects, and those who could bear his intrusions on the custom of psychoanalysis and who could stand up to him (almost to represent another civilisation view of a democratic order and the right to speak!) did well by him' (Bollas, 1989: 39).

Khan furthers Winnicott's use of the 'holding environment' in his clinical work with adult patients stating that, given the right holding conditions, integration of previous split-off or divided aspects of the self could take place (Khan, 1983). He emphasizes how he 'accommodates' to the quirks and needs of a given patient before, he believes, true interpretive analytic work can materialize.

Actually, Khan's natural style veers towards therapeutic manage-

ment and analytic care with classical interpretation rarely taking place. He is clearly most comfortable with cases where it is more apt to treat with 'one's personality than with the instruments' (Khan, 1983) and, by responding to the 'authenticity of resourcelessness' in his patients and himself, through sharing and mutual endeavour, he manages to utilize the most bizarre behaviour within the 'analytic framework' and harness it into the equivalent of Winnicott's 'squiggle-game' for children: converting it into a playful and creative encounter (e.g. Khan in Frank, 1977).

From his last book *When Spring Comes* (1988) which is not at all theoretical he describes seven patients and his dealings with them. He emphasizes that he is a psychoanalyst with an entirely different approach: 'I do not recommend it to any other clinician'. Indeed, it is most definitely the imperious (phallic) style of an Eastern potentate, capable of both nurturing care and sadistic punishment. It is a style which results in active involvement (many would call it interference) in his patients' lives.

Khan has had his share of criticism but was accepted as both learned and distinguished. Yet, unlike Winnicott who, despite his critics, was always accepted under the psychoanalytic rubric, many would argue that the frame and setting that Khan provided were far from psychoanalytic. He was not merely a maverick in the analytic world but unique as a clinician. But this did not always make him a good psychoanalyst.

Angry and preoccupied with his own impending death, in *When Spring Comes* (1988) he certainly manages to highlight his lone style of phallic holding and therapeutic management. This book illustrates his willingness to take risks and plunge full-scale into a directive role, dictating both the clinical and domestic settings of his patients. It conveys his intrinsic generosity and magnanimity and the lengths to which he will go to caretake for his patients. It shows his dictatorial stance: his arrogance and omnipotence, particularly in the unfortunate chapter on Mr Luis (Khan, 1988: 87–116).

Working mainly with pre-oedipal conflicts and with borderline and schizoid phenomena in patients, his natural lure to paternalism and his own epic sense of father served him well and did his abilities justice. From first to last he worked as *himself*, using his roots, his background, his experiences and his feelings to guide him. He did not hide behind transference interpretations or by being in any way a 'blank screen' analyst. His impact was real.

Robert Langs interactional frame

Robert Langs has become a tireless campaigner for the frame in psychoanalysis and psychotherapy. By introducing a scientific approach to formulating unconscious meaning he has been led to recognize the importance of a strictly maintained frame, and in his communicative approach he looks at the effects of the physical setting and the therapist's behaviour on what actually transpires in the therapeutic interaction.

Langs strongly criticizes the analyst (Langs, 1989). Most analysts, according to his terms, provide a deviant frame and consequently obscure or collude with patient madness by unconsciously displaying therapist madness. This means that no real change or insight can take place and patients are badly abused and betrayed. Thus, Langs is a specialist in countertransference and therapist errors. He highlights the interactional aspect of the therapeutic alliance and quotes Bateson as saying 'There's no such thing as a patient and analyst, only a therapeutic interaction'.

The communicative approach can provide a tool for understanding meaning. By looking at a patient's encoded communications, one can hope to find out what is taking place in the therapeutic interaction. Langs stresses the analyst's responsibility in the therapeutic process and feels that analysts often hide from their contribution to their patients' states: even their jargon has defensive qualities with words such as 'regression' and 'transference'.

For Langs the psychotherapeutic space is very special and unlike any other and a session is an emotionally charged space which needs very specific boundaries. He calls these 'ground rules' and they include: a single setting in which the therapist sees the patient (not a clinic or his private residence); a single, unchanging fee and a set time and exact length for each session. In addition, there are other advised ground rules, such as advising the patient to use the couch and to free associate, the therapist sitting out of sight with a relatively neutral and anonymous approach; total privacy and total confidentiality (Langs, 1988: 136).

It is the therapist's responsibility to arrange the frame and Langs feels that silent holding and a secure frame are the most powerful therapeutic tools we have and that analysts overestimate the value of interventions. He points out that even when there are lengthy periods of flat, empty sessions, it can still mean the patient is benefiting from the secure holding of the frame.

The main aim of a communicative analysis is to analyse the derivatives of the unconscious and to create an environment in which the unconscious can express itself as freely as possible. This is not done through 'transference' as in classical technique (Langs talks of non-transference) but through looking at the patient's exquisitely tuned and accurate perceptions of the other and the emotional implications of the here and now reality in the therapeutic interaction. These are not based exclusively on the patient's infantile past.

In communicative therapy, the patient expresses what unconsciously comes to mind about the therapist in reporting dreams, memories etc. but, when so called 'transference' behaviour emerges, it is felt that the therapist has behaved in some way to merit this. The unconscious has a rather different function here: in communicative analysis it is thought to be accurately perceiving, whereas in classical psychoanalysis it is seen to be distorting.

Boundaries in a psychotherapeutic relationship are a direct descendant of the incestuous relationship. To Langs, the deep unconscious system is very, very sensitive to ground rule violations: deviations are powerfully sexually driven and every deviation is an act of madness. A clinic might be flourishing but the fact that a client shows deviant behaviour reflects on the therapist's mismanagement of the frame (even if it is unavoidable) and it should be communicatively confronted as such.

Where a deviant frame is inescapable, as in most clinics, the effects are apparently less detrimental than when a therapist in private practice 'knowingly chooses to alter a ground rule' (Langs, 1988: 144). However, if one does achieve a perfect frame, one comes closer to transference than in any other way. It is only by feeling really safe and held that a patient can expose his madness: life and death issues emerge together with the most primitive phobic, persecutory and separation anxieties.

Langs feels that the analytic setting is like the maternal space only up to a point. It is principally based on a parent-child exchange but with its austere boundaries it is more reminiscent of oedipal taboos. Langs writes of 'secure frame sensitive' patients (1988: 141) who have had deep and early traumas and deprivations. These individuals cannot stand the rigidity of his ideal secure frame. Perhaps it was just this (borderline and psychotic) class of patient population for whom Winnicott was trying to extend analysis to make it a possible experience. Langs' frame seems ideally suited to Freud's classic oedipal patient whose main difficulty is relating in the three-person world.

For those who can thrive within the strict holding of the communicative approach, the therapist knows when he gets it right by the patient's validation of his interventions. He does this with positive derivatives and 'with sound, valid, and telling unconscious perceptions that are selected from the universal implications of a particular intervention in terms of the patient's own madness' (Langs, 1984–1985: 5). He goes on to say that 'validated interventions cause their own difficulties in the emergence of disturbing aggressive, sexual, self-demeaning regressive and primitive perceptions of the therapist by the patient' (Langs, 1984–1985: 15). Hence, therapists often avoid valid interventions as they arouse such unease.

Langs' preoccupation with the frame and the analyst has led people to criticize him for being unaware that there is also a patient in the room. But he says the adult/parent/analyst has the main responsibility. He does not deny the patient's role because we are not slaves to our parents or our history. However, he is very aware that traditionally, starting with the history of psychoanalysis and Anna O., the analyst's responsibility has been denied or minimised. Langs feels that it would not have been possible to start psychoanalysis without the denial inherent in transference but the communicative approach attempts to redress this bias in analysis.

For Langs a secure frame is the essence of successful therapy and he blames many failures of analysis on the analyst. According to him, analytic failure is not due to a patient's illness/resistance/defences but is due to therapist madness in unacknowledged violations of the frame which inevitably come up in the patient's unconscious encoded derivatives and are ignored.

Langs writes cogently on the necessity of working as a consistent and dependable therapist within a secure frame but where is his warmth and humanity? In this writer's opinion one does not really get a sense of him as a clinician, only of his boundaries.

Summary and Conclusions

Starting with Freud's gradually increasing emphasis on the importance of providing a safe atmosphere in the analytic setting, I have looked at how the concept of the frame has evolved in psychoanalysis. I have described how three more recent theorists, each placing a more explicit emphasis on the frame than Freud did, have used the frame and setting in rather different ways. Although, to a greater or lesser degree, Winni-

cott, Khan and Langs all believe in the analytic encounter as an interactional process, the interpretation and results of this encounter are viewed somewhat differently.

Personally, I think the frame that each advocates is aimed at rather different patient populations. I feel that Winnicott and Khan are aiming for the pre-oedipal nurturing and inequality of the earliest parent-infant relationship (Winnicott as mother, Khan as father), and Langs' frame, harking back to a boundaried classicism, I would see as more appropriate to the oedipal struggle.

There are, obviously, countless ways of structuring the frame. I have chosen to discuss the work of three clinicians who have consciously attended to the issues involved in the symbolic significance of the analytic setting. They have each come up with different answers which suit their own particular limitations and styles but, nonetheless, also succeed in extending the frontiers of psychoanalytic thought and practice.

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SHAME, GUILT AND COUNTERFEITING

SIMON ARCHER

Introduction

I want to look at shame and the way that the idea of 'counterfeiting' is linked with it. I will try to do this by reviewing some theoretical approaches. Then, using the plot of a contemporary novel, along with some material from analytic work, I will try to illustrate some of the consequences of unconscious shame.

Shame and the structural theory

When Freud attends to the idea of shame within the Drive Theory he usually links it with the repression of a sexual-exhibitionistic drive: It is a 'Damn against sexual excess' (1905). With the elaboration of the Structural Theory this then takes the form of the superego causing the ego to censor the expression of the drive, shame being the resulting defence.

Revisions have tended to regard this as an inadequate account of shame. Pines (1987), suggests that self-analysis as practiced by Freud was unlikely to be conducive to the discovery of unconscious shame: The 'I' that is within us is too easily misled to enable us to see what we do not want to own. Pines proposes that psycho-analysis has had difficulty encompassing shame because the Drive Theory reduces affects to drive-discharge phenomena, and that because shame cannot be so reduced it thereby became almost invisible within classical theory. Perhaps another reason is that the classical psycho-analytic arrangement, with patient reclining and face invisible to the analyst, obscures the usual shame-reaction of averting the eyes (an infantile-magical idea that if one cannot see the other then one cannot be seen).

Following Freud, writers such as Erikson (1950), incorporated shame within the Structural Theory of Id/Superego development as being, like guilt, a part of conscience. Conscience had been regarded as arising, like guilt, at the oedipal stage when the child attempts to master the sense of helplessness caused by castration anxiety, by identifying with an internalised parental aggressor. Erikson makes a clearer

separation of shame from guilt by proposing that shame arises out of conflicts around what he calls the stage of 'Shame versus Doubt and Autonomy' in which the child attempts to master feelings of helplessness. So, in ordering itself about, for example, the pre-oedipal child masters passivity by identifying with the 'aggressor' parental figure. This internalised voice later merges with and affects the developing superego.

Miller (1989) suggests that there are hints that Freud himself sometimes thought of shame in a different way. She refers to Freud's well known idea of shame as a particularly feminine characteristic; a defence against what Freud calls 'genital deficiency'. Also, Freud's explanation of the Wolfman's aggressive fantasies are that they are an active compensation for his unconscious feeling of passive helplessness. Miller believes that in each case shame is being dealt with by Freud as if it were an *affective state*, (rather than a defence), connected with an awareness of vulnerability and helplessness, in which the self-image of the subject is threatened. In the case of the Wolfman this gives rise to defensive, object-directed aggression which causes an overlay of guilt.

Kinston (1983) suggests that in the *Interpretation of Dreams* where Freud (1900) takes a dream of the unhappy wanderer to illustrate shame, Freud is actually putting shame (to quote Kinston), 'beyond the pleasure principal'; as *not* to do with repression of a sexual drive. The wanderer is naked, exposed and wishes to hide. Kinston believes that Freud is describing the effect of narcissistic trauma in which the subject desires approval but experiences negative valuation.

Chasseguet-Smirgel (1985) takes up various direct or indirect references to shame made by Freud which also indicate that shame is being regarded as if it were an affect indicating anxiety due to threatened narcissistic equilibrium. For example, Freud refers in 'On Narcissism' (1914) to 'social anxiety' as being due to a loss of the external love which feeds narcissism. Chasseguet-Smirgel says of this, 'The loss of love, to the extent that this is equivalent to a loss of esteem ... may result in very particular affects (that we all experience to some degree) that have been linked to shame.'

Revisions of the Freudian model of shame

Among others, Erikson (1950), Chasseguet-Smirgel (1985), Kinston (1983), Miller (1989), Mollon (1984), Pines (1987, 1990), point to evidence from their own work and from the literature, that shame

emerges as a key factor in *pre-oedipal* development at a time when the infant struggles internally with narcissism, self-scrutiny, development of the Ego Ideal and the recognition of the other. For example, for Pines it is the mirror stage in which 'the child begins to recognise that he/she is now an object in a world of other objects, visible in a world of other visible persons, and that he/she can therefore be the object of the scrutiny of others in a disappointing or critical manner' (1987). Revisions have tended to shift the emphasis away from Freudian structural theory on the grounds that it has not been sufficiently able to distinguish shame from guilt. There has been a questioning of the Freudian idea of shame as a reaction-formation and a shifting of the proposed origin of shame into a distinctly pre-oedipal period of development. Crucially, re-examinations of shame have led to a new view which sees shame not as a defence but as an affective state which gives rise to defences. More specifically, as a *signal anxiety* which will activate particular sorts of defences. These may be temporary manoeuvres or, more drastically, defences which may lead to permanent character pathology.

Kinston (1982) defines such manoeuvres as 'object-narcissistic', object-narcissism being a primitive object-relationship in which separateness is denied. In this state 'the object is destroyed and the emotional dependent needy part of the person is deprived of support and nourishment.' For Kinston shame is the signal anxiety which indicates that the subject is experiencing the presence of an unconscious negative self-image. This causes a disturbance in on-going narcissistic equilibrium which in turn will cause the subject to try to move from a state of too-painful self-scrutiny into a merged object-narcissistic state. By so moving, emerging shame is abolished but at the cost of loss of autonomy. A move by a patient into a merged state with the therapist can, therefore, be the signal of anxiety and of the presence of unconscious (or conscious but concealed) shame. A permanent move into a merged object-narcissistic state allows the subject to be *shameless*. This is the state of refusing to allow feelings of shame into consciousness, the consequence of which is that the subject will feel 'in control' (of his objects) but at the cost of not feeling truly joined up with himself or with others in any meaningful way. This state is precarious as the split off negative self-images will permanently threaten the subject's equilibrium.

Kinston directly links the origin of excessive shame reactions and consequent defences with a repetition by passive-into active means, of trauma caused by the impingement of narcissistically disturbed parent-

ing upon the relatively helpless and immature infant psyche. Placating and the formation of temporary or permanent false self moves or structures are therefore to be regarded as a particular form of *identification with the aggressor*, the aggressor in this case being a narcissistically impinging parent who imputes negative value to the infant. Kinston clearly designates the dynamic site of shame as an *inter*-psychic one which is then internalised as an *intra*-psychic *object-relationship* by the infant/child.

Chasseguet-Smirgel (1985) extends Freudian theory by expanding his concept of the 'Ego Ideal'. She too re-defines shame as an affect rather than as a defence while retaining Freud's theoretical link with cathexis, libido and the drive theory. The ego ideal originates in, and emerges out of primary narcissism in which the self is taken as its own ideal. The development of the ego is a move away from primary narcissism and this causes a rift between the pleasure principal and the reality principal in that the pleasure principal would insist on the shortest route to gratification in a return to primary narcissism while the ego insists on a move towards the reality principal. This is the 'narcissistic wound', the pain of which the individual will seek, via the pleasure principle, to avoid by means of a return to primary fusion.

The Ego Ideal is created in order to mediate between the two polar opposites of the pleasure and reality principles. The unconscious regressive libidinal force of the Id is 'bound' by the ego ideal which is then able to drive the individual forward by displacing the regressive wish for a return to primary narcissism onto ever more complex identifications with external objects. This displacement causes self-narcissism and 'primary megalomania' to be slowly replaced by object-love. The mother's developmental task 'is to bring the child to project his Ego Ideal onto successive and ever more advanced models. Frustrations and gratifications, correctly applied, should encourage the child to renounce certain satisfactions which go with the aquisition of specific functions and a specific way of being, so that he may acquire new ones. Each phase of development must bring with it gratification enough to counteract any desire to turn back, and frustration enough to urge him onwards rather than halt his evolution through fixation' (1985).

In adulthood we maintain our sense of ourselves via the 'mirrors' provided by the presence of our peers. Because our sense of ourselves is intrinsically fragile and because we have a tendency to hide from our ego that which is contradictory to the ego ideal, 'we fear being seen by our peers in situations that are narcissistically unsatisfactory'

(1985). The mirrors of our peers represent the psychic ego that sees us as we are and not as we would like to think of ourselves as being. The unconscious ego ideal pushes development ahead through the oedipal stage via intermediary stages including homosexual identification with the same gender parent. Normally, as the ego ideal carries the individual foreward into adulthood, this homosexual libido is 'bound', desexualised and displaced onto ordinary social relationships. The approval that we seek is exhibitionistic: 'the wish to receive narcissistic confirmation from one's peers (to diminish the margin between the ego and the ego ideal) leads the subject to exhibit himself to them. If this exhibition fails to ensure such satisfaction (if a narcissistic injury or a "social humiliation" results) the resexualisation of homosexuality renders the narcissistic injury equivalent to castration' (1985). The resexualisation gives rise to the signal anxiety of shame as the individual feels defeated, passive and small.

If there is an unconsciously perceived discrepancy between the mirror and the ego-ideal then shame anxiety will be the signal. This view differentiates shame from guilt: 'whereas guilt is aroused when a limit (established by the superego) is touched or transgressed, shame arises when a goal (set by the ego ideal) is not reached. Shame accompanies defeat, guilt transgression' (1985). Chasseguet-Smirgel particularly explores the effects of maternal seduction and overstimulation in the production of perversion. What then of the effects of de-valuation via narcissistically disturbed parenting? The ego ideal contains the idea of unconscious 'hope' and of forward moving development. This is re-enforced by the maternal environment. Therefore one would expect that in situations where there is in the parent an impoverished ego-ideal imbued with little hope, and a need for the child to reflect the parent's damaged ego ideal, that the effect on the child would be to produce a fragile surface development with counterfeit oedipal identifications, a strong underlying wish to return to primary narcissism, with accompanying hopelessness and unconscious shame. This is the situation I will describe later.

It is noteworthy, given the links between shame/need for recognition/self-image/seeing and being seen, that individuals coming from situations in which there is deprivation of positive valuing, use 'excommunication' (putting out of sight), as a punishment for betrayal of loyalty. With certain patients one hears frequently of family members who have been shunned for months or years. In the family backgrounds and internal worlds of such patients one finds counterfeit relationships which can appear as loving but which are actually narciss-

istic protection rackets designed to ward off shame and negative self-images. These structures are based on ensuring that the truth is not seen. The price for betrayal of this rule is the psychic equivalent of a mafia killing. This applies inter-psychically in that the other is annihilated, and intra-psychically in that a seeing part of the self is destroyed.

Fusion of shame and guilt

In everyday life, shame and guilt become fused and confused. It has been pointed out, particularly by Erikson (1950), that this happens because it is an ordinary developmental tendency for shame to be submerged by guilt and it is therefore hard to distinguish them retrospectively. Miller clarifies this by suggesting that it is probable that there is subsequent fusion and confusion over shame and guilt because of the difficulty of retrospectively discriminating between various pre-verbal or only-just verbalisable affect states. These affect states derive from a stage of development (separation-individuation) in which the dichotomies 'good/bad' and 'right/wrong' tend to be interchangeable in the parent-child interaction, so that 'bad' and 'wrong' can *feel* equally applicable to shame concerns or guilt concerns.

This might be illustrated in the following way: If we think of observing a child in a shop reaching for an object and dropping it, he may feel and be made to feel a shameful sense of loss of control, smallness and inadequacy; a sense of 'I am wrong'. The parent's own infantile shame is aroused and is projected into the child. This meets with, and re-enforces the child's already internalised shaming object. At the same time the child may feel, or be made to feel a guilty sense of having caused anger in his parent; a sense of 'I am bad'. A subsequent attack by the parent may increase the spiral of shame-guilt anxiety in the child as it struggles with the two issues of loss of control and fear of loss of the caring object.

Miller and Kinston try to pinpoint the way that within psychoanalytic theory, confusion and fusion of shame and guilt might be caused partly by Freud's attempt to contain shame within the structural (ego/superego) model. Miller and Kinston each draw extensively on Erikson's ideas about shame being an issue around control/loss of control. Miller states that Erikson's view is that 'personal and interpersonal circumstances that thwart the early growth of self-esteem will lead to internal events that can be characterised as *superego* developments, or developments of *conscience*. Since the conscience or superego

is the agency that generates guilt (whenever its dictates are violated), excessive growth of conscience results in predisposition to guilt feelings' (1950). Miller cites a body of psychoanalytic literature which supports a view of shame as a signal anxiety about the state of the self and that distortion of narcissistic concerns early on will contribute to a particularly punitive superego. This will be caused by the individual's attempt to avoid passively accepting shameful feelings of helplessness in the face of exposure to a harsh, internal, critical voice. Action (psychic or actual) is used as a means of defence which causes guilt and the further re-enforcement and internalisation of a punitive object which makes up the superego. Miller believes that to retain the dynamic development of shame within the Freudian structural will lead to an over-valuation of guilt related issues and an under-valuation of shame related ones.

Shame-guilt cycles

Revisions which place shame in the area of narcissism propose that it makes sense to consider two separate lines of development: the lines of narcissism/ego ideal and of id/superego development will continually interact with each other in infancy and that these interactions will manifest themselves in adult behaviour, in character formation and in the transference (and countertransference). Miller emphasises that even assuming a separate line of development for shame, the dynamics of shame can have an influence upon the development of the superego: severe narcissistic disturbances which mobilise equally severe defences against shame will contribute to disturbed superego development. In other words, poor self-image, due to the presence of unconscious, potentially shame inducing negative self-images will not build an internal world which will help the individual encompass later issues around guilt.

Kinston and Miller detail the way in which individuals who have problems caused by the presence of negative self-images (which may be denied or split-off from consciousness) will feel a continual sense of helplessness. Both authors unravel the submergence of shame by guilt by proposing that there are shame-guilt cycles in which the infant/patient tries successfully or otherwise to move from a passive, helpless and therefore potentially shameful state of 'being done to', in which ongoing narcissistic equilibrium is disturbed, into an active, aggressive state of 'doing'. Kinston summarises that the classical view of these cycles is that they arise from an instinctual impulse which

'leads to guilt and inhibition; passivity and inaction generate feelings of inferiority and shame; these evoke acting out which in turn lead to guilt' (1983). Kinston and Miller each offer an alternative view: emerging shame arises out of disturbances of ongoing narcissistic equilibrium due to the presence of negative self-images. Passivity and helplessness may be avoided by means of destructive, defensive attacks upon the seeing object, causing guilt, fear and further re-enforcement of helplessness and of the negative self-image leading to further shame, and so on. In the transference the move from passivity to action might mean a sudden attack upon the therapist. In this way paralysing guilt/shame cycles can arise. In these cycles two separate lines of development are interacting in a way that is particular to the separation-individuation stage but it may be possible to make a differentiation in the clinical setting between the two lines. Miller says 'Shame and guilt presumably are *different* experiences, with shame aroused when personal authority is minimal and guilt when it is used sadistically' (1989). If shame-guilt cycles are ignored then, as Mollon says, 'A therapeutic stance that is oblivious to the pervasive role of shame in narcissistically disturbed patients may tend to provoke a sado-masochistic relationship and a therapeutic stalemate in which the patient is constantly struggling to master narcissistic injuries unknowingly inflicted by the therapist' (1984). Mollon's point is that if the underlying strata of shame due to negative self evaluation is not attended to, then the therapist, whose interpretations may be felt as diminishing 'attacks', may inadvertently cause the patient to react defensively with hostility. A situation that can become intractable in which a shame-guilt cycle is perpetuated in a repetition-compulsion without insight by means of an unconscious sado-masochistic relationship in the transference and counter-transference.

Shame, humanity and evil

Other than by attacks upon the object, potential shame can be avoided in character-formation, and in the transference in various ways. Kinston lists, for example, deadness and idealisation. These defences have the purpose of removing the individual from sight. They serve to deny, subvert or annihilate the presence of the seeing other (the projected version of the internalised seeing 'I'). They include such things as hiding, camouflage or concealment (wishing to disappear from the internalised seeing other); trance-like states in the transference

(attempts to prevent oneself thinking about oneself and to prevent the therapist thinking about one); lying (attempts to deceive oneself and the other); perversion (attempts to avoid proper but too threatening intercourse with the other); fusion with the other (denial of the other-as-other); placating and false-self character formation (denial of one's true-self needs in the face of the narcissistic demands of the other).

Kinston, like Winnicott, says that in development the care-giver will not always be good enough. A degree of shame will be inevitable because in parenting there is bound to be a necessary degree of socialising by means of coercion. Any child is bound to feel at times a sense of discontinuity between its spontaneous gesture and the wish of the parent. I would add that there will also always be some degree of projection into the infant/child of unwanted, negative self-images by the parent (in ordinary development this also happens the other way round in that it is commonplace for children to feel ashamed of their parents for no justifiable reason as they struggle with ownership of their unwanted negative self-images). In disturbed development almost perpetual discontinuity in this sphere will lead the infant to construct ways of surviving psychically based largely upon placating and denial of true-self needs. The consequences can be, for example, obsessive-compulsive formation as the individual tries fruitlessly to control the self and the feared, internalised other, or a sense of alienation, deadness and psychopathy, hidden or overt. It is interesting to see that Greenacre (1952), writing about the psychopath's ability to fake emotions, notes what she calls the 'special negative narcissistic relation to the parents' in which the child, instead of being specially favoured is regarded by them with shame.

Shame is linked with our humanity. It is the signal anxiety that tells us all is not well inside ourselves and in relation to the other. It is the force which socialises us in that we use it to regulate our dealings with our inner selves and with others. It is the denial or avoidance of shame which makes us inhuman, ruthless, callous and evil. In an intrapsychic system in which shame is denied and cannot therefore be used constructively, there is no internal democracy of selves which can bear witness to each other, using shame as a regulatory mechanism to adjust the self in relation to the other. Without shame there is a tendency towards the sort of internal organisation described by Bollas (1991) as a 'fascist state of mind' or by Rosenfeld (1987) as an internal 'gang' which rules by denial, perversion or coercion.

Pines and Kinston indicate that shame is a very powerful force therapeutically for humanising the individual whilst distortions leading

to excessive or rigid defences against it can lead to de-humanising characterology and actions. Pines (1990) emphasises the socialising aspects of shame. He views shame and guilt as 'signals, affects giving us information about our social connectedness, about our limits and boundaries;' that shame tells us 'that we have failed to earn our self-respect and therefore feel exposed to and invaded by the higher aspects to which we aspire ... so as an essential guide to social living shame makes us aware that what we do and how we appear to others matters'. For Kinston 'Unlike the guilty act for which one can make confessions, expiation, penance or reparation the shameful act requires an alternative of the person. The person thinks "I cannot have done this. But I have done it, and I cannot undo it because it is I". Shame is provoked by our experiences which question our preconceptions about ourselves and compel us to see ourselves and society: it is a necessity for personal growth.' He adds, 'Shame is the signal experience that the individual, faced with painful awareness and still with the capacity to relate meaningfully to another, wishes to abandon this and to adopt a state of mind which is essentially evil, that is to say, characterised by a denial of all that is human: need, dependency, conflicts, meaning, imperfection' (1983). Kinston points out that Erikson specifically links shame with evil. Kinston says that defences against the emergence of shame can lead to the dehumanising of the self and others. Kinston emphasises that the same identification can lead to the robotic and inhuman treatment of others as well as the self, and cites the Nurenberg defence of 'I was under orders'. One might therefore characterise the Nazi system with its atrocities, its attention to detail and its ideas of control and perfection, as an evil, obsessional *offence* which defends against unconscious shame. Miller emphasises the way in which an attempt to escape from a painful shameful identification with an over-controlling and over-critical parental figure can lead to a dehumanisation of the self via obsessive-compulsive defences in attempt to seek illusory power and perfection. The self becomes a non-autonomous robot.

Shame and guilt as two sets of internal dramas

I will now try to summarise shame and guilt as two interacting internal dramas:

On the one hand there is what could be regarded as self-maintenance in the face of needs *for* and the needs *of* one other in which a dyadic

relationship is internalised which contributes to the development or distortion of self and self-image. Loss of self-continuity is a real threat. The parent-other that is internalised becomes the shaming mirror-I that *sees* approvingly or disapprovingly. This potentially shaming Other-I may be perverted, subverted or annihilated. This is the realm of Shame. Envy, being dyadic in its dynamics, goes with shame. Shame is to do with who we know ourselves to be. It is primarily self-referential and is caused by the activation within the individual of the presence of negative self-images. An ability to encompass shame allows the individual to re-assess and change his *total* relationship with his self and the world. The avoidance of shame can lead to the omnipotent *annihilation* of the seeing-object as once more the self is taken as the object. This annihilation leaves one shameless, but with an unconscious awareness that one has obliterated the seeing-object leaving one alone, alienated and internally dislocated. There is an unconscious sense of loss, both of the object and of a part of the self which is that internalised seeing-object. Failure to allow shame can lead to permanent sadistic attachments or to detachment. When the true self needs are given a negative connotation, originally by the parent and then internally by the individual then there will be a denial of vulnerability and of these true self needs. A wish to disappear (merge into primary narcissism) and to hide are the concomitants of unconscious shame.

On the other hand there is the maintenance of Self and one Other who might be lost to, won, or stolen from yet Another, in which an internalised triadic relationship contributes to the development of self-other images. Loss of self-other continuity is a threat. The internalised Other can become a partner in crime with the second Other judging, and either or both of these Others can become an ally in the service of eventual separation from the triad. Either or both of these Others can be seduced or attacked. This is the realm of Guilt. Jealousy, being triadic, goes with guilt. Guilt is to do with what we know we have done. It is primarily other-referential and is caused by the activation within the individual of the presence of fear inducing *self-object* images caused by a *sadistic attack* upon the object. The ability to encompass guilt allows the individual to repair his temporarily damaged self-object relationship. Failure to encompass guilt, due to the denial of sadism, will lead to a permanent state of anxious attachment to the object, with depression, or manic attempts to repair the object and there is a constant fear of punishment by the object. An unconscious wish for punishment, as Freud (1916) observed, is a concomitant of unconscious guilt.

Such a framework allows one to think not only of oedipal issues but also of the possibility of underlying issues to do with negative self-images.

Some very disturbed patients are adept at counterfeiting 'normality' and will pass themselves off as 'neurotic'. In order to fit in with a world to which they do not really feel attuned these people develop, early on, a highly defensive false self organisation. John LeCarré's novel *A Perfect Spy* (1986) is a vivid account of one such character. It may be viewed as a dramatic representation of the consequences of an internal world dominated by aspects of shame.

Here is the plot: Magnus Pym has all his life been a spy. He has disappeared from Vienna along with secret documents and is hiding in England under a false identity in a lodging house which he has periodically used as a bolt hole from which to escape his tortured relationships. This time he is on the run because the edifice upon which he has built his entire external and internal life is about to collapse. Magnus's father has recently died. Three people who depend upon Magnus for their own survival are racing to try to find him: Mary, his wife; Jack, the intelligence officer who runs Magnus; and Axel, a Czech double-agent who is inseparably tied to Magnus.

At the start of the novel Magnus is about to commit suicide and is writing an explanation of his life for his son. The rest of the story is told in the form of flashbacks, beginning with an account of how his father, Rick, and his mother, Dorothy, met. The novel ends with Magnus's suicide.

Mary, Magnus's second wife, does not know where her husband is and LeCarré takes us into the heart of her sense of desperation and confusion as she senses that her world is about to fall apart. Mary's sense of panic and loss is an active repetition by Magnus of his own, early, overwhelming trauma.

Magnus's father, Rick, is a flamboyant con-man; a vividly drawn character whose emptiness and narcissism are clearly portrayed. This Dickensian character speaks throughout only in empty clichés and mottos; 'I'll see you right' being his main watchword. Entrusted at the start of his criminal career with the church funds, Rick secretly 'invests' the money. As an insurance policy lest he should be exposed, he has seduced and made pregnant, Dorothy, the gullible sister of the Preacher who is, ironically, a Justice of the Peace. When cornered Rick avoids exposure and shame by threatening to expose, and shame the preacher.

Magnus is born into an insane, narcissistic world in which truth or goodness of any kind is blurred or obliterated. As if to dissociate

himself from the terrible pain of his childhood, the early part of it is described in the third person. Shengold (1989), has remarked on the tendency of writers who have themselves had traumatic childhoods, to use this device and on the way that some patients in analysis will also switch into third person narrative when there is a trauma present. This can also be seen as a remnant of the child in the separation-individuation stage who struggles with the ownership of self-images by referring to himself in the third person. Magnus therefore becomes young 'Pym', at the mercy of an utterly self-centred father and an incapably depressed mother who soon goes mad and is taken away to an asylum, never to be seen again.

The so-called 'court' where Rick is King and Pym comes to see himself as a Prince, consists of a group of unscrupulous racketeers always on the look-out for someone weak-minded enough to invest money in one of Rick's many 'enterprises'. In this world there are no moral guidelines, no positive values imparted by the parents and no boundaries to help the boy form a positive core-identity. Magnus later says of Pym's world, 'In paradise when Rick was in Residence there was no night and nobody went to bed. Pym could join the festival any time he chose.' Pym learns very early the impossible task of pleasing these parents by suppressing all signs of his own true self needs. He spends his life searching for a loving father and a loving mother but, of course, is too damaged to be able to love.

Pym goes away to a third-rate, sadistic private school where he feels an outsider but longs to fit in wherever he can. His disownership of his own needs and feelings is by now almost automatic and he is willing to bear any punishment or humiliation in order to find someone who will notice and value him. In his chameleon-like ability to please whoever he is with at the time, he makes relationships with both teachers and boys, adopting whatever views or ideas seem to be required of him. He sees early that he must sometimes betray one of his 'friends' in order to please another. Pym begins to construct a fantasy world in which he can escape and join the mother he longs for. A succession of 'Lovelies' replace his mother and for a while each one of them appears to be what the boy is looking for. He longs to have one of them for himself. Later, he makes an attachment to one of these women, a kind German refugee who is appointed as a sort of nanny. Herself a victim of terrible losses, she sexualises her relationship with Pym. She becomes disturbed and commits suicide. Once more Pym experiences devastating loss. He fantasizes about suicide but deals with his helplessness by constructing an omnipotent, alternative self

in which he is 'God and Hitler'. It is at this point that Pym is drawn irrevocably into the external and internal gang when he makes himself feel powerful by dedicating himself to his father's 'mission' to 'put the world to rights'.

This woman remains in Magnus's mind as a kind of dream, a sexualised version of his mother. His eventual suicide is an active repetition of this loss of Lippsie; his wife and son are the passive victims of this repetition. In his distress over Lippsie's death he falls into a trance-like state and, in an identification with his hero at the school he carves this boy's initials in a door and it is the hero who is punished. When his hero rails against the culprit, Pym promises to help him kill the perpetrator. Magnus says of Pym, his boy-self, at this time: 'Like Rick he was learning to live on several plains at once. The art of it was to forget everything except the ground you stood on and the face you spoke from at the moment. ... He learned the great lesson of Rick's example, namely the importance of a respectable appearance. ... He developed his determination to be a secret mover in life's events.'

Pym is called back from school by father to a meeting of the 'court'. Rick's latest 'lovely' is a self-proclaimed aristocrat who has persuaded Rick to help her recover some valuable family property in Europe in return for a cut of the profits. This woman needs money to arrange the deal and Rick agrees to provide it. Because he has learned German at school Pym is sent to Switzerland on this bizarre mission. He is excited by this, his first clandestine task. He is to hand over the money in return for the goods. Rick does not realise that he himself is being swindled by an accomplished confidence-trickster. Once in Switzerland Pym is relieved of Rick's money by the phoney baroness and her accomplice. He is left stranded and penniless. He decides to try to break away from his father. For 'cover' he enrols at the university in Bern and concocts for himself a false cover as a law student, making his father believe he will later join the Court as a lawyer.

Next Pym meets two people who are to have decisive influence over the rest of his life. First he meets Axel. Axel is a refugee, lost like Pym. His family and his home town have been destroyed in the war. Pym and Axel are living in the same lodging house owned by an eccentric and warm family (more echoes of Dickens). Axel is confident, clever, has a sense of humour and is a success with women. Everything that Pym is not. They meet and Axel takes to him. This is the only period of Magnus's life when he feels happy. Axel and Pym become friends but given that Pym hardly knows what friendship is, all he can

do is try to ingratiate himself with Axel. At Christmas Axel provides hand-made, carefully thought-out gifts for everyone while all Pym can think of in an imitation of his father is a box of cheap cigars.

Pym then meets Jack Brotherhood. Jack is an older man who is on the lookout for recruits for the intelligence services but Pym does not realise this until much later. Jack pretends to like Pym in order to recruit him. Pym, as always, is desperate for someone who will care for him. Pym fabricates a version of himself which he thinks will please Jack. 'In a single Christmas, God had dished him up two saints ... Both admired him, both loved his jokes and his voices, both were claiming to occupy the empty spaces of his heart. In return he was giving to each man the character he seemed to be in search of. ... What version of himself Pym supplied that day, and had to live with for the coming months, I do not remember. As best he could, he gave you what he thought you were looking for.'[1] Eventually Jack asks Pym to provide information about communist student groups. Pym is excited by this and his life as a spy begins. Soon, in a test of Pym's loyalty, Jack asks Pym to tell him everything he knows about Axel. In an echo of the plot of Joseph Conrad's *Under Western Eyes*, Pym betrays Axel (thereby removing his rival for the affections of the family) who is taken away and deported. Pym knows that the information he gives Jack may damage Axel but he needs to please his substitute father, Jack, and he has already learned to compartmentalise his mind so that he can avoid knowing exactly who he *is*, a betrayer, thereby by-passing any shame. (He avoids knowing what he has *done*, thereby by-passing guilt).

Pym returns to England. Rick's 'court' now calls itself 'The Firm' and this title is an ironic parallel with the other organisation, the Intelligence Service, also known as 'The Firm' which Magnus later joins. In an attempt to provide himself with spurious 'cover' Magnus's father Rick tries to legitimatise himself by standing for parliament (as a liberal!). At this point Pym, who is drawn into aiding his father's campaign, is faced at a public meeting by what he has always known but has chosen to un-know: A woman in the audience speaks out and exposes his father as a swindler. She appeals to Pym for help and wanting to please her, Pym provides her with evidence which leads to

[1]In Norman Mailer's (1991) disturbing novel 'Harlot's Ghost', (1991) about the fictionalised life of a C.I.A. agent, there is a passage about the methods used to recruit spies: 'Identity is no more than how we perceive ourselves. To become an agent, therefore is equal to assuming a new identity. But note; with each change of identity, we are born again, which is to say that we have to take another voyage through childhood.'

one of Rick's many brushes with the Law. Rick is not elected but carries on regardless. Pym secretly betrays his father but in his split mind he also remains loyal to him.

Magnus joins the army. Because of Jack's influence he joins army intelligence. He is sent to Austria where he is contacted by Axel who has risen in Czech army intelligence. Axel contacts Magnus because he knows that the situation in the post-war communist block is unstable and he may need help one day. (Axel does not want to defect. He, unlike Magnus, has a genuine belief in his country but conceals his lack of faith in the communist system.) Magnus vigorously disavows his betrayal of Axel and their meeting is ecstatic and child-like as they plan a future based entirely on deception. Axel arranges to provide Magnus with information which will assure Magnus's eventual rise through the ranks of the British Secret Service. Magnus says to Axel, 'Axel – 'I've done it! We're free. We've put the world to rights, exactly as you said we would! ... we have founded our own country with a population of two.' The plan succeeds and Magnus is noticed by his superior officer. Things get difficult for Axel when his bosses begin to question his work. In order to escape exposure he persuades Magnus to provide low-level intelligence from his side so that he can ensure his own survival and himself rise to a position of security. Thus, Magnus and Axel become partners in a double deception.

Magnus returns to England where he is formally recruited into British Intelligence by Jack who has heard about his work in Vienna. Magnus is sent under cover to Czechoslovakia. But, as a real spy he is incompetent and is arrested by the Czech authorities. Axel has found out about him, and it is he who takes Magnus in for questioning. For the benefit of his superiors Axel pretends to interrogate Magnus. Axel has had a hard time through various communist purges but has managed to survive. Axel arranges for Magnus to be released and persuades him to continue their previous arrangement (Magnus is always passive/compliant, never actively instigating anything.) Magnus returns to London with valuable 'information' from Axel and is soon promoted to Station Head in Vienna from where he runs an entire network of fictitious spies concocted by Axel. Axel also rises rapidly to a position of power and security. Jack Brotherhood's superiors (but not yet Jack, who cannot afford to suspect because his own career has been built upon the success of Magnus's non-existent spy network) begin to think that there is something wrong. Magnus realises that the game will soon be up.

Meanwhile Magnus's father has become decrepit and dependent,

turning up inappropriately at all sorts of crucial moments facing Magnus with shameful reality behind the illusion he has created for himself about his own concealed origins. Rick dies in a hotel in Berlin where he has come to pester Magnus. Magnus's world is about to collapse and as he has always done, he escapes from shame and self-awareness into suicide, taking revenge, as he does so, on all those who depend upon him.

Identification and self-image

As Magnus's life unravels, crucial pieces of the jigsaw that is his life are exposed. We learn about the way that he is identified with his father in a way that makes it impossible for him ever to have developed a positive self-identity. This identification allows him to escape painful rejection by a father who would otherwise condemn him as disloyal. When Magnus receives the news of Rick's death, Mary, his wife, cries but he does not. Magnus says he is 'free' after Rick's death but this is an illusion. He cannot escape because he is his father. Similarly, earlier, when his father is taken away by the police 'A great calm descended over Pym. He felt refreshed and freed of an intolerable burden.' But the loss of his father is the same as the complete loss of his own identity and cannot be tolerated. Struggling constantly with an internalised negative father from whom he cannot separate Magnus says, 'Rick should have died when I killed him.' Completely fused with his father Magnus responds to Rick's decline with horror and impotent rage: 'Get off me damn you, I whispered. What death was I wishing you? All of them by turns. Die, I told you. Do it on the pavement where everyone can see. Stop adoring me. Stop believing in me. Did you want money? Not any more. You had waived your claim to it in favour of the greatest claim of all. You wanted Magnus. You wanted my living spirit to enter your dying body and give you back the life I owed you.' When Rick finally dies Magnus has the look of 'an actor without a part.' Of Magnus, Axel tells Mary 'I sometimes think he is entirely put together from bits of other people.'

Magnus identifies with Axel and with Jack in a desperate attempt to escape from his father only to find that he repeats externally the same internal dilemma of being controlled by objects more powerful than himself and therefore only re-enforces his primitive identification. When Mary meets Axel (who has known Magnus longer than Mary) she recognises all of Magnus's mannerisms in Axel and realises with

a shock that Magnus, having no identity of his own, has taken on Axel's.

A patient told me, 'I was treated like shit ... anything I did, good or bad, was treated as bad.' He had been dealt with in a sadistic and abusive way by his narcissistically disturbed father. This father would physically abuse the patient's mother and the children. The father forbad all signs of vulnerability and weakness and in the home ridiculed and destroyed all comfort and potential love. In this patient's family in which he had never known tenderness, shame was itself something of which to be ashamed. He had been manipulated by a self-centred mother who demanded loyalty and played off the patient and his brothers against each other. The patient told me that he had emotionally abused his own children and had physically abused his wife who had eventually left him. He wished to make it clear to me that he felt no guilt about any of his own behaviour, wanting to let me know exactly whom he knew himself to be, shameless but with fear of the physical symptoms of anxiety which had brought him to therapy. Hiding behind his identification with father he felt it was the father inside him who carried out these acts. Finding a real self would mean accepting shame currently felt to be unbearable.

This patient told me how he impulsively went to the cemetery to his father's grave. He began to kick at the grave-stone and shout at his father. He realises as he tells me that he had been trying to kill his father and that he *is* his father. He manifested the results of this terrible internalised struggle in the transference when he said, 'I can't fight ... I need your help ... and yet I pull you in ... I am my father ... I have no self with which to fight ... he wins all the time ... you have to be my real self but you become me ... and then you are useless; shit like me. I am shit ... I was treated like shit ... I turn everything to shit. If I try to work on this and tell you how I want to be separate from my mother ... the work goes and I *become* my mother enjoying destroying my mother. I am my father ... and I am my brothers ... my parents destroyed me ... I have to get a self ... I don't know how.' Faced with the full realisation of his potentially shameful self-image over and over again in the transference this patient would become frightened of me and placatory, denying his own true self. Alternatively falling into what he came to call a 'trance' in which all thinking or self-observation would be abolished. I too, in the countertransference would sometimes succumb to this numbing symbiosis, merging with him into a semi-conscious state. Only with a tremendous struggle could I pull myself *out of him* and his negative identity and back into some

sense of my self as having some positive value. When I would succumb, I would feel nothing mattered and afterwards *I* would feel ashamed of my incompetence.

Spying and identification

Magnus in the novel bears the ironic title of a 'Perfect Spy'. He sees himself but cannot bear the shame of what he sees and so constructs a cynical world view in which he secretly finds fault in others. My patient came telling me that he felt himself to be an observer or spy in the world but not part of it. In the emerging transference it became clear that a part of him would spy upon me, constantly trying to find fault. This was based upon his need to see me as shamefully helpless and incompetent. He was determined that I should have, and share, his negative view of his self. While apparently relating to me in a constructive way, a secret part of him acted as a double-agent, giving me what he felt I wanted while covertly collecting negative impressions of me. The patient described to me how he constantly scrutinised others for faults in order to 'bring them down to his level'. Predictably this 'spying' extended itself into the sexual sphere in that the patient could only use sex in a hostile way. He would experience himself attacking the woman, just as he recalled his father sexually attacking his mother. He said to me, 'When I am with a woman, it is not really me. I am my father ... I am me as a child spying on my father having sex with my mother. ... I am my father *and* I am the child spying on myself having sex ... spying on my father having sex ... having sex with my mother ... I want it to be me ... but it is not me because I don't know who "me" is.'

Counterfeiting, deadness and alienation

Like Pym, this patient learned early on to fit in as best he could, feeling all the while not part of the world; not joined-up or properly involved. He had learned to suppress his own true self needs for comfort and warmth in the face of desolating experiences. He learned to counterfeit and the more he did it the emptier, more dead and passive he felt. He had long had the experience of observing his fear of contact with others, watching himself placating them, or sadistically attacking them, all the while despising himself for having to do it. He

had long felt that his existence was mechanical. He would say of himself 'I am dead ... there is no feeling. I am a Zombie, controlled by my mother and father inside.' Occasionally, to relieve himself of the awareness of potentially shameful helplessness he would be driven to active attacks upon me. He would then fantasize demolishing objects in the room, unconsciously annihilating me, and then feeling panicky about the total loss of me. Or, he would look for flaws in my character or would trick me so that he could shame me into realising that I too was a 'con-man'.

I have found, with this patient, and with others like him, that these attacks do not lead to secondary guilt (unless some progress has been made in the therapy), but rather to unconscious terror in case of the total loss of the annihilated object. The annihilation of the object-that-sees (the therapist in the transference), leaves the patient shameless but dead (because of a loss of a part of the self-that-sees), and alienated from the world of objects. Patients with such a profoundly de-structured sense of self tend to collapse again and again into states of helpless and potentially shameful states of negativity and falseness. Sadism is used to ward off depression and shame. This does not give rise to guilt but only to fears that the sadism will be exposed and this will lead to cracks in the patient's 'cover'. My patient told me that he felt no guilt at all about beating his ex-wife. He would worry only on his own account in case his projected version of himself as a caring husband and father should be seen and exposed as a sham. It is different with less disturbed patients who *do* have positive self-images and who consequently can identify with the therapist as having his or her own positive self value. It is this ability to identify with the positive aspects of the therapist which will lead to unconscious or conscious guilt if a hostile attack is made in order to ward off shame.

In the world of Pym, of the patient, and of other patients like him, everything is false. Pym's father is not a father, he is a 'Pal'. In this collapse of role differentiation the parent depends on the child for unconditional support. Oedipal competition leading to constructive self-development has not been possible. Magnus's father does not really adore or encourage Magnus, as he pretends, or as Magnus pretends to himself he does. Rather the two are engaged in a mutual protection racket, an infinity of narcissistic mirrors in which individual identity does not exist. It is a 'country with a population of two' which is really a narcissistic universe of one. Magnus, like my patient, rages inside against his parents: 'I wade at them. I punch and flail and butt them while they smash my face in. But even with no face left I am

doing what I should have done thirty-five years ago, to Jack and Rick and all the mothers and fathers, for stealing my life off my plate while I watched you do it.' As Rick deteriorates the true state of affairs emerges as the father becomes helplessly dependent upon his son. This is the dependency that has been denied all along, and the actual deterioration and death of Magnus's father mirrors the internal deterioration of Magnus's false self organisation. Magnus has to die because he *is* his father. It is at this point of internal deterioration that patients like this (Magnus is 50 years old at his point of suicide) will often seek help. Shame-anxiety begins to break through into consciousness in the form of nameless dread. Because the patient's experience does not encompass any means of incorporating shame. He simply brings anxiety to the therapist and wants the therapist to get rid of it for him.

The pattern, of counterfeit admiration between father and son, which collapses into dependency is repeated throughout the novel. Jack pretends to admire Magnus who provides Jack with the version of himself that he sees Jack wants. Jack's personality begins to collapse when he realises that Magnus, on whom he utterly depends, is a fraud. Magnus's son Tom admires Magnus as if he were a hero but becomes pitifully confused as he realises that there is something wrong with his father. Tom looks up to Jack, who is his godfather but as Jack begins to panic, Tom is hurt as Jack uses him ruthlessly to get from him information about Magnus and Axel. Axel admires Magnus, and Magnus becomes dependent upon Axel. But, Axel does not realise that Magnus's calm is paper thin and Magnus's disappearance means the end for Axel.

Magnus has a counterfeit marriage. In fact it is his second marriage. His first is short lived and is to the friend of the girl he idealises at a distance but whom he is afraid to approach. He separates from this first wife without any feelings except relief. The idealised girl is equivalent to the idealised version of his mother for whom he continues to search. Eventually Magnus marries Mary for 'cover'. He takes Mary from Jack with whom she is having an affair, in an enactment of his wish to take Dorothy, his mother, away from father. In Mary he needs a companion and someone who will value him but he cannot tolerate the closeness for long and periodically escapes into hiding; hiding away from his potentially shameful image of his self as he really is, as someone who ruthlessly uses his wife to give him a sense of spurious reality.

My patient and others like him, similarly do not marry the idealised woman they desire from a safe distance (the lost mother-object with

which he unconsciously desires to merge). Each of them says that this idealised woman is 'too good for him', meaning that he repeats the internalised experience of being too 'bad' to believe that this idealised mother-object would want him. Each instead chooses a woman he does not know how to love, and whom he instinctively perceives will, for her own reasons, be blind to his ruthlessness and counterfeiting of maturity. Each by-passes oedipal rivalry by taking the woman he marries from another man.

In an extraordinary attempt to cope with his potentially shameful self image, another patient (who had suffered a childhood with little positive valuation from a narcissistic mother, and who had attacked and nearly killed the father who had abandoned him), told me how he had impetuously emigrated with his wife to Australia. While in the transit camp they met another couple. The patient was drawn to the other equally lost couple. Not able to make use of companionable support, he became excited by the woman and seduced her. The patient announced to his own wife and the other woman's husband that he wanted this woman. The patient's wife immediately left for England and they never again met. Six weeks later, and just as impetuously, he returned with this new woman to England and soon married her. Years later he had come to see me in a state of vague anxiety, just after he had impulsively walked out of the family house, leaving this wife and two children, to go into hiding in a flat. This episode, painful to hear about but containing no conscious pain for the shameless patient, illustrates a combination of defensive fleeing from passivity into action along with going into hiding from the other and from the self (emigrating). There is the by-passing of oedipal development (identification with the other man and stealing his wife). There is defensive fusion with an idealised object (the other woman) and a disavowal of dependency along with passive-into-active repetition of early trauma (abandoning of his wife). As with Magnus, genital maturity is illusory.

In the novel Magnus's relationships are narcissistic ones and if he were a patient we might conclude that these identifications are re-enactments of pre-oedipal homosexual ones. In an attempt to flee from his own shameful sense of himself as weak and helpless the (Australia) patient impetuously took a holiday abroad with a new aquaintance. On arrival at the hotel he became extremely anxious about this man who became very dependent upon the patient. My patient became frightened and took the next flight back on his own, abandoning the companion. He had no shame (or guilt) about this but he anxiously

wanted me to assure him that I did not think he was homosexual. The cemetery patient would be perpetually beset with painfully negative images of himself as filthy and helpless. Attempts to ingratiate himself with me in the transference would make him feel false and would lead to rage and helplessness. He would worry at times lest I should think he was homosexual. Shame and panic result from the breakdown of the pseudo-oedipal identification into repressed, negatively valued homosexual identifications as they emerge in the transference. This man had memories from childhood of his father persistently ridiculing any sign of femininity in the children.

Forced early on to construct a simulation of themselves in order to survive, such patients become adept at counterfeiting ordinary emotions in order to fit in with a world in which they actually feel alien, dead and haunted by lost objects of a split, fearful and idealised kind. Moved to tears in a sentimental way by suffering at a distance, like Magnus's father who could 'weep buckets at the drop of a hat', they can make themselves appear to themselves and to others as warm and caring. They are able to manufacture an appearance of guilt which will pass quite rigorous scrutiny. Like all sentimentality theirs is a counterfeit identification with the plight of the other. It is really self-pity; sadness for the state of the self which is unable to effectively identify with others. It is crucial that in the therapeutic encounter with patients in this state of mind they are able to meet someone who recognises that (consciously) they are shameless.

Because shame is to do with states of *being* rather than states of *doing*, Kinston (1983) discusses the way in which the therapist, when dealing with shame and negative self-images, needs to be thinking about the patient in a 'you are' mode rather than a 'you feel' mode. It is painful for the patient when the therapist does this because it uncovers what is hidden and potentially shameful. (Kinston answers the possible objections to this and includes the need to avoid using this approach as a cover for a sadistic attack upon the patient). This confrontation with the truth is a relief for the patient because for the first time he encounters someone who recognises that *he is as he is* (needy, dependent, helpless and ashamed), and not how he pretends to be (independent and shameless). This, of course, is only the beginning of a long journey into the heart of darkness for both the patient *and the therapist* as the patient's defences against shame are mobilised. The therapist will become at times the shame-denying or shame-driven parent within the patient as the ghosts of past object-relations begin to haunt the transference and countertransference.

Conclusion

It is not easy to discriminate in clinical work between the two internal dramas of shame and guilt as they are played out in the transference and countertransference. Shame and guilt are usually found in conjunction. Also it is easy to manufacture guilt and so deceive others into thinking that an inner change has occurred. With the kinds of individuals I have described there is great pressure exerted by the patient to repeat the original trauma situation. The fragile ego ideal pushes the individual forward into becoming a patient while the stronger pleasure principle pulls the patient back into a desire for an immediate solution which never appears. The inability of the therapist to provide this quickly creates unbearable frustration in the patient who will want, as one such individual put it, a 're-spray' (his father was a used car salesman), which would would cover up shame and negative self-images. The patient will try to subvert the therapist by playing upon the therapist's own narcissistic disturbances. The patient will do this by provoking and scanning for weaknesses in the therapist and then reinforcing the therapist's unconscious wish to see himself as not having any shameful, negative self-images. The therapist will then become unable to *see* the patient or himself. The therapist, standing in for the narcissistically disturbed parent, will be given by the patient the unconditional loyalty and approval that the patient unconsciously perceives the therapist wants. The therapist then wards off potential shame and becomes shameless, thereby losing his ability to avoid dealing with the patient in a sadistic or fraudulent way. It is the awareness of shame anxiety in himself which moderates the behaviour of the therapist and allows him to monitor his countertransference so that he can communicate with the patient in as unashamed a manner as possible.

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A PATIENT HAS A HYSTERECTOMY: THE IMPLICATIONS FOLLOWING ABUSE IN CHILDHOOD

ELISABETH MACLAY

Introduction

In this paper I shall describe one of the most challenging and instructive patients in my experience as a psychotherapist. Anne, as I shall call her, was severely abused and rejected as a child and would come into the category of people designated by Shengold as victims of attempted 'soul murder'. At the outset she presented with depressive symptoms, difficulties in relationships, and anxieties about her body. During the course of treatment she developed fibroids and as her anxieties mounted she demonstrated a predominance of primitive mechanisms of defence and nonspecific aspects of ego weakness which in Kernberg's view are characteristic of borderline personality organization. She underwent a period of regression and acting out as the time for her hysterectomy approached, and although the patient has described this experience as 'like a living nightmare' it has proved a valuable opportunity to begin to work through some of the preoedipal conflicts which beset her. During the period of regression she developed an intense raging transference which presented difficult management problems. Seelig and Person, (1991), describe a similar patient.

Background

A heart-rending account of Anne's childhood has emerged slowly during the course of her therapy. Often words have seemed inadequate, both in order for the patient to express her feelings, and also for the therapist to convey her empathy.

As a child Anne always felt unwanted. Her earliest memory is of her mother saying she wished she had never been born. She is the elder of two girls; her sister seven years younger. During her infancy the family lived with the maternal grandparents. Her father, although in her view intelligent, suffered from phobic anxiety symptoms and never earned much money. When Anne was about two, they moved

into a home of their own, consisting of a small basement council flat with no bath, where they remained until she was fourteen, a fact much resented by her mother who reacted with headaches and depression. Anne had few toys and relates sad tales of two dolls: one whose face melted and became horribly deformed due to being left too close to the fire, and another which mysteriously disappeared and turned up years later in a forbidden cupboard. These dolls stand in her fantasy for herself as a neglected, maltreated child. She was bored and unhappy and, not surprisingly, she did sneaky, retributive things like cutting the curtains. When challenged she would attribute the blame to an imaginary companion.

Although she has some fond memories of her father telling her bed-time stories when she was very young, the picture she paints of him is of a man dominated by his fear of upsetting his moody, complaining, neurotic wife. He was, perhaps in reaction, prone to violent outbursts. It seems Anne became the scapegoat and he would blame her if mother was upset. At the end of each day mother would complain about her, and sometimes he would work himself up into a frenzy and beat Anne about the head, telling her she was evil and full of maggots. This has come to be seen as of considerable importance. Years later she had occasion to have a skull X-ray and an old fracture was discovered. When *she* had temper tantrums they would tell her she was mad. When unhappy she would notice her mother smirking as if it pleased her, and sometimes her father would pretend to ring social services and ask them to take her away; so she learned not to show her feelings. She has described how, at about the age of four she had a broken collar bone; her mother was angry that she was slow to dress, slapped her face and forced her arm into her sleeve making her scream with pain. There have been many such examples of cruelty and neglect. She clearly was, on a number of occasions, a victim of unrecognised, physical and psychological child abuse. One might also wonder about sexual abuse, but of this she has no conscious memory.

Her experience of school was hardly any better. She remembers feeling humiliated when asked by her teacher in front of the class, 'Haven't you got a tap at home?' There were occasions, however, when she was asked if everything was alright at home. She never complained, partly because she believed she was bad and deserved what she got, a fact which I will comment on later. In her teens she started truanting. She once missed six months before any action was taken. Then her father received a warning letter and, characteristically,

she recalled him as being concerned only for his own reputation, in this case fearing that he might have to go to court.

She left school at fifteen. Her father nicknamed her 'Red Indian' because of her garish make-up. Sometimes she would stay out all night wandering the streets, telling her parents she was baby-sitting. However it is perhaps remarkable that she was not promiscuous. Her ambition was to train as a nanny, and in identification with her charges she found a job working with deprived and disturbed children. She noticed that one little boy began to come out of his shell, until one day something he did enraged her. She only made a face, but it was enough. She could see his terror and she felt so guilty that she left. She did a series of jobs ranging from clerk to working in a petrol station, leaving either because she was sacked or because in some way the job had become intolerable to her. One Christmas at about the age of seventeen she developed a horrendous, weeping, scabby rash on her neck and face which did not respond to treatment from her G.P. It seemed to her to confirm her fantasies about why she was not loved or wanted, and was accompanied by terrible shame. This heralded an adolescent breakdown, she became agoraphobic and was unable to go out unaccompanied. She had a period of psychiatric outpatient treatment (with drugs which were of no help) and was six months off work. Always having been an avid reader, she found a book about anxiety and depression which became like a Bible to her. She experienced her mother as more accepting of her as a sick child, and as soon as she began to get better, life at home seemed impossible again. She met her future husband and spent a lot of time with his family whom she idealised, and she escaped into marriage at twenty-two in fulfilment of a longstanding wish to find an alternative family.

Her marriage to a kind, stable, mostly tolerant man was not the panacea she had imagined, and her problems continued. She was moody with an easily roused temper, had difficulty sleeping, sexual inhibitions, and often thought of suicide as a last resort. The birth of her child, a girl, when she was twenty-seven, was fraught with difficulties, and far from banishing her self doubts as she had hoped, deprived her of even the possibility of suicide as a solution, for being closely identified with her baby daughter who needed her, she now felt trapped. She did at one stage fleetingly consider jumping, babe in arms, from a tower block, as a way out for both of them. For a while she found a partial solution through getting out to work, leaving her baby to be cared for by her mother-in-law.

Before referral to myself she had four years of counselling, arranged

by her G.P. as an alternative to tranquillisers which she had sought for panic attacks and insomnia when her daughter was a toddler. The counselling enabled her to get in touch with feelings which had been long buried. She experienced a great deal of sadness and warmth, encouraged by the counsellor's well-meaning attempts to mother to her, which included physical contact. However from Anne's account, it seems she presented only what she felt to be the acceptable side of herself, keeping careful control, never crying, never losing her temper until one day she exploded. She jumped to her feet in a rage, shouting, and the counsellor told her to go home. Although the counsellor was aware of the concept of transference she had taken it personally and did not know how to cope. She decided to refer her on and contacted me. She saw her about four more times whilst Anne was waiting to commence with me.

Course of treatment

When she came into treatment she was beginning a degree course at a polytechnic. Her studies proceeded uninterrupted and she obtained a good degree. She coped well, on the whole, in the external world, despite the turbulence she was to experience in her intrapsychic life. She was aware there were certain areas untouched by the counselling; she remained prone to panic and depression, she was experiencing fears about her body, her self esteem was low, and there had been total avoidance of sex since the birth of her baby.

As she started her therapy, her sister was expecting a baby, a circumstance reminding her of her own emotionally and physically problematic pregnancy, and she was having to cope with the loss of her once loved and trusted counsellor. She initially impressed me as a likeable, articulate, highly motivated patient. In the early sessions I soon became aware of tension due to guarded emotions, and a wariness of her new, unknown therapist, so different to her warm, friendly counsellor. Always arriving punctually, often glancing at me with a rather forced smile, she would creep slowly down the hall and position herself in the chair or, later, on the very edge of the couch. She talked readily and we were both aware of a tumult of feelings not far below the surface. It was months before she began to let them emerge. Her first dream was of me telling her of the need for restraint and I had constantly to interpret her fear that, if she were to allow herself to become as attached to me as she had been to her counsellor, I too

might let her down. With hindsight it can also be seen as a warning about the period of acting out that was to follow later.

From the outset there has been a predominantly negative transference. I have stood for the feared and hated depriving parents, often being experienced as cold, indifferent, cruel or sadistic, though behind this we have sometimes glimpsed the feelings of a small child who loves and desperately longs to be loved in return. As for the countertransference, I have often felt uneasy, sometimes extremely anxious, sometimes filled with concern. However, throughout this treatment my feelings have provided important material as I hope to show.

The first summer break proved a horrendous ordeal for her. She felt as if in a diving bell, denying all feelings in an attempt to both protect herself from a sense of rejection and loss, and to protect those around her from her rage. Nevertheless her anxiety reached panic proportions at times. Her body continued the focus, but she could not bring herself to visit her doctor. It felt increasingly difficult for her to come to her sessions as the transference developed and I was experienced as the mother. The more she revealed of her inner self the more she feared that I too might seek a way to get rid of her. Interpretation produced a shift, the pain she had had since before the break vanished, but instead she felt dizzy and wondered about a brain tumour and whether I would think her mad. She wanted to scream. For *her* anger was equated with madness, badness and disease, whilst I was the father in the transference.

Developmental issues

Anne recalled, with tremendous shame, as a small child hiding her faeces in little bits under the mat in a passage way. One might speculate that at one level she identifies with a little piece of shit, and that in doing so she is identifying with the parents' denigrating view of her. Shengold (1988), says 'the underlying motivation for fixation at and regression to the anal level is the need to control and contain primal affect. ... The emotional sphincter is needed to master murderous orality.' In the same section he says, 'All the basic psychological dangers ... can bring on the threat of regression toward nothingness: toward nondiscrimination, anonymity, need-fulfilment rather than love; loss of identity and individuality; loss of the ability to care about others; and finally dehumanization. If any developmental level gets

too charged with archaic affect (cannibalism and murder), an anal sphincteric regressive defense that revives narcissism can be initiated.'

Quite early on in the therapy her name became an issue between us. Whenever she was feeling angry she would begin to berate me for not using her name, not addressing her by it, calling her Anne as her counsellor had. The link with her mother became clear when she told me that her mother used to refer to her in the third person; depersonalising her by talking to her father about 'she' and 'her'. There were moments when at her most regressed she would describe a sensation of shrinking and would say she felt like a 'nothing' or a 'nobody'. This reflected a childhood memory of feeling like a cornflake: small, fragile, inhuman and extremely vulnerable. On one occasion when complaining bitterly and trying to quiz me about my refusal to use her name she said it was like a denial of her identity. I pointed out that it seemed rather that, because of her own uncertainty, she sought positive confirmation of her identity.

In a paper on narcissism, self-esteem and object relations, Dare and Holder (1981) define self esteem as the conscious and unconscious self-regarding and self-evaluating aspects of a person's total feeling state. They point out that a child whose mother is consistently negative towards him may come to regard himself as the cause and source of the mother's unhappiness or hostility. This is borne out in Anne's case. Throughout her childhood she never breathed a word about her mistreatment or unhappiness at home to outsiders because she believed she deserved it.

The subject of sex was taboo in her family. At ten years of age while Anne was being bathed in front of the fire, her little sister commented on her pubic hair. She felt accused and ashamed as her mother angrily sent her embarrassed father out of the room. Thereafter she had no more baths in the living room. Her menarche at twelve years of age was marked by a change in her father's attitude and behaviour towards her. From that day on he no longer beat her. Anne thought her mother seemed reluctant to recognise that she was growing up. She developed eating problems and her father warned her that if she didn't eat she would be all hunched up and no-one would ask her to dance. She felt like a cuckoo; big, ugly, awkward, and unwelcome.

As we embarked on the third year of treatment she found herself wishing for another child, but was aware that she found it very difficult to talk about sex. I took the opportunity of suggesting that she might find it easier on the couch. She responded, 'In this chair I hate myself, but on the couch I might feel it was coming from you'. Thus she

demonstrated how inclined she was to externalise her hypercritical superego. I replied that we could talk about it, and she ventured onto the couch.

A screen memory, that will be referred to later, was of being put over her father's knee, pants down, and spanked, whilst her mother looked on. She tearfully went on to tell me that she had thought of this as she had recently started to masturbate. She could not understand why, but the idea of a powerful person in control had become sexualized. She had stopped herself masturbating, because these memories brought painful humiliation and shame. She stressed that she had never been sexually abused by her father, indeed she spoke of a time after puberty that she accidentally touched his hand, as they both leant forward to pick up a newspaper. He snatched his hand away saying 'Ugh! you touched me!' sounding disgusted, she said, as if she were a slug. Next session she told me she had felt afterwards as if she had left the room filled with shit and vomit and was expecting me to hate her. Indeed she was feeling beaten both physically and mentally and near to giving up. I interpreted that she was experiencing me as if I were the father who beat her and was repelled by her, and as the mother who didn't care or who even took pleasure in her suffering.

Body image and the fibroids ... the 'evil' within

Early in her therapy she dreamed of being in a picture gallery with a group of men, looking at a picture of a huge vagina filled with blood. Her feeling was of shame and humiliation. Her sister Jill's first baby was now eight weeks old and Anne had been to baby-sit for the first time. She spoke of her own pregnancy, during which fibroids were diagnosed, and of her fear of cancer. She was admitted after the birth for a myomectomy, which in the event was not performed because the fibroids had shrunk and disappeared. Not so her fears and fantasies. Since then she had avoided sexual intercourse, despite a wish for another baby of her own, because she needed 'to keep herself safe' as she later put it. She imagined that if she were to allow intercourse she would bleed and it would trigger something dreadful, and she would be found to be rotten inside. She was unable to look at her own body or, since the first time she came to me, to touch or allow her husband to touch her breasts. She had to deny her femininity.

Six months into treatment she again became aware of a lump in her tummy, at first she was unsure, it was only palpable when her bladder

was full, but it was enough to make her very frightened, and to reawaken her fear of cancer. Whilst acknowledging a possible physical cause such as the recurrence of fibroids and encouraging her to see her G.P., I began to point out links between her fears about her body and her mental self representations as bad, unwholesome and riddled with maggots. She experienced abdominal pains and diarrhoea which at one level fuelled her fantasies but which at an intellectual level she could understand as a physical reaction to her anxiety.

In her sixteenth month of treatment she noticed her period was followed after a delay by a brown discharge, presumably pent up menstrual blood. She told me with much hesitation and shame, that she was reminded of a time in her teens when she had stored used sanitary towels in a cupboard. These were inevitably found by her mother who was terribly angry and who got her *father* to speak to her. In the transference it was as if she stored up the physical evidence of her periods to a point where it was forced upon my attention. She remained uneasy until I interpreted her fear that, despite my outward acceptance, inside I might be really shocked like her mother. Shortly after this she was alarmed by excessive menstrual bleeding, and telephoned me in a panic. I urged her to see her G.P., which she did. For the first time she was able to speak of her fears with the doctor instead of merely presenting physical symptoms. Fortunately the G.P. proved sympathetic and was able, over a period of time, to gradually gain the patient's confidence.

During the course of the second year there was an unavoidable, unexpected two-week interruption in the treatment. On my resuming work she said she had been unable to imagine coming back, and had gone to her G.P. who had prescribed antidepressants. While all this was worked through from various angles in her therapy, she paid several visits to the surgery and was able to have a sebaceous cyst removed from her neck under local anaesthetic at hospital. Meanwhile her fibroids were indeed enlarging, and she could easily feel their outlines like 'a couple of tennis balls'. (By the time she had her operation, four and a half years into treatment her uterus had reached the size of a twenty week pregnancy).

Envy, and the wish for another baby

When first married, Anne hoped to have several children. However her first experience of pregnancy and childbirth left her feeling she

never wanted to risk another. Her sister Jill's first child was a girl with whom the patient could identify and whom she enjoyed. She caught herself wishing that Jill and her brother-in-law would not return from their holiday so that she could keep her little niece whom she was looking after during their absence. She dreamed of a ferret or a minx which tore apart a kid, a baby goat, which brought a feeling of horror. She also dreamed, with a feeling of disgust and concern, of a three year old girl covered in diarrhoea. Her associations linked her child self with both the destructive ferret/minx (her father used to call her a weasel) and with the shitty little girl.

In the second year of treatment at the start of Jill's second pregnancy she was attending her G.P. with a lump in her neck fearing cancer. This turned out to be the sebaceous cyst already mentioned. The diagnosis brought relief but also a sense of anticlimax. She held the fantasy of something foul inside her for which she would be blamed. This fantasy, which linked with memories of her father telling her she was evil and full of maggots, is central to her psychopathology and is overdetermined. It will be referred to again in connection with her hysterectomy.

As Jill's pregnancy progressed Anne's desperation grew. The session in which she reported the pregnancy commenced with her saying she was aware of a *lump* of emotions. She was frustrated, angry, occasionally impulsive, wanting comfort and yet unable to trust me, envious of me, a mother with my own family, of which she could never be part. She yearned for another baby with whom she could identify and enjoy a sense of closeness. She tried to talk about her sexuality but, as soon as she let her husband get physically close, her mind would blank off and she would find herself having a row with him. Speaking about it with me, she would experience me as shocked or disapproving, like her mother, and would be silent or start berating me. However there had been a time before her daughter was born that she had been aware of experiencing genital sex and sometimes, now, she was able to dream of her husband's penis penetrating her.

Meanwhile visits to her G.P. continued and for the first time she was able to allow her to examine her abdomen. The G.P. told her she could feel the fibroids but reassured her they were 'nothing to worry about' and promised to keep an eye on them. She also indicated it might still be possible to have another baby. The next day Anne reported a craving for cakes and chocolate. Another day she asked the name of some flowers in the consulting room. In a lapse from my

analytic stance, I told her 'Fritillary'. Sometime later she said she had adapted the name to 'Fertility'!

When her sister reached full-term Anne dreamed about trying on a leather coat and that she could not get into her skirt. In her associations the reality was that her tummy was indeed getting fat; her husband commented that she looked pregnant. She said she had been reading a book in which women were interested in a catalogue showing erotic leather clothes. Telling me this was accompanied by a feeling of shame. She wanted to punch herself in the face, behaviour which she had previously reported but had only recently enacted for the first time in a session, in identification with her father. The book had stimulated her to masturbate. She reported another dream fragment, of a filthy mattress, under which there were 'bugs and creepy-crawlies'. The feeling was of sadness and depression, as if she had been dragging that mattress around with her for years, and now while her sister was producing a baby she Anne was growing a monster or a cancer. In the context of Jill's second pregnancy, however, one might speculate that a disavowal of a wish to destroy her sister's baby, (paralleling a childhood wish to destroy mother's babies inside her), may well underlie her fear of cancer. The unconscious wish may have been that her sister's baby might turn out to be a monster. Turning the wish against herself may have resulted in her expectation/fear of a cancer, hence the sense of anticlimax when her cyst and later her abdominal tumour proved benign, as her unconscious guilt was unassuaged.

Primitive defence mechanisms: denial, splitting and projection

Anne shows a split in her perception of herself, a vertical split in the ego, or an 'as if' personality. Outside her therapy she has friends, is active in politics, and can function as a student or in a job, whilst keeping hidden her inner feelings and reserving for her sessions a version of herself who often would rather be dead.

She presents a consistently negative view of her mother; in contrast, I never hear a bad word about Mavis, a favourite aunt. In the transference, much of the time, I am the hated mistrusted mother, while her former counsellor is idealised like Mavis. When I wear a certain pair of earrings she experiences me as the bad mother and she cannot cry, just as she could not or would not in front of her mother. As regards her father, she has become aware of two contrasting mental representations of him; on the one hand a benevolent loving father who took

her on his knee and told her stories, on the other the monster who would get into rages and shake and beat her. When first married she was able to retain some trust in her husband only by idealising him, splitting off his 'bad' parts, and projecting them into strangers. Thus on her way to work each morning she would become terrified as she passed a man waiting in a parked car.

A further example occurred in the third year of therapy. She reported that she had discovered that her mother was associating with her mother-in-law. This caused her great distress because she had come to regard her husband's family as a haven, and now, typically her mother was usurping it. Hitherto Eileen, her mother-in-law had been her idealised 'good mother', and now she seemed insensitive and disloyal, allowing her hated real mother to insinuate herself and to rob Anne of her hard-won acceptance in this new family.

Regression and acting out

In the fourth year of treatment she was told she would probably need a hysterectomy. This proved to be the trigger for a period of regression and acting out which at times threatened to disrupt the work. With hindsight it became apparent that the 'fourth year' had significance for her in terms of both her childhood, and in her experience of counselling.

At the end of one particularly tense Friday session, during which Anne had been feeling dissatisfied with herself and with me, she left as usual. Two minutes later there was an insistent ring on the doorbell. As I opened the door she shot back in, saying angrily 'I will not be thrown out like that!' In the consulting room she tore up the next patient's bill and sat down. I spoke gently to her about how angry and frustrated she was feeling, to no avail; she sat tight, glowering at me defiantly. I then left her saying I would give her two minutes to cool down. Just after the hour she left but sat outside for a further five minutes in her car. Much to my relief she had gone before my next patient arrived; fortuitously ten minutes late. In the next session she was initially unrepentant. 'If you think I'm going to say sorry you're wrong!' I interpreted that she had felt angry at being excluded over the weekend and had made sure that she had stayed with me, at least in my mind. Towards the end of the session she became reflective, she caught glimpses of me as kind and caring, and of herself as a normal woman going for a routine gynaecological appointment.

The following week she had another outburst of rage. There was thick snow on the ground and she had had a difficult car journey. As she entered she raised her large handbag abruptly above her head in such a way that I felt threatened. I raised my hands in self-defence just as she brought the bag crashing to the ground, in the course of which my fist accidentally met her head! We both apologised, and again she was able to reflect that she gets so angry here she doesn't know why she comes. Each time she would arrive with a glimmer of hope but she would expect to leave unsatisfied.

After her out-patient appointment tension in the sessions subsided sufficiently for her to resume the couch. She said sadly that she had not kept herself safe. She felt that her outbursts had destroyed something valuable in her, namely the self-control that had been her means of survival in her parental home. I commented that her control may have served her well at that time but that it had been such tight control that it had forced her to restrict part of her personality, and that it had been necessary to undo this blanket control in order for her to be free to find new ways of coping. She responded sadly that she used to be a lively child but later became like a shadow.

Regrettably but perhaps inevitably her acting out occasionally spilled over at home. After speaking of a 'splitting headache', she reported having lost her temper with her daughter. She had grabbed her and shaken her, as her father used to do. In retrospect she felt guilty and sad as she recognised this manifestation of her identification with him.

Management and use of the countertransference

At the height of her regression and the period of acting out, I found myself feeling increasingly anxious as Anne's sessions approached, and uncertain how to proceed. I began waking at night, grappling with thoughts and feelings about her. I anticipated, and was tempted to avoid certain things which might provoke her anger. One day, when she was telling me she felt 'a nothing', of no importance or consequence, I related this to my own feelings and decided to confront her. I told her she terrorised me. I added that I felt she needed to know this because she believed she had no effect on me. I said that sometimes feelings are so difficult to convey that she had to make me experience them, and if I, as an adult, felt terrorised how much worse for her as a child. Her level of functioning changed at this point and she could

reflect with me, about the terrifying rage inside her and her fear of it getting out of control. She remembered that every weekend her mother, without using her name, would say to her father, 'You had better speak to her', a euphemism for the beating which invariably ensued and she was indeed terrorised.

Anne was appalled to discover that she had wet her bed on two occasions. She stopped using the couch during this period having discovered that to lie on the couch fostered the emergence of little girl/baby feelings, and a sense of being out of control. However the fibroids were relentlessly growing and with them her sense of being under threat. She felt unhelped by me. In the transference I continued to be experienced as the uncaring, cold, disinterested mother, and she frequently thought of stopping, or seeking a new therapist. At the same time she showed dogged determination to try to turn me into the kind of substitute mother/therapist that she believed she needed. She would try anything to dispel my apparent indifference, and to test out whether she could induce me to finish with her, as her counsellor had done. On one occasion she emitted a long, ear piercing scream. Interpretations at this stage were angrily dismissed. She was functioning largely at a preverbal level and experienced me as if I were actually her mother. She said again and again that she needed reassurance, kind words, comfort. She resented my formality and above all she could not stand my not using her name, Anne. Sometimes she would walk out in the middle of the session, hurling abuse and slamming doors, but often after a short interval she would return, afraid that if she did not do so now she might feel unable ever to return.

There came a point when my ability to function as a therapist was seriously threatened. The issue of management was of paramount importance. I understood my feelings to be the result of projective identification, but interpretation alone had failed to produce change. I was aware that to introduce parameters in order to limit the acting out might be experienced as sadistically controlling, but had to weigh this against the threat to our work together which I was experiencing, and the risk that the escalating acting out might bring the treatment to a violent and catastrophic end. She spoke of a fantasy of murdering me if I should let her down. She was intensely preoccupied with me, not only in sessions but during all her waking hours, and the insomnia which had been a problem for many years became a torment. She complained that her therapy had unleashed her feelings but that getting angry did not make her feel better. I commented that there is a time for sympathy when a little girl has been badly treated, but also a time

to say to her, now that she is adult, that this behaviour is not helping her.

Eventually there came what has proved to be a crucial session. It was preceded by one in which she felt full of rage and frustration with me for failing to comply with her demands. The session had ended with her fantasising doing something terrible as she left my house. She commenced the next session by referring to this. I said to her 'Yes, there are things you could do that would make it necessary for me to say that I would never see you again.' I specified that would include doing anything to disturb or upset my family, other patients or my neighbours. I added that I promised to do all in my power in a professional capacity to help her, nothing more and nothing less. Initially she was incredulous, then, as she began accusing me of not caring, I pointed out to her that I set these limits in order to protect her therapy and that it lay in her hands to respect them or otherwise to bring her treatment to an abrupt and unsatisfactory end. She was angry that I had not set the limits sooner and had allowed us both to suffer behaviour, which made her feel deeply ashamed and hateful. She was apologetic. She became once again able to reflect, and in ensuing sessions to show, to her own surprise, that she actually felt relieved. In fact, the articulation of this boundary proved a turning point, and to date she has resorted to no further disruptive acting out. Much later, musing about what it had all meant she was able to recognise it as a reworking of the rage left over from childhood, and to tell me with gratitude that she felt better for it.

The hysterectomy

When her G.P. referred her for a hysterectomy her anxiety level soared, her fear was that she would be discovered to be rotten inside, full of maggots as her dad had said, or eaten away by raging cancer. She commented on the irony that she had been avoiding getting pregnant in order never to have to face the horrendous experience of being opened up again and here she was having to face it, but this time without the reward of a baby to look forward to. She reported a dream at the end of one session, of being at the swimming baths looking after a little girl about two years of age. I said that if the two year old stood for her child-self we would have to look after her together.

She had a nightmare in which she 'knew' she had cancer, and was

wearing a shroud-like nightie, stiff with blood, like she was 'mummified'. Then she was avoiding looking at her father in a coffin. Her associations showed that she could no longer maintain a belief in an idealised father. She felt utterly bereft, and could see no good in her parents, nor in me, nor in herself. She went away and vented her rage secretly on her former counsellor, making an abusive, obscene phone call, about which she was unable to tell me for some time, and at the same time she was acting out in sessions as already described.

Several months later she was seen in the out-patients' department by the gynaecologist, and put on the waiting list for hysterectomy. There followed a long and agonizing wait during which there were opportunities to work through much that we had already touched on. Besides her fears she also had to contend with grief. She had heard that fibroids indicate a 'disappointed womb' and felt sad that she could have no more babies and that she had deprived herself and her husband of a sexual relationship. She grieved for her child-self too, as she remembered how she had been so unappreciated.

Having finished her degree course and found a job she now felt unable to call upon her adult achievements and to hold down the job. She felt suicidal and imagined crashing her car, the only thing stopping her was her concern for her daughter. She regarded me as useless and was constantly demanding to be referred on to another therapist.

She was eventually given a date for admission a fortnight ahead and this brought her near to panic at times. Nothing would shift the fantasy that they would find something horrifying inside her, and she was worried about the part to be removed and sent to the laboratory and later to be incinerated. She thought it may sound ridiculous but it would feel like part of her still, a secret part. She cried a little. I commented that perhaps there was some secret part of her mind which she had not yet felt able to share with me. 'Yes', she said 'something sexual'. The shame which accompanied this idea was so great that she could not bring herself to expand upon it. In the next session she dreamed of a rat; she saw its tail moving along in a slit, the obvious sexual symbolism being supported by her associations to a forbidden cupboard. She remembered her mother saying if she looked in that cupboard she would 'knock her into bloody next week'. The little girl asked in terror, 'Where is next week?' Her mother apparently considered this insolent and told her scornfully not to try to be so clever. The cupboard she later discovered contained mysterious things which still later she could identify as condoms, douches, and so forth. The dream brought an awful feeling which stayed with her until after the

operation: the feeling of a frightened two year old, dimly aware of something forbidden but exciting, which brought with it the risk of violent punishment. As the dreaded unknown 'next week' approached she could barely imagine surviving and she set about putting her affairs in order as if condemned to die.

Masochism and the beating fantasy

She felt she might as well 'kill two birds with one stone'. She had hoped when she started therapy that she would never need to speak of her fantasies, but if she did not do so now on the eve of the operation, she would be afraid she could never come back to me afterwards. So three sessions before admission she disclosed her 'secret'. She said that at the age of two or three, and I quote, 'I was treated like a toy, my father thought me cute like a kitten until one day, I don't believe I had done anything to deserve it, he put me over his knee, ...' (the screen memory already referred to, but this time described in more detail and with intense feeling) 'he took down my pants and gave me a good spanking, with all his strength, it really hurt, mother was watching. I went to her seeking comfort, mother said, "Let me look!" That was taboo, no-one in our house looked at bodies. As my pants were taken down I saw that my mother and dad were looking at each other, in a conspiratorial way ...' Here she broke off in sobs. 'It brings a terrible feeling, I can't describe.' She went on to say that it has stayed with her and has become inextricably linked with sex. In her fantasy she is being beaten, by someone, usually a woman, who is loving, except when Anne is feeling suicidal then the beater becomes harsh and cruel.

Anne's fantasy had undergone a disturbing change as time for the operation approached. Whereas usually, she as her adult-self was the victim, now she saw herself as a little child and it brought it too close to the painful memory, which was why it now felt necessary to bring it to her therapy. The memory continues: from the time of the first beating incident something changed, and instead of being the object of her parents' pride she was neglected as if she had become something offensive to them, and she tearfully added she could sense they regarded her as a sex object. This was most likely a manifestation of her own disavowed infantile sexuality, but also it seems likely that she aroused strong feelings in her sexually frustrated father. However, as time went on and she approached puberty she could not avoid the realisation of

her masochistic perversion. At around that time she would tie herself tightly round the waist with a cord and would beat herself. Whenever this material emerges in the treatment she becomes acutely distressed and ashamed and experiences me as indifferent, cold and useless, like her mother looking on sadistically.

Hospital admission now being imminent, she had a terrific struggle to hold onto an internalised 'good' therapist. Aware of her unstable hold on her adult self, I tried to cater for the two year old part by giving her a card with times she could ring me. She was admitted to hospital in the following month and came within a hair's breadth of walking out on the eve of the operation, but was able to restrain herself and to have the hysterectomy. She availed herself of the opportunity to telephone on two occasions, once to tell me she had survived and could hardly believe it, and on the next occasion to confide in a whisper that although the doctors were pleased with her progress she had no-one but me with whom to share her inner feelings of still feeling threatened. She afterwards told me she had clung to the card I had given her throughout her stay in hospital, like a child with a teddy.

Discussion

I have found that several other authors throw light on the nature of this patient's pathology, and on the problems encountered in trying to help her. Higgit and Fonagy, in a paper entitled 'Psychotherapy in Narcissistic and Borderline Disorders' speak of the 'universal agreement that the therapist is in nearly as great a danger of acting out in the course of treatment as the patient'. They comment '... borderline patients can have an eerie empathic understanding of the vulnerability of others. They can confront the therapist with an almost infinite variety of situations for which no training can adequately prepare one. Being regarded by the patient variously as someone who has the capacity to make things better, but also the person who is responsible for the patient's pain, someone who is irrelevant and then as the patient's last hope, yet also someone who is hopelessly inadequate and out of touch, it is inevitable that therapists develop intense reactions to their borderline patient.'

Mahler, in discussing the rapprochment subphase of the separation individuation process states that it may in some cases become and remain an unresolved intrapsychic crisis. She says oral, anal, and early

genital pressures and conflicts meet and accumulate at this important crossroad in personality development. She mentions heightened awareness of body image and pressure in the body, especially at the points of zonal libidinization. She speaks of the beginning of superego development during this subphase, and of the fear of loss of love which goes parallel with highly sensitive reactions to approval and disapproval by the parent.

Kernberg (1975) has said that the child's experience of the mothering person tends to be polarised during the second year as a 'good' and/or 'bad' object and as such imprints itself on the experience of the self and hence has a profound effect on narcissistic development. Dare and Holder add that conversely the child also builds up a picture of himself as being made up of a 'good' and 'bad' self which mirrors the response of the object to the child's expressions of himself. They point out that a number of polarisations are produced in the anal phase, these include sadism/masochism, omnipotence/impotence, love/hate, and so on. Lack of integration tends to give a primitive, fragmented quality to the emergent self. There is, in the normal course of events a crisis of self esteem in the second year of life, during the anal phase, one which for Anne evidently left her severely traumatised. She had begun at a very early age to make links between her sexuality and her parents' rejection, and at puberty it seems she obtained confirmation that her feminine development made her unacceptable to them.

Kernberg in his book *Borderline Conditions and Pathological Narcissism* says that a direct manifestation of splitting may be selective lack of impulse control, with episodic breakthrough of primitive impulses which are ego syntonic during the time of their expression. Anne demonstrated this especially during the fifteenth month period, in the fourth and fifth years of treatment, when at times of acting out she clearly felt she had every right to do so. An example of this was when she stormed back in and tore up the next patient's bill. Only later was it possible to gain access to her reasonable ego and to look at this incident with her.

In a paper on transference regression and psychoanalytic technique Kernberg describes the sudden development of transference that may not be immediately apparent because the patient continues to free associate, and he says, it is usually in the countertransference that the analyst first notices a shift has taken place. At this point the analyst may experience a sense of helplessness based on an unconscious identification with the patient's projected regressed self. At such times it is important to stop working with the content of the material and to

base interpretations on what one is able to learn from one's feelings. This became clear to me after the period of acting out which I have described.

At one level Anne had come to equate her womb with all that was 'bad and evil' inside her and with her sexuality, and she feared the operation both as if it were a sexual assault, and as if her body were the forbidden cupboard that contained the source of her deepest shame. However with the help of her therapy she could recognise these fantasies for what they were, at least some of the time, and this enabled her to face what has been a major hurdle in her life and therapy.

To add one last word concerning the difficulty for the therapist; how hard it is not to fall in with the patient's implied and expressed wishes for comfort and reassurance in an attempt to supply what was missing in the patients background. It is easy to see how the counsellor fell into this trap and was unable to continue. Shengold (1989) says, 'Instances of soul murder ... are apt to provoke compassion in the analyst. Although this is natural, it must not be allowed to interfere with amnesia removal, reconstruction, or both, or with the general technical management of the analysis. The latter still requires what Freud, somewhat unfortunately, called "surgical coolness".'

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INFANT OBSERVATION

GERALDINE GODSIL McGUIGAN

> 'A space in the mind where thoughts can begin to take shape and where confused exeriences can be held in an inchoate form until their meaning becomes clearer.'
> Rustin

The baby I observed from birth to 18 months is called Jim. He has two sisters, Vicky aged 5 who was adopted and Natalie aged 22 months. During the infant observation a fourth child was conceived who was born three months before Jim's second birthday. The parents, Dave and June, were in their middle thirties at the start of the observation. Dave is a successful business executive and June worked until she had the children.

The couple have had a difficult history in trying to become parents but they finally succeeded in adopting Vicky who was then 9 weeks old. They were delighted to find three years later that they could after all have children of their own. Both parents had been seriously ill earlier in their lives but made good recoveries. Natalie, the second girl, was there whenever I observed Jim, so watching how she competed for attention and how mother, toddler and baby coped with the tensions of this triangular relationship was an interesting feature of the observation.

The nursing couple

> 'There was a time when meadow, grove and stream
> The earth and every common sight,
> To me did seem
> Apparelled in celestial light,
> The glory and the freshness of a dream'
> Wordsworth

Observation at 3 days

My first observation took place in hospital. Dave had told me on the phone that everything had gone well at the birth except that Jim had broken his collarbone on the left side while being born.

Although I knew observing an infant meant entering a powerful emotional force-field I was still unprepared for the impact that the baby and mother had on me in this first observation and the conflict

between mother's needs and my wish to uninterruptedly watch what the baby was doing. In the first session, with mother's permission, I made a very brief note from time to time of what the baby was doing. I continued this for the first ten months. Gradually, I came to understand this as, at least in part, my need to shield myself from the powerful feelings evoked in the observation, the short written note anchoring me when I might have felt overwhelmed.

Jim was asleep in his cot when I went into the ward and for the first 20 minutes June told me about the birth and the hospital provision. The last part of the labour had been fast and painful and Jim had been propelled out before the staff could do an epesiotomy and June had torn. His collarbone had been broken by the force of this exit. June felt disappointed that no doctor had been present and also felt the aftercare had been poor. As an experienced mother she had been left to get on with it, but she seemed to have coped with the difficulties well and been quite resourceful at getting the care she and Jim needed. Breastfeeding too had gone well even though she'd had no help.

At this point I asked if I could sit and observe the baby quietly while she had a rest.

> 'As I watched various movements and expressions happened. Sometimes they seemed connected to an outside noise like an ambulance going past but mostly there was no outside stimulus or sound that could account for them.
>
> There was a startled movement of the right arm but the hand remained half closed.
>
> There was a movement of the whole face so that the forehead wrinkled up. When this happened the mouth often opened too and made sucking movements.
>
> Frequently the mouth moved in a sucking motion.
>
> The eyelids fluttered briefly from time to time.
>
> Twice the right hand opened out and moved across the face clutching at the nose.
>
> On another occasion the fingers poked his cheek and eye.
>
> Towards the end of the period of observation I thought he was going to wake up. He moved over a bit onto his back, stretched his neck and head back and the eyes opened and closed several times but he did not wake. The eyes when they opened were glazed and unfocussed.
>
> For quite long periods he slept with no expression or movement at all in complete stillness.'

The contrast between periods of intense rhythmic activity perhaps governed by fantasies of a feed and the stillness and peace of the motionless sleep that also took place was striking. He seemed at times to be feeding again in his sleep, or searching for the breast with his

hand as he moved it across his face, grasping his nose and poking at his cheek. As he stretched back his head in a rooting purposeful movement, was he again seeking the breast that he dreamed of? His capacity to sleep soundly, uninterrupted by the noises of the ward and the street seemed to augur well and to indicate what was also present in later observations; an ability to hold onto good experiences and to recover from bad ones. At this early stage, perhaps he was also recovering from the violence of his entry into the world.

There was a quality to this first observation of tranquil wholeness that impressed me deeply and reminded me of Fordham's concept of the primal self as a 'state of peace'. Sidoli refers to this as the 'primal integrate' which deintegrates soon after birth; a process that I believe we can see happening here in the rhythmic searching for the mother's breast.

Observation at 10 days

This was the first one at home and showed Jim and mother establishing a close and tender relationship. June managed to respond to his needs with great sensitivity while doing her ironing and tending to Natalie when she woke up.

Mother talked to Jim as she changed his nappy, even though he was half asleep, soothing and comforting and reassuring him of her presence and attention. When she left him and moved over to the ironing board he seemed content for a while as if he still had a sense of her presence and his mouth moved as if he was rubbing his gums, perhaps providing a substitute for the lost breast. Gradually he seemed to realise she had gone; the arms and legs stretched out and found nothing and he looked round. Her voice from the ironing board wasn't enough to hold him on this occasion, but the moment she picked him up he was instantly reassured. Her rocking and stroking sent him back to sleep. Again, when she put him down he seemed to miss her but on this occasion her voice alone held him and he dozed off. When he cried again mother offered him the breast but soon recognised that it was her he wanted, not food.

As he lay in her arms and she stroked his head it was a moment of such tender eroticism that I felt embarrassed and intrusive and broke the spell with a comment about his stillness. The blissful moment was dispelled and replaced by an anxious comment from June about the stillness of death: 'He's one of these you wonder if he's still breathing'.

Jim went on sleeping peacefully coping with some discomfort without waking, but was finally disturbed by Natalie's crying. He made a nipple of his tongue for comfort and lay hiccuping but not crying while June changed Natalie. We can see, even at this early stage, the tender reciprocity of the nursing couple and Jim's capacity to respond to mother's sensitive care and to hold himself together while still registering her absence.

Observation at 6 weeks

The whole of this observation was carried out against the background of Vicky's constant bids for attention. It was the school holidays so all three children were at home. She kept up a barrage of comments and disruptive activities, threatening to cut her fingers, quarrelling and fighting with Natalie.

In the midst of this mayhem Jim fed at the breast with great intensity seeming to shut out the noise by losing himself in the feed. However, Vicky's and Natalie's jealousy seemed to be fuelled by the feed: Natalie shoved her face into his making him cry and Vicky shouted 'Jimmy, Jimmy, Jimmy' in a nasty taunting voice. Mother by a mixture of cajoling and threats fended the girls off. Mother was somehow able to maintain her relatedness to Jim through all of the disturbance so that he was not totally overwhelmed.

> 'June laid him down on the pillow on her lap – he started crying, she stroked his tummy and talked to him and he quietened down. Vicky kept shouting from the floor – "I'm going to cut myself, I'm going to cut my finger off" and June said "It's best to ignore her".
>
> Jim cried a bit but June rocked him on her knee and made little soothing noises, he fell silent and lay quietly looking at her for some time, then started crying again. Vicky didn't let up from the floor and June's replies got more and more irritated – she'd have to take her out and talk to her, put her in her room, tell her dad how naughty she'd been ...
>
> The phone rang; Vicky answered it and I held Jim while June went to talk to the caller. I walked around with Jim on my shoulder and talked to Vicky who showed me all the photos and told me about the family. She was fine once she had my attention. June came back and she and Vicky tussled again, Vicky refusing to get off the chair and then lying on the floor shouting "I'm dead, I'm dead, I'm dead you know it". June had Jim back on her lap, holding him facing her supporting his neck. This was a position he seemed to like. He sat quietly gazing at his mum for a long time. Natalie came close, shaking a rattle but he seemed interested rather than disturbed by it.

June was still holding Jim facing her. He was quiet and attentive for long periods looking at her face. Then he started crying again. Was it hunger or the fuss Vicky was making?

Vicky settled down to play with Natalie's shop. Jim was grizzling. Vicky served me cups of tea and pills from her shop and her mother too; at last she had found a way of getting included! Jim was alternately grizzling and looking quietly. When June changed his position to the crook of her arm he started crying loudly. Vicky was sitting on the floor cutting up the big Christmas card she'd made for Jim, then she came over close to him saying "Jim's adopted so he has a bottle". June said that was nonsense, Vicky had felt him in her tummy. June thought Jim's crying might be hunger so she put him to the breast again.'

Mother managed to contain and survive Vicky's destructive angry protest about the new baby; all the more unbearable for Vicky because she had not been inside mummy's tummy like her brother and sister. June also protected and soothed Jim by talking, rocking and putting him in a position where he could gaze on her face. Jim held himself together by focussing on June's face. On three occasions in the observation he gazed at his mother for long periods; taking her in, holding on to the good experience and shutting out the bad. So even when Natalie shook a rattle in his face he seemed to be able to respond with interest rather than fear. Eventually, however, things did become too much. When June put Jim in the crook of her arm so that he lost the face to face contact he lost her *and* became exposed to Vicky's hostility. June responded to his distress by offering him the breast again so he was returned to a safe haven.

The first two months of observations showed the family settling in with the new baby and the two other children working through their feelings about being pushed out. Natalie oscillated between aggressive poking and proprietorial motherliness. June skilfully included her where she could. By nine weeks Jim had almost got over the colic that made him fretful in the evenings and mother was resuming some of her social activities with pleasure. Jim was taking in the world, mother's breast and face and body with mouth and eyes, and was able to survive and recover from persecutory experiences.

Weaning anticipated

'But at my back I alwaies hear
Times winged Charriot hurrying near:
And yonder all before us lye
Desarts of vast Eternity'

Marvell

From 10 weeks June began to anticipate weaning Jim. It was not clear what made her so eager to force the pace over separation. Around this time she was preoccupied with thoughts of Natalie going to playgroup in September and how much she would miss her. It was almost as if she needed to take control of another potentially painful experience of loss and move from blissful at-one-ness to complete independence without a sufficiently gradual transition. At 13 weeks she said 'she thought boys were more whingey than girls' as if Jim was too clingy and dependent which was far from the truth. Also from the moment she began to wean Jim at 15 weeks there was a noticeable tendency to substitute toys and activity for holding, feeding and inter-relating as if she wanted to encourage him to become prematurely self-sufficient and independent. This was still interspersed with moments of tender relatedness between them, but from three months the balance subtly began to shift. The Christening, planned for Easter, was also talked about a lot at this stage. Perhaps this public rite of passage also brought home that time was passing. Jim was growing up.

Observation at 14 weeks

'My arrival had interrupted a feed. While June went to make a cup of tea she laid Jim down on the pillow on the floor. He lay there quite happily smiling up at me. Then June came back and picked him up to feed him. He didn't seem at all interested and lay there looking around, more interested in watching Natalie than the breast. Eventually he did begin to feed and with his eyes wide open all the time, clutching onto mum's top, pulling it away from her body and also holding her hand from time to time.

Natalie came over with an engine that made a loud sound. I could see Jim trying to look at it without letting go of the breast. Natalie tooted the engine again and Jim did let go at this point and looked at mum very alertly, his right hand and leg waving around. He went back to feeding, but now he seemed to be quite active at the breast, grabbing at the front of mum's top and making little noises. As he fed June talked to me about the poll tax and giving up as secretary of a voluntary group. She also said that she felt Jim was really beginning to emerge as a person. Jim came off the breast and smiled at mum, then went back again. After a few minutes he came off again. Natalie was leaning over him with a boat. Mum said "Are you stuffed again?"

June wanted to wind him and lifted him up onto her shoulder. He looked and smiled, his recognition of me is clear now. Natalie held him on her lap for a few minutes. He smiled and Natalie kissed him. June offered him the other breast. Jim looked around, holding his hands and didn't seem immediately interested. Natalie came over with a car and he

looked around. Mum chatted to me while he lay looking around, kicking his legs and waving his hands about. Mum talked to him. Natalie came over a bit noisy and rough. Jim cried but still didn't seem to want to feed. June lifted him up and Natalie came over with her sponges for a kiss. Jim looked round at me. Natalie, Mum and Jim were all cuddled up together; "Have you had enough looking about now, do you want the other side?" Mum chatted about Jim being christened in April and seemed more aware of gender, talking about buying him a train set and what he would wear to be christened in.

Eventually Jim began to feed, one hand on top of another.

Natalie was out in the kitchen so June asked me to go and have a look to see what she was doing; she was mopping the floor! Jim was still feeding but his eyes were closing. June said she liked to feed Jim because it was the only time she got to sit down and have a rest. Jim stopped feeding; it was 40 mins. into the session. June lifted him onto her shoulder where he rubbed his head into her body. He looked round, smiled and burrowed into her again.'

Jim didn't appear to be upset that I had interrupted his feed but his loss of interest in the breast seemed to suggest that it had turned from good to bad. However, he recovered but the anxiety was expressed in his clutching hands, eyes open and watchful. Almost immediately, he had to contend with another intrusion, this time from Natalie. He seemed to cope and recover again, attacking the breast with great determination but his smiling at mother perhaps concealed the split off protest and anger. Mother's rather cynical comment 'Are you stuffed again?' also seemed to strike a wrong note. She may have been feeling that Jim's arrival had taken a lot out of her (like paying the high poll tax) and deprived her of things she enjoyed doing, in this case the voluntary work.

Certainly Jim didn't seem to want to take to the breast again. Perhaps he sensed the impending weaning, started a few days after this observation, and mother's wish to see him grown up as she talked of the Christening and the future train set he would play with.

Eventually the feed resumed and mother and Jim shared a moment of closeness again as he rubbed his head against her, burrowing into her shoulder, wanting to get right inside her.

Weaning

'It is not now as it hath been of yore; –
Turn wheresoe'er I may,
By night or day,
The things which I have seen I now can see no more'
Wordsworth

At 15 weeks mother began to introduce a little rice and fruit and at 16 weeks was reporting that Jim was beginning to give up his last feed of the day and was not so hungry in the morning. At 17 weeks he was on three 'meals' a day, although the breast feeding continued. In the observation at 16 weeks June first mentioned wanting to have a fourth child. It was almost as if the loss had to be coped with by introducing immediately the thought of a substitute. Instead of a gradual transition with time to take in the emotional experience of separation, in June's mind Jim was ushered out rapidly into independence and another replacement baby was ushered in.

She found it difficult to contain and gradually work through the experience with him, perhaps because of the many losses she had already sustained in her life. She coped with painful change by keeping busy and looking for new distractions but then the feelings she couldn't contain became split off, taking the form in Jim of illness and aggressive muscularity (Bion, McDougall, Bick).

I became aware in the course of the observation of her reliance on me as a containing presence and felt it was no accident that at every break illness and visits to the doctor and hospital increased; June may also have been affected by a difficult situation in Dave's family, involving his mother. This coincided with the weaning, taking up a lot of Dave's time and energy and wasn't resolved until just before Jim was one.

Jim's reaction to the onset of weaning was dramatic and painful. At 15 weeks he had an asthmatic cough and by 16 weeks was covered in eczema. June suffers with mild eczema and Natalie has also had infantile eczema so there was an inherited predisposition already there in Jim when he somatised his distress. On the surface he seemed unperturbed, but he began to spend more time asleep, perhaps withdrawing defensively from the pain.

However, Jim's somatisation of his distress was not without effect. He managed to get mother to compromise. The eczema, which resulted in two emergency visits to the hospital made her give him special attention, two baths a day and a massage with special oils and creams. Also his refusal to drink anything except breast milk made him dehydrated. June had to re-institute the 'feeds'; this time they took the form of feeding Jim drinks in spoonfuls from a cup which was the occasion for much tender talk and play between them.

What follows is a summary of the progress of weaning and its vicissitudes.

Observation at 17 weeks

As the breast began to fade Jim turned to his own body and to objects to compensate for its loss. Perhaps he felt that he couldn't control the breast, but he could control the little men that were hung in front of him for him to play with. He played with his tongue, lifted his cardigan up and down, chewed his fingers, rubbed his feet together, sucked his lips and made the little men dance about hitting them with his hands. Eventually, at the end of the observation he was put to the breast and fed hungrily. Mother seemed to tune in to his anxiety 'Are you saying your prayers, Jim? Praying that there will be enough for you?' It was hard to be sure at this point whether a defensive muscularity was setting in or whether there was a genuine reaching out for new experiences of the outside world.

Observation at 21 weeks

Jim was now sleeping in his own room and June was obviously getting impatient to get on with her own life. She'd left Jim grizzling the previous night while she did her typing and he'd scratched a patch of eczema on his head and drawn blood. She wanted Jim to go straight from breast to trainer cup with no bottle in between. However, both mother and baby seemed ambivalent about growing up. Jim played independently for quite some time, but when June fed him he lost himself in the breast, holding mum's hand and raking his nail across her middle finger in a rhythmic movement, perhaps enjoying the fantasy of controlling the breast and getting right inside. Mother remarked that he'd be sitting up soon and then held him closer as if drawing back from the thought of his independence even though it was also desired.

Observation at 22 weeks

Both June and Jim were suffering badly from eczema. Jim played with the muslin nappy that June used at breast feeds. June was preoccupied with Dave's family problem and talked to me about it. Jim played with the muslin nappy for fifty minutes, pushing it into his face, pulling it over him, getting himself tangled up in it. At times both June and Natalie played peep-bo with it with him, and he kicked and looked

excited. His capacity to wait and find a substitute for the breast was marked, but the eczema suggested it was at some cost to himself. That night the eczema became so inflamed that he was seen at the hospital and prescribed steroid creams.

Observation at 25 weeks

Jim had been ill again with a bad cold. He didn't look well and was lying on the mat crying and coughing. Initially June tried to distract him with toys, songs and bouncing games, but the cough became worse. June fed him and then held him on her lap which was what he seemed to want more than a feed and she played with him tenderly. Again her conflicting feelings were very marked, at one point in this observation she talked about giving up breast feeding at nine months, she'd enjoyed it, but she didn't want a toddler hanging onto her and yet at other times in the same observation she showed a tender concern and sensitivity to his dependency and need for her. This oscillation between opposing states continued but in the next observation the wish to push him into premature independence began to dominate. Stimulation, excitement and activity took precedence over quiet, tender relatedness.

Observation at 27 weeks

The lunchtime feed had now disappeared. Jim's mobility had increased and he could crawl backwards for quite a distance. Jim grizzled and wheezed in an asthmatic way throughout the observation, but June was unresponsive: 'If you pick them up all the time you'll make a rod for your own back'. Mum seemed to have little capacity to connect with his need of her. She was preoccupied by Dave's continuing involvement in the unresolved situation with his mother. Perhaps she felt deserted so Jim was also left comfortless. Significantly in this observation she seemed agitated by Jim getting his hands covered in shit and the thought that shit would fly everywhere. The world had turned bad.

Observation at 28 weeks

Jim was put in the new baby bouncer for almost the whole observation, while mum went upstairs with a visitor from her voluntary group. At

first he seemed to experience real fear, suspended as he was in space with his feet barely touching the ground. He became very distressed and I held him for a moment until he calmed down. He then went into a whirl of activity, bouncing, spinning, turning round, his hands and feet shooting up and down. The anxiety, fear and despair he felt initially were quickly translated into a frenzy of excited movement. The feelings were lost, bounced away by the muscular activity. Mother had lost herself in activity and so had he.

Observation at 29 weeks

June was ill. She looked pale and tired and was on antibiotics for an infection. Again, the pattern of bouncing away feelings by vigorous activity was evident. She played a football game with Jim which involved holding him in front of her and darting from side to side saving imaginary goals as June ran the commentary. Even Natalie had been given a new trampoline. There followed a much shorter period in the baby bouncer for Jim while mother had another meeting with a visitor from the voluntary group. This time, even though he was lost again in manic excitement, he seemed to retain a sense of mother. He listened to her voice upstairs and looked up towards where she was.

Observation at 32 weeks

The breast feeds had now been reduced to last thing at night and first thing in the morning. Perhaps as a consequence Jim was restless at night so June often took him into bed and gave him the breast during the night. In this observation she played a singing and bouncing game with Jim; he seemed most happy when he was held between her legs, but he was fretful and cross a lot of the time, pulling at his ears which mother saw as a sign of tiredness. He sucked his fingers and seemed out of sorts. Mother was preoccupied with getting the weaning finished so she could go to Paris for the weekend with her husband, but Jim seemed out of sorts; his dependency and need for the breast were being denied. At an unconscious level mother seemed tuned in to the more traumatic aspects of the weaning for Jim. It took the form of a frequently expressed anxiety on her part about cot deaths. But allowing herself time to think about the emotional experience of weaning for both of them didn't seem possible.

Jim's eczema became very bad with swollen glands in his neck and groin and he was seen at the hospital again. June received conflicting advice and felt criticised by the medical staff. She was by now very concerned for Jim and identified with him as she'd had eczema badly as a child. In this observation he refused to take any water from the cup, turning his head away angrily so that mother had to give up. The distress was again discharged in muscular activity. He beat his shoe up and down on his leg and waved it in the air, then he exploded into kicking like a jumping jack. The last part of the observation was very distressing, he pushed the muslin nappy into his mouth, biting it and ramming his fingers in through it so he nearly choked. A desperate quest for the nipple.

After the summer break when Jim was nearly ten months things gradually began to improve. Dave had been promoted at work and the family were better off so they extended their house. Mother's tiredness had also been recognised and father had suggested she get help with Jim. Jim's eczema was beginning to respond to treatment; two baths a day with special oils given by June at the suggestion of the hospital. She was also having to breast feed him during the night as the doctor had diagnosed that he was dehydrated. Jim was adamant that he would take nothing except the breast but gradually June established a 'feeding ritual' (described later) that compensated for the lost breast and he began to sleep better at nights.

He was now crawling everywhere and able to stand up when supported. His increasing capacity for symbolic thought and play also helped him cope with the changes.

Natalie settled well at playschool and June, who had inherited some money, was able to buy herself a car. She seemed in a much better state and no longer wanted anyone else to look after Jim. At 43 weeks Jim and mum played, laughed and talked together, demonstrating that both were feeling much better. June fed him juice off a spoon sitting on the floor opposite him. He was very keen, opening his mouth wide and watching the cup and mum hungrily. It was a complete contrast to the time before the summer break when mum had eventually given up. He was now drinking 3/4 cups a day, but only by this method; he refused to have his own feeding cup, although he was quite capable of holding it. The feed continued with intense eye contact and a wide open mouth. This feeding ritual compensated for the lost breast and continued well into the second year.

It was salutary to observe the active way in which Jim had contributed to the changes, compelling mother into altering her behaviour and responses to him and stimulating her capacity to recover her confidence and pleasure in mothering him. This seems to bear out Fordham's contention that 'a baby is able to adapt himself to his mother as she is – as a person' in sophisticated and powerful ways in order to influence the relationship positively.

External factors also played a part: father, June's mother and grandmother and the hospital had all given crucial support to mother and baby.

The capacity for symbolic thought and play

> 'These beauteous forms
> Through a long absence, have not been to me
> As is a landscape to a blind man's eye:
> But oft, in lonely rooms, and 'mid the din
> Of towns and cities, I have owed to them,
> In hours of weariness, sensations sweet,
> Felt in the blood, and felt along the heart;
> And passing even into my purer mind
> With tranquil restoration.'
>
> Wordsworth

As Jim continued to grow and develop, his ability to explore the external world by crawling and eventually walking was paralleled by his acquisition of language and his increasing capacity to play. An inner mental space revealed and explored in play became increasingly of interest in the last six months of observations. There was still evidence in the continuing mild eczema, several bouts of ear and throat infections and a thin frail appearance that some of his experience with mother remained 'indigestible' or 'unthinkable' (Bion, Segal), but his capacity to contain and think about experience in the absence of mother was evident. He had been sufficiently held, both physically and in his mother's mind, in spite of the difficulties already described in weaning, for Jim to learn to be comfortably alone with his thoughts, to turn to others with curiosity and pleasure and to be separate but remain related as he lost himself in play.

In his play we see Jim's unconscious phantasies being explored and worked through. This inner world has a dynamic rather than a static quality where the objects have a life of their own inside Jim that emerges spontaneously in play (Klein, Bion, Segal). Now it is not just

mother who mediates the deintegrating/re-integrating sequences, if we look at it from a Jungian perspective, but Jim himself who begins to take on that role, sustained by the 'good mother inside' or in more poetic language by 'the beauteous forms' celebrated by Wordsworth in *Tintern Abbey*. In his play, Jim doesn't just *remember*, he actively works on and transforms his object experiences.

Observation at 44 weeks

Jim and mother seemed to be playing out separation. As he fed, June putting spoonfuls of liquid in his mouth from the cup, he held onto his hair and the liquid in his mouth for a long time before swallowing it, but also kept picking up his rattle and throwing it away. During the feeding Jim and June played a game of imitating sounds, initiated by mother. She repeated sounds he made, then Jim reflected her sounds back as if taking in and giving out mother. This became a feature of the feeds. There was a particularly deep chesty expulsion of sound that had a very primitive resonance, perhaps representing both getting rid of the breast and also celebrating it in a kind of musical intercourse. This feeding ritual became a substitute for the breast feeds that were waning. Jim fed from the breast/cup with a look of intense pleasure, his eyes became moist and his cheeks flushed. He savoured the liquid in his mouth sensuously before swallowing it. Often his eyes glazed over as if he was lost in ecstasy. This need for a concrete substitute, indistinguishable from the breast lasted for several months. It seemed appropriate to continue to call the drinks from the cup 'feeds', although breast feeding during the day had long gone and stopped completely even at night at 14 months.

Observation at 45 weeks

For the first time I noticed Jim being lost in thought in a sustained way. Mother was out of the room and he sat by the door to the conservatory, fingering the curtain and the door frame. He was lost in his own world, registering mother's absence but finding a substitute for her as he fingered the curtain and door. (Bion – 'No breast – therefore a thought'). He can think about an absent mother and also find a symbol for her in his play.

Later in the observation, when excluded from June's attention,

because she was busy with Natalie, he crushed a large sheet of drawing paper between his legs and then crawled over to his chair and pushed that around with his feet. But the frustration and aggression were expressed rather than denied and he was happy to be included and snuggle up to mother when she was free again. He did not cut off and withdraw into an omnipotent world. As they hugged and kissed he leaned back and looked at me as if to say 'I've got her, now you're the one left out'.

Observation at 47 weeks

Jim's play still showed a preoccupation with the breast and its loss but now father entered the picture. Jim was losing the breast and he had a rival. Hanna Segal writes interestingly about the role of father in facilitating mourning in relation to mother. 'It is an important aspect of the depressive position that the recognition of mother as a separate person includes the recognition of father as her partner, rather than as a part-object seen as her possession or as an object confused with her, as in the phantasy of the combined parents'.

In the first part of the observation Jim pulled parts of a robot out of the box and tossed them onto the floor. Then he spent some time banging separate parts together. He also played with the 'My Little Pony' toys. He fingered the crib and took the little ponies out of their box. He went in and out to mother in the next room; at one point he took her in a tambourine and they both held it and shook it together. The emptying the parts and little ponies out of the box shows him working through the loss of the breast but still enjoying an exciting intercourse game with mum, banging the separate parts together and shaking the tambourine. Later, he played on the sofa like a small animal, turning and burrowing, rolling around and pushing his head into the sofa; celebrating the breast before losing it.

When Dave rang up and talked to June, Jim who had been sitting by the telephone seemed to register this intrusion by father into his blissful world with mother. After the call he sat in the hall playing with dad's slippers and pulling bits of lambswool out of the inside. He seemed tired and grizzly and when he went back into the living room became fascinated by Natalie's shiny pink pencil case. Perhaps his destructive play with dad's slippers was an attack on the parental couple and he turned to the shiny new object, disillusioned with mother who is not all his after all.

Observation at 48 weeks

Jim's increased capacity for symbolizing showed in his ability to play independently of mother for quite long periods of time and with absorbed concentration and tenacity. But he also continued to play out the separation *with* her. They played a throwing, chasing and retrieving game with a ball over and over again. There were still moments of intense closeness, when he would bury his head in her lap or exchange the throaty sounds that I began to call 'the intercourse game'.

Observation at 49 weeks

Jim's play in this observation had a developed reparative function. He had climbed onto my lap and then slipped and bumped his chin. Then mother had accidentally stepped on his hand when he had gone to find her in the kitchen. He was very upset and cried loudly. June comforted him and sat him on her knee, spooning the drink into his mouth. But he didn't savour the liquid in quite the way he usually did. Later, when put down on the floor to play he eventually settled on a plastic block and a draught, banging these together vigorously. By this action perhaps he restored the link between mother and him, bringing them together again. June also restored him, giving him a lovely ride in the toy box up and down the room. Eventually this stopped and Jim became absorbed for 15 minutes at the toy box.

> 'First he took out a plastic cup, examining it intently before dropping it on the floor. Then he became absorbed by the plastic saucers. He chased them around the box showing great perseverance in lifting them off the bottom of the box, which was quite hard to do as they were face down. He had various games he played with them. He banged them together, he also rubbed them together making a noise – he placed them side by side on the floor and he held one while rasping his finger across the bottom of it. He gave both of them to mum, but then whipped them away when she went to take them. Finally, he put them together on top of each other.'

This play sequence had a form and rhythm to it that set it apart; an aesthetic experience. After the bad experience of the accidents and hurt fingers and chin Jim seemed to have found new capacities for creating and curiosity. The play with the saucers seemed to celebrate his re-emergence. He was not frightened and victimized but able to explore the violent angry feelings and bring together the saucers in a final resolution.

However, there were still times when this positive forward movement could falter. There were inevitably fluctuations in Jim's capacity to cope and mother's resources. In this observation Jim and Natalie both had bad colds and had kept June awake for most of the previous night. Initially, Jim reacted to me with interest, giving me toys to hold and then retrieving them, but when he went into the kitchen he had to wait for his drink and it was too much for him. He started to cry very loudly and would not be consoled. He went on crying for 20 minutes. Mother remained very calm and soothing and held him on her knee. Eventually the sobbing subsided and he lay on the floor as she stroked his back. He refused the offered spoon of drink and crawled towards mum's tea. When she said 'no' quite mildly he broke into a storm of crying again. June distracted him with toys and he began to forget the tears and eventually played with the cups and the little men. He put the little men inside one of the cups and gave it to me. Then he took it back; if the little men fell out he would put them back in and give it to me again. He seemed to be repairing some of the damage, putting himself back together again after a frightening disintegration. But it seemed as if the play didn't quite reach to the hurt. There was a compensatory and omnipotent quality about it as he put the cups inside each other, stood them upside down and placed one of the little figures on top. Later, there was another interruption, a delivery man at the door. Jim crawled out to look but then returned uninterested, picked up my cup and threw it forcefully at my knee. He seemed to be recovered and went back to rummaging in the toy box as if nothing had happened, but this time the feelings had not been fully worked through. He projected his anger, splitting June and me and hurling his anger at the bad observer mother.

The holiday break came shortly after this observation and Jim was ill again both before and during the holidays with a cold and throat infection. He had to have antibiotics. The next time I saw the family Jim was 1 year 7 weeks and the family were about to go for a holiday in America with Dave's mother. June told me she was pregnant again; the new baby would be born 3 months before Jim was two.

After the holiday and over the next 3 months Jim began to relate to me in a very affectionate way. He would come and sit on my knee, pushing his hands down on mine and pressing his fingers into my palm. At other times he crawled onto my lap and explored my face and body, patting me and stroking me with his hands. June explained

that he played a game with father of putting hands on top of each other and then taking them out. When I tried this he responded immediately. Jim now had a clear sense of father. I could 'stand in' for father and represent him for Jim as I obviously do here but at times, as he explored my body and patted my chest I felt I was also the mother he still wanted just for himself. June's pregnancy may also have prompted him to turn away from mother towards me. Although father can be an ally at this stage of separating, Jim both seemed to appreciate this and also to hanker for the lost, exclusive relationship with mother. He continued to explore this ambivalence in play.

He still clung tenaciously to his feeds from the breast/cup, but gradually he began to intersperse drinking with playing as if beginning to let go a little and risk a less concrete and more symbolic way of thinking about it. Initially, during the feed, he played with the round plastic container, putting his little Fisher Price men into it and taking them out, shaking the container to hear them rattle and putting his hand inside. The action seemed to be saying 'I am securely in possession of this plastic breast and I will always be inside it'. Some weeks later, during the feed, I saw him building cups up into a tower and then knocking them down as if playing out the experience of 'there' and 'gone'. Later still, he lost himself in a picture book between spoonfuls. But it was not until 18 months that he began to play out relinquishing the breast/cup and even then it was accompanied by great anxiety.

Observation at 1 year 12 weeks

In this observation I first heard him use the word 'gone', verbalising what he also played out, when mother went into the kitchen. He went on playing and brought me a large plastic container and a smaller one which he put inside it. He could still have the concept of 'June and Jim together' in her absence, but not for too long. After a while he went off to the kitchen to look for her.

Thoughts about separating from June and the advent of the new baby who would replace him at the breast seemed to intermingle at this stage. I was often not sure whether the games he played of emptying all the toys out of the box and then replacing them were about getting rid of the new baby and putting himself back inside or playing at losing and regaining the mother who goes away but comes back. Natalie and he began to play *together* more and so there were advantages too in growing up.

Observation at 1 year 13 weeks

In this observation it was half-term and both the girls were at home. June was reading with Vicky so Jim and Natalie read together imitating the other pair, then he came to me and sat on my lap. Eventually, as mother was still preoccupied with Vicky he went off to play on his own with the toy box. He used it as a shield *and* as a space to create his own world, putting little men into it and lowering the box like a barrier while he kept an eye on mother and Vicky. Natalie opted out and went to sleep but Jim never completely cut himself off, peeping round the edge of the box and eventually sitting sideways on to the reading pair. At the end of the observation, the family came together again, Jim and Vicky waking Natalie up and they all laughed and played. So Jim was able to cope with exclusion without cutting off or withdrawing completely but establishing his own separate space.

Observation at 1 year 15 weeks

June seemed to be tired and worried about the new baby; she was having various tests to determine whether the baby was all right as it was a late pregnancy. My impression was that Jim adapted to his mother's mood and was undemanding and slightly anxious, following her around. The next week he was ill again with a sore throat and mother was quiet and rather depressed, asking Natalie for cuddles and kisses. Jim was also very affectionate to mother as if sensing her distress.

He fetched his jacket and put it in the washing machine and then brought it over to June to have it ironed, making it clear that he wanted to be close to her but in an undemanding way. He also emptied out the toy box several times and then put the toys back in, one by one, with elaborate care.

I wondered about the recurring sore throats and the over-careful replacing of the toys. Perhaps some of the rage at the loss of the breast and the new baby was somatised. Also, he had learned that June responded to him when he was ill; it was a sure way to get her attention. There was a fragile thin look to him and the next week mother told me the doctor was referring him to the hospital as he was underweight for his age and they were going to check for hormonal deficiencies. Fortunately this proved to be a false alarm.

Observation at 1 year 17 weeks

Jim played with great care and thought, leaving things with me for safe keeping and then retrieving them, actually enacting the process of selection and replacement as if anxious about whether he would be 'deselected' with the birth of the new baby. He brought me four figures and a piece of construction kit making five separate journeys to do it. He left them with me and went away. Then he returned and took them back, again one by one; twice he couldn't make up his mind and came back and swapped one he'd taken for another one before putting them in the toy box. Later he took three figures over to mum and when he dropped one he went to enormous trouble to retrieve it, squeezing past Natalie and hunting under the chair. When mother got fed up with having them on the ironing board she stopped him playing. He didn't cry but went and lay on the floor exactly as he'd seen Natalie do earlier when she was cross with mother. He seemed to be playing out anxieties about whether he might get lost, but he encounters a busy worried mother who doesn't seem able to contain these anxieties and has to be protected from the full force of his feelings. The protest perhaps gets split off, expressed in the failure to thrive and the sore throat and cold that continued over the Easter holidays.

Observation at 1 year 21 weeks

After Easter, for the first time, the children were hostile to my re-appearance. With June's pregnancy now quite advanced, they didn't want another intruder! Gradually, both became more friendly. June talked a lot about the new baby. At this point Jim began to systematically remove the nappies from the plastic packet, spread them all over the floor and laid them on top of the toy box but in a tidy way. Mum kept saying 'no' but in a half laughing manner. He continued with great determination until mum got up and tidied them up. He didn't protest but stood by quietly not seeming to mind too much. However, when Natalie pulled Jim over roughly by the hand I saw him push her away with some force. He was making his feelings about the new baby clear. The nappy/babies were removed with ruthless efficiency: the aggression was directed at Natalie, his immediate rival, but perhaps he displaced the anger from mother to spare her.

Jim's capacity to think about inside and outside, to destroy and repair symbolically and to have his own world of play and thought separate from mother was again in evidence.

> 'Jim played with his toy box. He threw several toys in quite roughly. One hit Natalie and hurt her and she had to be comforted. He then threw all the toys out and collected them one by one and put them back in the box. He pushed the box up the other end of the room, but mum brought it back so he was more within my view. He eventually settled on play with three little cups which fit inside each other – mum says they are his favourites and he takes them to bed with him. He went and took one off Natalie and it seems to be realised that they are his special toys because she gave it up quite readily. Then he took a red cup with a handle and put two little figures in it – they fell out as he turned back towards the toy box. He got the little cups and put them inside each other. At one point he turned the toy box upside down, then lifted the side nearest to him to see what had fallen out. Later he played with the three little cups again, this time putting them on top of each other so they made a tower.'

The range and emotional complexity of the play and the confident use of his symbolic objects, both mother and Natalie recognised the cups had special meaning for him, seemed to confirm advances already noticed in his capacity to think. The breast has been given up but he has a new potency which he celebrates as he builds his tower out of the little cups. The breast is let go of, but also incorporated into the new construction both outside in the play and inside as a thought. He has a creative space inside himself symbolised by the box and its contents which helps him let go of mother and recover from the pain of ejection caused by the weaning and the new baby inside her.

In the next observations the breast/cup began to lose its intense significance for Jim. By 18 months he was playing out throwing it away but with some attendant anxiety.

> 'Jim sat on the floor with two pencils in his hands as mum fed him from the cup. He threw one of the pencils right across the room and it fell behind a box. He said "gone" very clearly and began chirruping away quite excitedly. He went to look for the pencil but couldn't find it. He came back and started throwing everything around in an excited state – books, papers and toys. June was quite tolerant and amused. The drink was completely forgotten. He frolicked around mum, rolling about and falling against her very excitedly. The play continued on the sofa, June tickled his feet, took his socks off and kissed his feet and they laughed and talked together. The feeling of excitement continued – eventually as he stood beside her banging his hand on her lap he seemed to hurt himself and burst into tears. June lifted him back onto her knee and comforted

him, kissing the sore finger which he bites when teething and the hurt hand. The drink was forgotten and finished off by Natalie.

Later Jim and June played together. He hid his pencil inside the plastic on the disposable nappies and it got lost. June joined him on the floor and they played hiding and finding the pencil together.'

As Jim celebrated his exciting independence it went too far. When he burst into tears it wasn't clear whether it was a phantasied or real hurt that was the cause. The phantasy may have been that he'd thrown mother away and now he needed her so he experienced a fear of destroying the breast and hurting himself in the process. June was able to respond intuitively both to the excited independence *and* to his anxieties about it and make him feel better. Then together they played a calmer game of 'getting rid of' and 'finding again', integrating the experience at a pace that he could tolerate.

In this observation we can see that Jim has developed sufficiently in his ability to use language and symbols to begin to dispense with the breast/cup. His need for a concrete 'symbolic equation' for the breast is fading (Segal). But the moment of relinquishing the concrete object is fraught with anxieties. Paradoxically, at this point he needs mother more not less to help him manage the transition. Here she *was* able to help him by empathizing with the pangs of growing independence, both the excitement and the pain. Jim could then make another step in internalizing mother as a '*thinking* object, not merely a *serving* one' (Meltzer). However, her physical presence, the concreteness of touch and kiss, was still the vehicle of her empathic thoughts about her son and underlay the return to symbolic play that they both shared at the end.

After thoughts

It seemed inappropriate to end this paper with anything as final as a conclusion. My experience of observing confirmed that this early relationship is endlessly shifting, responding to inner and outer events that interact in mysterious way, forming subtle and often unpredictable patterns and sequences all the time. So I end with a series of thoughts activated in me by the process of observation and still being pondered in ways that I hope will inform my current and future practice as a therapist.

My thinking has been influenced by the many fruitful discussions enjoyed with the seminar leader and fellow members of my infant observation group. I would like to acknowledge the pleasure and

interest of this creative discourse as it wove in and out of my observations of Jim. Theoretically, Fordham, Winnicott and the Kleinian tradition as it is developed in the work of Bion, Segal and Meltzer have been most helpful to me in trying to conceptualise the experiences observed.

One of the most striking aspects of the observations for me was Jim's capacity to survive and positively influence the difficulties he encountered. Jungian archetypal theory with its emphasis on the physical and mental poles of the archetypes and their importance as 'organisers of experience, innate pre-dispositions' (Sidoli) seems to parallel closely the Kleinian view of phantasy as the 'mental corollary ... of instinct' (Isaacs). Both theories place emphasis on innate factors in the child being powerful determinants of experience. These innate factors are helpfully conceptualised by Ogden not as 'inherited thoughts but a biological code that is an integral part of instinct' which predisposes the infant 'to organise and make sense of experience along specific lines'. Certainly Jim seemed to bring qualities of tolerance and constructive responsiveness from the start, to have an unusual capacity to hold onto and take in good experiences and not lose heart in the face of the weaning difficulties.

This innate capacity to tolerate frustration Bion sees as of critical importance for the process of thought formation and the capacity to think. I have, throughout this paper, drawn on his theory of thought and his model of container/contained to try and understand aspects of Jim's development. What seems to have happened with June and Jim is that a good relationship was temporarily disturbed by events in June's life both external and internal. Her capacity to function as an effective container for her child's thoughts and feelings and to be open to these projected needs was damaged. The external pressures which affected her 'capacity for reverie' I have already mentioned. The internal events we cannot know with certainty. Her illness as a teenager suggests there were conflicts for her around separating and growing up. Whatever the reasons, Jim experienced a mother who could lapse into states of mindlessness. This had consequences for him of a distressing nature and he became seriously ill with eczema. In Bion's theory when the mother cannot receive and detoxify the infant's projections, her alpha function fails to transform the beta elements (the raw sensory data received) into alpha elements so that they can be used for thinking. The eczema can be seen as expressing primitive emotional experiences (beta elements) that cannot be thought; they remain concrete and untransformable. In McDougall's telling phrase 'our bodies ... "think"

in our stead'. Jim's prolonged need for a breast/cup is another example of difficulties in symbolising, although being able to find a substitute to prolong the needed experience was a constructive regression and he was gradually able to let go of the concrete symbolic equation through playing.

The breakdown in mother's containing function was eventually restored and was never absolute. Jim's illness played a part in restoring her to a state of receptivity again so even this symptom of failure had a communicative dimension, but it may be that there will always be difficulties for Jim around change and separation. Hanna Segal writes, 'One can look at unconscious phantasy and the structures evolving out of it as determining the basic structure and character of the personality, as the matrix of our mental structure and life'.

Quite how Jim will develop remains to be seen. June has agreed that I can continue to observe at monthly intervals until Jim is two, and I hope to keep in touch with the family after that so some of these questions will eventually be answered.[1] However, as Martha Harris reminds us in 'Some Notes on Maternal Containment in "Good Enough" Mothering' 'areas and states of non-containment, of two dimensionality and mindlessness exist in the development of every infant and are therefore in us all'.

There were times when I found the abstraction of Bion's language unpalatable and turned to Winnicott's formulations about playing for a different way of looking at the interaction between Jim and June. Playing and thinking are closely related, the ability to play at all being dependent on having an alive and thoughtful internal object. Jim had this sufficiently to play out his experiences, work through unconscious phantasies creatively and stimulate mother into playing with him. Playing also combines the conceptual and the concrete: both pain and pleasure. There is effort and struggle and also achievement. Perhaps this is why it is so helpful in separating because the lost pleasure is restored both concretely and symbolically in play. The child has potent, loving creative parents inside, not a dead empty intercourse.

[1]At 2½ years Jim was a small, rather vulnerable looking boy compared to the three other children in the family including the baby. Mother perceived him as difficult and needing more attention than the others. At the follow up visits he seemed active and affectionate, not particularly troublesome, although a little anxious, and noticeably advanced linguistically. Mother located the cause for his vulnerability in the broken collarbone at birth and at times considered alternative healing methods for this. Perhaps, unconsciously, she was aware there had been a 'break' in their relationship early on. It was interesting to see that she was still breast feeding the new baby during the day at nine months.

Gradually, an alive set of theories emerged for exploring and making sense of infantile experiences. This strengthens my work as a therapist since I have more ideas to think with as I work with patients. But there is also a way in which the observations operate like an amplification in the classical Jungian sense. Often, as I work, a memory of a particular exchange or a sequence of play will illuminate and clarify what is happening with my patient and enable me to understand and respond appropriately. So the experience of observation has increased *my* capacity to play. I will leave the last word with Winnicott who has done so much to illuminate our understanding of the creative potential that exists in the experiences of childhood and the experiences of therapy.

> '*Psychotherapy is done in the overlap of the two play areas, that of the patient and that of the therapist.* If the therapist cannot play, then he is not suitable for the work. If the patient cannot play, then something needs to be done to enable the patient to become able to play, after which psychotherapy may begin.'

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OBITUARY

MICHAEL LANE 1944–1992

Michael Lane died suddenly on October 16th. For all who had worked closely with him over many years, the shock and incredulity of such a sudden departure of an intelligent, gentle, reliable and supportive colleague will remain for a long time.

He was born in Harrow in 1944, and spent his first years in Southend-on-Sea. In 1957, his family moved to Rhodesia. He never felt at home either in Southend or in Rhodesia and when he finished his medical studies at the University of Capetown, he moved back to England, training as a G.P. in Kettering, Northants. He joined a general practice in nearby Rushden, and his first two (of four) children were born there. He came to London in 1978 and did sessional work in family planning clinics to support himself. In 1979 he began the BAP Jungian training, qualifying as an Associate Member in 1985 and as a full member in 1989.

Soon after qualifying, he devoted himself solely to analytic work, and he very quickly became involved in BAP activities. His identification to the analytic attitude made him a logical choice for a place on the Training Committee.

His diffident and shy manner belied a powerful personal capacity for deep commitment to all areas of analytic endeavour, whether clinical, theoretical or organisational. To accomplish this, he brought a wonderful sense of wry humour, a deep capacity for insight, an adroit summing up of situations and personalities, and above all, an ability to dedicate an enormous wealth of energy and support for those goals he shared with colleagues with whom he felt of like mind, a support that was untainted by envy, rigidity, or mean-spiritedness.

If he was diffident and shy publicly, interiorly he was strong in thinking and feeling. He was wedded to the analytic attitude and this gave him an inner strength and confidence which enabled him clinically to relate to patients who found themselves in primitive and fragmented states. It also meant that, in his work with colleagues, he could support wholeheartedly, as well as initiate, efforts that would further the development of analytic understanding and clinical practice. This included all aspects of training, even the nitty-gritty of financial management

and policy, and extended beyond the training to other teaching projects, pre- and post-professional qualification, including publications. He was broadly responsible for the Newsletter and argued stoutly for a second BAP Journal. Lengthy discussions were conducted with colleagues via the answerphone.

His thoughtful and energetic support was an enormous source of energy to the Training Committee. He was very enthusiastic when the Introductory Course was launched and he campaigned for the Monographs, which broadened the BAP publication portfolio. He gradually became more and more involved in the other working Committees of the BAP; Post-Graduate, Publications, Finance, and finally Council.

He loved the BAP, and worked especially towards strengthening it in its potential capacity for fruitful dialogue between the Sections. He was a deeply thoughtful clinician, who had just begun to make theoretical contributions to the literature. He had sketches for further contributions to that area of his particular ability: the interaction between the primitive levels within the patient that touch the therapist's own primitive responses.

In losing Michael, we have lost a committed colleague and friend who had already revealed to us those inner gifts and resources that would have made further rich contributions to the BAP in the future. He had only just begun.

Hester Solomon

OBITUARY

JAFAR KAREEM 1930–1992

Jafar Kareem was the founder of the Nafsiyat psychotherapy centre, the pioneering service in North London which first offered dynamically orientated psychotherapy to patients from minority ethnic groups. He was born in Calcutta, the youngest son in a professional family. After he had completed his university education, he was expected to follow his elder brothers into an influential professional position, but during his studies he became involved in the anti-colonial political struggles of the 1940's which led to the partition of India, and in the personal tragedies that followed. His activism resulted in his being imprisoned by the British authorities. During one demonstration he witnessed the death of a student friend, an experience to which he later attributed his passionate commitment to reconciliation.

After completing a psychology degree he travelled to Britain for postgraduate work, and then to Austria in the 1950's to work with refugees and other people displaced as a result of the Second World War. It was there that he became interested in psychoanalysis and began his own personal analysis. He continued his therapeutic work in Israel, working in Hebrew, German and Yiddish. After three years he returned to England to train as a psychoanalytic psychotherapist with the British Association of Psychotherapists. With Josephine Klein of the Group Analytic Society and the British Association of Psychotherapists, he ran the Black and White Group in the seventies to enable members to explore personal issues of racial identity and racial difference. After working with children and families in the National Health Service he began the Nafsiyat Intercultural Therapy Centre with the support of his wife Heloise, a social worker with International Social Service (UK). He gathered around him like-minded colleagues, including general practitioners and hospital consultants, many of whom are still actively involved in the Centre.

Nafsiyat, now in its tenth year, developed a new theoretical and clinical approach to understanding the issues of race, culture and gender in psychoanalysis; one which acknowledged the reality of the external political world. Undeterred by the scepticism he met, he persevered in confronting those who did not see the significance of

racial differences in therapeutic work. He also maintained that psychotherapy should be available to those who could not afford it privately. The Centre has now achieved the respect of the psychiatric and psychoanalytic establishment and Kareem's teaching and research has been recognised by the Department of Health, the United Kingdom Standing Conference on Psychotherapy and the Royal College of Psychiatrists.

An Honorary Senior Lecturer in Psychiatry at University College London, Jafar Kareem was the founder and joint organiser of its Diploma in Intercultural Therapy. As a teacher he posed a challenge to traditional psychiatry and its complacency over the high representation of black people in psychiatric institutions. Throughout its existence, Nafsiyat has been involved in research on treatment outcome and diagnosis, and on developing a theoretical basis for Intercultural Therapy. A book of that title was edited by Kareem and Littlewood and was published earlier this year.

Kareem introduced some important concepts to psychotherapy which will live on: he provided access to the inner world of experience with all its richness and complexity for black people and other racial minorities who hitherto had been considered psychologically unsophisticated and unable to benefit from psychotherapy.

In doing this he has made the psychologically orientated professions look at themselves and their own deficiencies; notably in maintaining that clinical emphasis on the subjective, and on the private, can never ignore the shared social world.

Lennox Thomas

BOOK REVIEWS

Toddlers and Their Mothers. A Study in Early Personality Development

By Erna Furman. International Universities Press, Inc. 1992 pp 414 Hb £34.65.

This richly-rewarding book is for all of us, those who work with adults as much as those who work with children. It is really several books in one: a fascinating picture of toddlerhood built up through observations at the Hanna Perkins Toddler Group; a perceptive theoretical exploration of this crucial stage in human development; a model for future research with an accompanying manual; clarifications on a hundred matters about which we may have wondered, but rarely thought so clearly. It contains much that is moving on a human level, for Erna Furman *likes* toddlers and their mothers, and her case vignettes convince by live example.

From the wealth of her experience, she has distilled an explanation as to how the child becomes his own person, illuminating our understanding of patients of all ages. She suggests that as the child develops there is a reciprocal change in the mother's involvement: her relating to him as a part of herself is gradually replaced by her relating to him as a separate person. This process is necessarily a flexible one, and will inevitably involve loss as well as gain for mothers.

First and foremost, the child must come to own his own body. 'He gauges his hunger and feeds himself, learns to know his sensations for eliminating and mastering toileting, dresses himself and cares for his clothes, learns to keep himself safe and avoid common dangers, is able to fall asleep on his own when tired.' (p 118) A person who can do all these things is indeed 'a somebody', and it is above all the mastery of self-care which makes the child feel he is a person. For this mastery is the vehicle by which ownership of the body is transferred from the mother to her child.

The author proposes four shared steps in the process of transfer: doing for; doing with; standing by to admire; doing for oneself. (It is worth considering some aspects of the analytic process in the light of these stages.)

What happens when things go wrong, when, for instance, the mother continues to cathect her child as a part of herself? 'Ultimately, being

loved only as a part of a parent means not being loved, being unacceptable as oneself. The lasting personality adaptations to such a state vary enormously ... but basically they are a means of coping with a lack of investment in one's real self.' (p 130) Any one of the four steps may prove difficult for mothers, but the stage of 'standing by to admire' can be particularly hard, especially if mother is not aware of how important she still is, how essential her continuing interest and admiration may be to the toddler who is so proud of being able to put on his own jacket.

This theory brings together the contributions of both inner and outer factors to the changing mother/child relationship. A step forward in any one area is seen to affect all other areas. Changes in relationships, for instance, bring changes in coping with aggression, in the balance between love and hate, and in the capacity for integration.

Such thinking will be natural to many of us, but some of the author's thinking will be less immediately familiar. Recent valuable advances in object relations theory and technique have sometimes been accompanied by a comparative neglect of the role of the drives. Mrs. Furman puts these back in place, but neither neglects nor over-stresses their role. For instance she fully recognises the intensity of toddlers' anal messing and aggressive impulses, but also recognises the impact of these impulses on mothers, and the threat of regression involved for them, a threat which will affect the mother's attitude to her child, and so, his attitude to himself. The interweaving can be complex: from an object relations viewpoint we can see how the toddler may use anal activities to try to reach a withdrawn mother, or to express moods and feelings – anger, helplessness and loneliness were often shown in a heightened preoccupation with anal and urinary activities. From the viewpoint of the ego, angry contrariness or provocative misbehaviour may be understood as attempts at the establishment of the self as an individual. But the bodily impulses involved are also *causative*, and provide active gratification. Central though relationships are to Mrs Furman's thinking, she believes it would be a mistake to disregard these 'id impulses'. Such ideas are very relevant to the multi-determined psychopathologies of our patients, and point to the need for understanding from different viewpoints in working through.

The interaction of the many complex factors involved in becoming a person can be clearly seen in the 'Toddler Profile', created on the basis of the Anna Freud profile, but with a new emphasis on the role of parents and on affects. One chapter is devoted to a format of the profile, with accompanying examples; it is in effect a manual for

psychoanalytic study and research on mother-toddler development. Along with the introductory chapters on the setting up of the mother-toddler group and the research methodology, it will be of most interest to child psychotherapists.

Adult therapists who want to begin at the section on 'Findings' will immediately be gripped. Within this section, the chapter on 'Feelings' should be required reading for any student of psychoanalysis. I think it will become a classic. We know that a child's progression from somatic and motoric discharge to the mental experience of feelings, and then on to the ability to recognise and name those feelings, is dependent upon the relationship with the mother and on her recognition of his feelings. Indeed, Erna Furman and her colleagues were among the pioneers of these ideas. Now she makes it clear that just as important, indeed vital, is the mother's ability to *feel with* her child. The child who is not 'felt with' remains or becomes literally unaware of his feelings, even, at times, of physical sensations: the child in day care often fails to experience physical pain, though he may become aware of it on re-uniting with mother.

There is convincing observational evidence that nearly all ego functioning, e.g. walking, talking, the development of particular skills, is similarly dependent on the mother's interest and support. Yet, surprisingly, some ego functions develop relatively independently at this stage. Among them is memory. The toddler (prior to the onset of infantile amnesia) has an excellent memory, and will defend it in the face of adult forgetfulness or denial. Some toddlers' memories, like that of peeing in the bushes at the zoo, seemed important primarily for instinctual reasons. But this was not necessarily so: one toddler insisted on his (accurate) memory of seeing a star in the evening sky, in spite of mother's denial.

This is a book to be savoured, to be consulted in many situations. Here I can take only a few further points from it:

On fathers

Much has been written on the role of fathers, and on the effects on children of new and different family arrangements. After meeting the toddlers in this book, you cannot but know that a toddler feels, 'I need my Daddy'. Debbie, for instance, had not seen her father since she was a baby. As mother became able to empathise with Debbie's longing for her dad, she began to come to life. Some minimal contact

was re-established. Father even visited the toddler group, and in the author's description of Debbie's response, her happiness shines from the page. But it was not just that she was happier: her whole self-esteem received a vital boost, she visibly became 'a somebody'.

The toddler is also well aware that 'my Dad is a man.' Such awareness, unless there has been over-exposure, does *not* necessarily imply knowledge of the genitals, but rather 'a much less explicit sense of him as a man, defined for the child by his special overall bodily characteristics, attitudes, pursuits, role in the family, ways of relating to each of its members, and expectation of the child's response to him.' (p 141)

On toilet mastery

What has been called 'toilet training', or, more recently, the lack of it, has often been the point at which mother and child fell out of tune, the origin of many later difficulties which we know well from the analyses of adult patients. Erna Furman and Dr. Robert Furman have already pioneered the idea that a child can be helped to acquire 'toilet mastery' as part of the whole process of becoming himself. Acquiring this mastery (*not* training) requires a lot of the child. He must first come to recognise and understand inner body sensations, and he must have sufficient sense of time to anticipate an event and act in the light of that anticipation. Mother aids him in this struggle. There is always an element of wanting to be 'big'. But there is a crucial difference between mothers who see being big in terms of being 'clean' and those who see it in terms of performance. In the first case the child can develop useful reaction formations, gain satisfaction and pride from a number of activities; if he messes, the situation can be retrieved. But where parents have stressed performance, being big like the grown-ups, the child misses out on the creative aspects of reaction formations, and messing leaves him feeling inadequate *in himself.* (pp 161–2) There are fine shades of difference here, and greater understanding of them can help us toward more finely tuned interpretation.

On aggression

Many adults, including parents, have a natural tendency to deny the extent and primitive nature of toddlers' aggression.

> John, at 22 months, made a pretend cake, offered it to others but refused it for himself. 'What had he put in? "People", said John. "No, no, we did not put in paper, dear, ..." clarified his mother ... "We put in sugar and flour, and what else?" "People," said John, quietly but firmly.' (p 148)

The author shows how much toddlers are pre-occupied with, interested in, terrified of, aggression. Above all they need to know that they will be kept safe, and that their parents can master their own aggression. At times when they are frightened of being *only* angry, it helps to be reminded of loving feelings; in the end they will control and tame their anger for the sake of love.

Erna Furman brings new understanding on the development of aggression, sadism and masochism. Her observations show masochism to be relatively rare in toddlerhood. Even where the child has encountered much early pain, perhaps through medical intervention, it is heightened *sadism* which follows. At first there is no guilt in regard to sadism; the reaction formation of pity develops only through the internalisation of parental attitudes. But pity is not always appropriate. The world does contain dangers, and the child also needs to learn to *use* his aggression in appropriate circumstances, needs to become able to defend himself.

Each reader will make his own discoveries, but I hope it has already become clear that *Toddlers and Their Mothers* can greatly increase our understanding of later ages. We all have patients with problems of individuation, those who have never been able to become themselves, who shape themselves to fit *our* perceived expectations or needs.

I think of Billy, 22 years old, who left his room at home only to come to treatment. He could not experience himself as separate, as owning his own self, his body or his needs. He did not even know what it was to be hungry, but ate to ward off stomach rumbles. He was unaware of body signals that he needed to go to the lavatory, but voided as a further precaution. In my struggle to understand Billy's pathology, to find technical means of helping him, I was greatly aided by this book, which helped me to see the toddler in him. Moreover, without this book I might have put too much emphasis on defence. The other day, for instance, Billy told me that he had had no feelings about my being away on holiday, adding that had he *told* anyone I was away, he might have been aware of missing me. Clearly his lack of feeling had not been primarily the result of defence. Like the toddlers in this book, Billy had been unable to feel his feelings when his therapist/mother was not there to 'feel with' him, or to recognise his feeling. This needed technical handling very different from straightfor-

ward defence interpretation, which would have added insult to injury. Billy is an extreme case, but more neurotic cases are also illuminated by Erna Furman's work: toddlerhood is a time when things can easily go wrong, and we see the consequent distortions in our consulting rooms.

But if mother and child can be helped to be 'in tune' at the toddler stage, things may well go right thereafter. Given the facilities, it is astonishing how much easier it can be to set things right then than at later stages. And the right facilities are not so demanding of time and money as might be thought. The Hanna Perkins Mother/Toddler group meets only twice a week for one and a half hours. The central aim is to help each mother to be in tune with her child; workers never take over the mother's role, but act as facilitators and as objects for a different, more neutral type of relating. In addition, and importantly, mothers are seen weekly by a child analyst. These two types of intervention interact to produce a benign circle.

Erna Furman has a passionate commitment to the well-being of mothers and toddlers, and to mental health. This commitment is matched by her intellectual power and her honesty, which led her to examine meticulously the effects of these interventions on the toddlers who attended the group. The results are indeed heartening. Her commitment has also led her to pioneer outreach work with those who work with children and, via their teachers, with the parents of the future. She provides a heartening example of the efficacy of early intervention and of preventative work. The Department of Health should read this book too!

ANNE HURRY

Live Company

By Anne Alvarez. Tavistock/Routledge 1992 pp 246. Pb £14.99

Anne Alvarez makes very live company. While her remarkable book is most immediately about psychoanalytic psychotherapy with very damaged, autistic or borderline children, it is also about the development of the living, relating self. In reading it, one meets another mind which is genuinely free to perceive, feel and think. Free, too, to use the understanding available from the various different schools of psychoanalysis, within an object-relations framework. This psychoana-

lytic thinking is integrated with recent findings in the field of infant and child-development research, about which Alvarez is impressively knowledgeable.

Her book is structured around the lengthy treatment of an autistic boy, Robbie, and the struggle for his sanity within the treatment and within herself. We develop with her as she describes the impact of Robbie's emptiness and despair, the horror and the desperate need to reclaim him which she felt, or the disgust and boredom aroused by his deadening and perverse stereotyped behaviour.

We have all struggled with such feelings at some time, with some patients. Often they were Anne Alvarez's only guide, enabling her increasingly to focus on the relationship between herself and Robbie, even when that relationship was least apparent, when he was at his most autistic. Often the interventions which she made occurred spontaneously, and were understood later. What she learned from Robbie's responses she applied to her work with other disturbed children, and she sought for its counterpart in normal development.

There is for instance a most moving account of Robbie's first 'awakening' to a relationship with her as a separate person. The session occurs just before the summer break:

> 'I had been speaking to him about his difficulty in believing I could remember him over the holiday, and his difficulties in using his by now 13-year-old self to help him to think about me. When I knew he was in great distress, which he was sure to be about breaks, I had always to speak with considerable emphasis and intensity. I was never sure if he was listening, or even hearing me, or if anything was sinking in ... because of all these things, I spoke to him with a great sense of urgency.
>
> While I was talking he had been shaking his hands and dispersing all his distress and anger in the ineffectual and draining way I have described before. Suddenly he stopped, came over and examined my face with great tenderness, then the area of my breast, and then said, slowly, "Hello", almost as though he'd just recognised an old friend he hadn't seen for ten years.' (p 30)

Consideration of this and similar interactions led Anne Alvarez to her theory of the 'reclaiming object': the caretaker figure who is 'enlivening, alerting, claiming and reclaiming'. The mother here, as in the observations of Brazelton and Stern, is no mere regulator of homeostasis, no simple provider of the breast. As Alvarez points out, the alimentary model of early development and the theory of anaclitic relating are insufficient to explain the lively dance between mother and child when all goes well. Nor is Alvarez's baby a mere cupboard-lover. He is a seeker. His active exploratory states *follow* a feed, result not

from drive stimulation but from his psychic need to be in touch with, and to get to know the world and his mother.

Her baby is a 'perfinking' baby: one in whom the development of perception, feeling and thought are intricately interwoven and interdependent. He is a baby who must be able to distance as well as to approach if he is to cope with the world and gradually to build up essential defences. (He must be able, for instance, to suppress or ignore one of two stimuli before he can co-ordinate his awareness of them.)

Alvarez respects the defences, and respects her patient's need for them. Like Sandler, she sees them as aiming *towards* a particular interaction or feeling state, not simply as aiming *away* from mental pain. Her thinking on the pre-stages of defence is consistent with this stance. She suggests, for example, that the earliest roots of the need to make reparation may lie not only in the baby's need to enliven his depressed mother, but, alternatively or additionally, in his tendency to make better an already good object: his smile may be used 'to give additional pleasure to a possibly already pleased and alive object.'

Recognition of such positive aspects means that interpretation cannot be reductionist. But I should make it clear that while Alvarez does fully recognise positive aspects and the manifold direct or contorted ways in which love may be expressed, she is equally well aware of negative aspects, and of how the harsh reality with which many of her patients have had to cope is reflected in their impact upon her. Clearly it would not be possible to help many of the children with whom she works without being well aware of just *how* harsh reality may be. Some patients, for instance, need to learn that an object can be present before they can react to its absence. In some, reparative tendencies will hardly have survived in the face of an irreparable real object.

Those who work with sexually abused or autistic children will find the chapters on these topics of particular use. They contain valuable technical suggestions, and a scholarly discussion of the different theories of autism which should be compulsory reading for all child psychiatrists.

But I believe Anne Alvarez's thinking can and should be applied much more widely. I agree with her that '... we need a general concept of overcoming to stand beside the concept of defence ...; we need specific terms such as potency to stand alongside that of omnipotence; a sense of agency to stand alongside narcissism; relief, joy and hope to stand alongside manic denial; order, structure and predictability to

stand beside obsessional defences against fragmentation, and many others besides.' (p 117)

There is much further illumination in this book. I cannot imagine a psychoanalytic psychotherapist who will not enjoy and value it. It has led me to some changes in the way I work, and it has explained some of the ways I had found I was working. Those BAP members who have been taught by Anne Alvarez are fortunate indeed.

ANNE HURRY

The Freud-Klein Controversies 1941–45

Edited by Pearl King and Riccardo Steiner. Tavistock/Routledge 1991 pp 958 Hb £100.

It is difficult to know how to do justice to this massive and important book in a short review. In the space of 950 pages, it chronicles the heady and troubled life of a particular scientific and professional organization – The British Psychoanalytic Society – from February 1942 to October 1944 (though King's framing chapters tell us of the crucial events both prior to and after these dates). The content of the book consists of the detailed minutes of the Scientific Meetings and Discussions that took place between these dates.

What, you might wonder, could possibly justify such an exhaustive documenting of the internal events of a psychoanalytic society over the space of two and a half years? The answer is that the drama played out at 96 Gloucester Place (the then residence of the Society) was a revolution in psychoanalytic thought, undoubtedly the most important such revolution since the introduction of Freud's ideas. It is also a fascinating account of a Society at war with itself.

This revolution was to do with the struggle to accomodate Kleinian thought within psychoanalytic theory, and to achieve the paradigm shift that has to occur when current scientific thought is challenged with a new theory. Klein had come to England in 1926 and began to develop her controversial theories during the late '20s and '30s, establishing a group of supporters around her during that time. Trouble began to brew when Ernest Jones brought the Freuds, father and daughter, to England in 1938, and the British Society thus became the stage on which the Freud-Klein conflict was enacted.

Three important threads weave together to form the context within

which this conflict was played out: the death of Freud in 1939, leaving the still youthful psychoanalytic movement in an exposed and vulnerable position without a father, mentor and protector; the war, with all the racial and cultural tensions and hostilities and primitive anxieties about survival that must have formed such a palpable part of the atmosphere of daily life in Britain during these years; and the economic instability with which many analysts had to contend, caused both by the war and by the factionalization of the British Society, which clearly affected to whom patients and candidates were referred. Although these factors are seldom spoken about explicitly in the 'Controversial Discussions', as they came to be known, they emerge between the lines of the debate in ways that are difficult to avoid and which helped this reader to understand the impassioned, bitter and sometimes ferocious quality of these discussions.

Klein had been developing her theory of the depressive position, and the differentiation of persecutory and depressive anxieties, in her two seminal papers on manic-depressive states of 1935 and 1940. Meetings prior to 1942 had been largely uncontroversial, mainly because many members, including Klein and several of her group, were out of London for the early years of the war, and the Society was thus mainly a meeting of the Viennese (i.e. Freudian) group. As well as her theory of the depressive position, objections were also raised to her interpretation of the theory of the death instinct so as to justify her emphasis on the role of unconscious aggression and hatred in the inner life of the infant; and her theory of internal object relations and unconscious phantasy as cornerstones of mental life and psychic reality. Klein and her group thus put forward a picture of the mental life of the infant which was felt by those who opposed her to be at variance with orthodox Freudian theory.

These were the 'scientific' objections. Equally important was the allegation, voiced constantly during the Five Extraordinary Business Meetings (February–June 1942) held to discuss the conflict, that the Kleinians 'browbeat' and coerced other members to accept their views. This claim of 'power politics' was most pungently expressed by the triad of Edward Glover, Walter Schmideberg and Melitta Schmideberg, who was Klein's daughter and Glover's analysand. Melitta Schmideberg's blistering public attacks on her mother during the Meetings of the first half of 1942 certainly make remarkable reading: while making comparisons with 'the Nazis' and 'Dr Goebbels', she stated that 'every member who is not 120 percent Kleinian has been systematically attacked'. Glover's denunciations of Klein and her work were

no less vituperative. Both the Editors (King and Steiner) make clear in their separate contributions that Glover's attacks on Klein were to some degree due to the fact that she was a non medical analyst who dared to try and explain psychotic anxieties and processes, which he considered to be the territory of the Psychiatrist.

Eventually, a Resolution was passed in July 1942 'to allot one Scientific Meeting per month to the discussion of scientific differences.'. Thus began, in July 1943, the first of ten 'Discussions of Scientific Controversies', which continued until May 1944. These Discussions were organized around four Kleinian papers: Susan Isaacs' 'The Nature and Function of Phantasy', Paula Heimann's 'Some Aspects of the Role of Introjection and Projection in Early Development', 'Regression' by Heimann and Isaacs, and Klein's own paper on 'The Emotional Life and Ego-Development of the Infant with Special Reference to the Depressive Position'. Of these papers, only the first was known to this reader; it is rightly regarded as a classic paper, in that Isaacs' rich and evocative account of the ubiquity of unconscious phantasy and her contention that all psychic reality is experienced in terms of unconscious phantasy has profoundly shaped how we now think about these basic dimensions of the internal world. Her paper also makes for fascinating reading in the context of the Controversial Discussions, for it allows one to understand its political as well as its scientific importance – for example, why Isaacs is at such pains to quote so extensively from Freud in order to demonstrate an essential aspect of the Kleinian case, namely that Kleinian theory extended and developed Freudian theory rather than departed from it.

Heimann's paper on introjection and projection is the other paper which stands the test of time, and is unjustly little-known today. The paper looks in considerable detail at these very complex mental processes, which she argues occur from birth, as do object-relating and the development of internal objects, thus challenging the orthodox Freudian view that a state of primary narcissism and auto-erotism dominates the first few months of life. Isaacs' paper also argues for the existence of unconscious phantasy from birth, and therefore the existence in the infant of a rudimentary ego and system of defences. Both of these papers describe the mental life of the baby as much dominated by violent and aggressive impulses and phantasies, due in part to the activity of the death instinct and the baby's intense internal battle to achieve a precarious equilibrium between the forces of life and death, love and hate, destruction and reparation. These views were attacked in detail and at length by the triad of Glover (who

chaired the first seven Discussions) and the Schmidebergs, as well as by the Freud group (Barbara Low, Kate Freidlander, the Hoffers, and to a lesser degree Anna Freud herself). The voices of moderation, but no less lively and intelligent debate, were those of Marjorie Brierley, Ella Sharpe, and above all, Sylvia Payne.

By the time of the last three Discussions (December '43–May '44), organized around the paper on Regression by Heimann and Isaacs and also Klein's own paper, the heat and fury seems to have been extinguished, to some degree, and one begins to hear voices not previously heard in these meetings, notably Winnicott, Bowlby, and Money-Kyrle. As Heimann stated on 16th February 1944 (the eighth Discussion), 'we have gathered that the majority of members have grown weary of this controversy.'. These meetings are notable for a quality of more civilised dialogue, especially between Klein and what came to be known as the Independent Group. This quality was produced not only from a state of exhaustion from constant dissent, but because Payne chaired these final meetings, as Glover was beginning to withdraw from the Society (finally resigning in January 1944), and with him the Schmidebergs. Anna Freud also resigned from the Training Committee around this time, but remained a Member. Payne succeeded Ernest Jones as President in July 1944, and over the next two years she worked to bring Anna Freud back into the Training Committee and finally the way was paved for the introduction of separate courses for training and the so-called 'Gentleman's Agreement' was forged, which stipulates equal representation of the three groups on all committees, and which is still maintained today.

Payne, in fact, emerges as the unsung heroine of these years of trouble and strife; in King's words, 'Payne was responsible for the fact that the British Society has maintained its unity despite its diversity.' As early as April 1942 during the Third Extraordinary Business Meeting, Payne stated her fear that, due to the violence of the debate at that time, 'there are forces in the Society working for rupture and disintegration, or at best a continuation of strife', and she tried to warn against 'a tendency to regression'. King argues cogently and convincingly that it was Payne's sustained capacity to mediate between the warring factions in a cool, intelligent yet emotionally alive way that actually prevented such rupture and disintegration from taking place. One gains the distinct sense, from reading Payne's contributions to these Meetings, that, regardless of how the scientific differences are resolved, for her the Society must survive the conflict, which is perhaps a cornerstone of Independent thinking.

Neither of the two central protagonists, Anna Freud and Melanie Klein, were actually prominent figures in the Controversial Discussions, generally preferring to leave the open conflict to their troops (the military metaphor may sound facile, but one can never forget the fact of the terrifying external reality of Britain and Europe in these years). This was not simply, or only, a tactical manoeuvre. Though she did make lengthy contributions on occasions, Anna Freud apparently felt, according to King, constrained by her sense of being foreign and of having been rescued from Vienna by Jones and offered a home in the British Society. Klein was constrained from active participation by other reasons; in a letter to Jones, quoted by Steiner, she wrote that 'I really don't like fighting ... the loss of my son, the grief about my daughter have much contributed to this ... the fact that my daughter is one of my main opponents has a bearing on this wish not to fight.'. Klein is thus almost totally silent throughout the Discussions until the presentation and discussion of her own paper in the final months of the conflict, though Steiner makes it clear that she was in constant contact with her group and closely monitored what they were to say and exactly how they were to argue the Kleinian case.

In addition to the minutes of the Meetings and Discussions, the book also provides us with an account of the ructions within the Training Committee. One of the main prongs of Glover's attack on Klein was that she was insidiously taking over the Society via the training of candidates by her and her group (Riviere, Isaacs, Rickman and Winnicott were at this time training analysts perceived as 'Kleinian'). The Training Committee was therefore in the eye of the storm, and in the autumn of 1943 the members of the Committee (Glover, Strachey, Brierley, Anna Freud, Sharpe, Payne and Klein) agreed to each write and circulate a short memorandum describing their technique when analysing candidates. These papers, comprising only about fifty pages of this huge book, make remarkable reading. Some of the analysts – Brierley, Sharpe and Payne – bravely describe their clinical work in considerable detail; Anna Freud states that 'the aim of the Freudian technique ... is to undo repression', while 'Mrs Klein's theory expects beneficial results from the transformations of the so-called internalized objects ... it is difficult to see how the same technical devices can serve both purposes.'. Klein's own contribution details in a short and highly condensed manner the essential features then – and now – of Kleinian technique: that 'transference is active from the beginning of the treatment ... and the transference situation permeates the whole actual life of the patient during the analysis'; and that 'the

analysis proceeds by analyzing the defences against anxiety and guilt', which, she believes, arise as a result of destructive impulses directed against the loved object. As Steiner points out in his Editorial Comments on this section of the book, the Memoranda of Klein and Anna Freud distill some of the fundamental differences between their 'schools', while those from Brierley, Sharpe and Payne essentially describe the technical approach of what was later to be known 'the British school'.

One of the central difficulties that underpins these conflicts and which forms a fascinating subtext to them, according to my reading of this book, is the thorny question of the relationship of psychoanalysis – a highly subjective and essentially private activity – to science. The 'scientific validity of Klein's ideas' was, according to Glover, the fundamental issue that these Discussions were instituted to address. He resigned from the Society because it had become 'unscientific'. Ella Sharpe, in her Memorandum on her technique, says:

> 'I believe those who conduct seminars or give illustrations of technique should ask themselves, "Am I showing how I work, how I arrive at conclusions from given data, or am I saying 'This is how it should be done, and these are the correct interpretations'?" One attitude is scientific, the other is personal and arbitrary.'

In March 1942, Winnicott had this to say to his colleagues:

> 'The one thing that should integrate the various elements of our Society is a scientific aim in our work ... the scientific aim is to find out more and more of the truth ... though a fear of the truth is inevitable. To continue Freud's work is to continue to reach out into the unknown in order to gain more knowledge and understanding.'

The intense struggle within an organization to maintain just such a scientific aim so as to reach out into the unknown, whilst contending with the powerful resistances against change and new knowledge, is exactly the struggle that this book documents. It is also a powerful account of an organization's capacity to contain conflict and to be ultimately enriched by it, from which many other organizations have much to learn.

This book has been meticulously edited by King and Steiner, who both provide clear and helpful introductions to each section. Despite its hefty price and daunting size, no psychoanalytic library can be complete without it. It makes for exhaustive, exhausting and fascinating reading.

NOEL HESS

From Fetus to Child
An Observational and Psychoanalytic Study

By Alessandra Piontelli. The New Library of Psychoanalysis
Tavistock/Routledge 1992 pp 260 Pb £14.95

In this book Alessandra Piontelli draws together her remarkable research (which she reported on in several papers in the International Journal of Psychoanalysis 1987, 1988, 1989) on the development of children from very early stages in the womb, through birth to infancy and childhood. As a medical practitioner, child psychotherapist and psychoanalyst, Piontelli is not only eminently qualified to undertake such a task but manages to integrate the knowledge and skills garnered from each of these professions in a most creative way. Fundamental to her approach is painstaking observation by a trained eye and in this Dr Piontelli was greatly influenced by the technique of infant observation as taught by Esther Bick and Martha Harris at the Tavistock Clinic in London where she spent several years in the seventies. John Bowlby was a major force at the Clinic at that time and was always an ardent promoter of the value of observation on which his own researches were based.

As in ethological research, central to the observation of non-verbal behaviour in infants is the assumption that their behaviour has meaning in the context in which it occurs. However, as other research has shown, the observer has to learn not only to 'see' what is there but, even more importantly, to avoid a misrepresentation of its meaning due to personal subjective factors in the observer. This is what makes a psychoanalytically informed observation so valuable. All this is particularly true of the observations carried out by Dr Piontelli on foetuses with the help of ultrasound scans.

She observed eleven foetuses, three singletons and four sets of twins, five or six times at monthly intervals, usually from about the 16th week of pregnancy until just before birth. She then observed the infants with their mothers in their own homes, weekly for the first year and then monthly until the age of two, and two or three times a year until the age of four. One little girl, Giulia, was taken into psychoanalytic psychotherapy when she was three years old. Dr Piontelli also reports on several two and three year olds whom she had in analysis but who had not been included in her pre-natal observations.

One of the main aims of the study, to discover whether there were continuities of behaviour before and after birth, is confirmed with a

resounding affirmative. The many detailed, clear and often moving descriptions provide ample evidence. Pina, for example, in her claustrophobia and feeding difficulties, lived out her sudden dramatic immobility as a foetus in response to the trauma of a threatened miscarriage and the effect of heavy doses of tocolytic drugs. Her relief at going outside her flat seemed to repeat her relief, noted by the obstetrician who delivered her by caesarean section, at being out of the womb, after which she again became an alert and vivacious infant as she had been as a foetus before the trauma.

Giulia's main activity in the womb was licking the placenta and appearing to be in a sensuous peaceful one-ness with her mother's breathing. After birth, she at first licked rather than sucked the breast and, aided by her mother and grandmother, became preoccupied with food and other sensual gratifications in a cosy world which seemed to fit snugly around her. When this idyll was broken by the birth of her brother she became disturbed and this led to her being taken into therapy.

Some of the most striking examples of continuity come from the observations of twins. Marisa and Beatrice hit each other in the womb and once outside it. Alice and Luca stroked each other in the womb through the dividing membrane and by one year of age their favourite game was to stroke each other from either side of a curtain. However, although such early established patterns continued there was no evidence that twins were more precocious post-natally than singletons in object recognition or responsiveness.

Dr Piontelli is careful not to claim that all the behaviour of the research children can be linked to their pre-natal experiences. What she is clear about, however, is that 'nature' and 'nurture' intermingle right from the start. To call all that is pre-natal 'genetic' is far too simplistic, since it denies the influence of the varied and far from neutral intra-uterine environment. She offers interesting reflections and hypotheses on the many issues raised by the study, such as the timing of the psychological birth (ie the mental and emotional life) of the infant and whether the foetus has some awareness of *me/not me* sensations.

In this observational and psychoanalytic study, Dr Piontelli has presented us with fascinating material which complements and extends studies such as that of D. Stern (1985). Stern can be said to have attempted a synthesis of the infant as observed and as clinically reconstructed 'in the form of a working theory of the development of self-experience'. Piontelli attempts to show the continuity of observed

behaviour between the foetus, the infant and young child, and the experience of the latter in the transference in psychoanalysis.

Stern's basic assumption is that 'some senses of the self do exist long prior to self-awareness and language'. In this sense, awareness of *me/not me* is at the level of direct experience, not *conceptual* self-awareness. Piontelli concludes that this cannot be before a significant degree of brain function has been attained, i.e. by about 13 weeks. With spontaneous movement the question of independent inner activation arises and foetuses certainly show highly individual patterns and a seeming propensity to react to pleasure-unpleasure sensations from an early stage.

We can never know what a foetus or infant is experiencing. Developmental researchers therefore generally keep to observational data and avoid inferential hypotheses. However, as parents and clinicians, we need to make such hypotheses to guide us in practice. Indeed, the different approaches to psychoanalysis arise entirely from the different assumptions about human development, particularly in its earliest stages, just as philosophies are based on assumptions about the nature of man. Theories may be abstract but they have very practical consequences. The hypotheses raised by research such as that of Dr Piontelli will enlarge our horizons as clinicians even though it behoves us to be mindful of the fact, as Dr Piontelli the scientist points out, that we are dealing with hypotheses.

DENISE TAYLOR

Melanie Klein: From Theory to Reality

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

The encounter between North American psychoanalysis and Kleinian concepts has in many ways mirrored the original antagonism between Anna Freud and Melanie Klein within the British Society. This is not surprising in view of the extensive Viennese emigration to the United States and the subsequent almost exclusive emphasis on ego psychology. However, rather than a controversial discussion leading to protracted yet (sometimes) creative theoretical and institutional tension, in the US Kleinian thinking was criticized and basically rejected by orthodox analysts.

Yet over the last fifteen to twenty years, especially in regard to the

attempt to understand 'primitive' or borderline/narcissistic psychopathology, American analysts and psychotherapists have struggled with Kleinian theory. They have either tried to integrate it with ego psychological formulations or to import it into their clinical work as part of a more general acceptance of British object relations theory. Notably (there are other examples), Kernberg, Ogden, Eigen and Greenberg and Mitchell have seriously considered Kleinian theory. Their greater openness, particularly to the clinical usefulness of Kleinian ideas – combined with a continuing sense of theoretical caution – is typified in Kernberg et al's (1989) recent book. In a chapter on separation issues in work with borderline personalities, Kernberg et al introduce their discussion of Klein's views on mourning, which they find extremely valuable in conceptualising the pathological mourning reactions expressed in the transference/countertransference enactments of these patients, with the following footnote: 'Although such a discussion [of Klein's theories] may seem to be too theoretical and although many of Klein's concepts are controversial, it is important that the reader keep in mind our restricted utilization of her contributions particularly relevant to the subject ...' (1989: 138).

I found the book under review to be more interesting as an example of work produced within the context that I have just sketched out than as an original contribution to the field, although Otto Weininger, Professor of Applied Psychology at the Ontario Institute for Studies in Education and a psychoanalytic psychotherapist who specializes in work with children and families, is as far as I am aware the first Canadian to present a review of Klein's basic ideas. The book consists of three theoretical chapters ('The paranoid-schizoid position: the birth trauma and the earliest mother-child interactions'; 'The depressive position: ego development and object relations'; and 'The Oedipal phase'); a chapter entitled 'Elective Mutism in Children: a Kleinian Approach', which shows how Weininger applies the ideas and offers material from psychotherapies with a five and with a six year old girl; and a thirty-three page schematic 'Outline of certain aspects of Melanie Klein's infant developmental theory'.

In his Preface, Weininger addresses the book to 'students and practitioners of child clinical psychology' (xx), but the Foreword by James Grotstein makes wider claims: 'In brief, Professor Weininger elegantly reintroduces Kleinian thinking in a way that removes many of the stigmata that have impeded the receptivity to her work ... Professor Weininger's contribution makes Klein's work all the clearer, more practical, more accessible, and therefore more useful' (xvii).

I don't think that any of these claims is very successful, nor that such success would *necessarily* be desirable. It all depends on whether the 'stigmata' are confusions, biases or obscurities in the ideas or in the understanding of the clinical experiences upon which they are based, on the one hand – all worthy of being 'cleared up' – or whether, on the other hand, the 'stigmata' are in the minds of the beholders, as Grotstein very much implies they are when he points out the narcissistic and cultural challenge of Kleinian thinking to North American values and myths. As Segal (1992) has written, 'Popularization can be only too easy ... It can be done by making disturbing discoveries seem anodyne, deep and complex thought appear easily understandable and acceptable when sufficiently watered down' (ix). While I certainly do not think that Weininger means to water down Klein's ideas in the way Segal indicates, the style of his writing as well as his formulation of key issues led me to suspect that the historical and cultural pressures to deal with 'stigmata' may have resulted in unintended but nevertheless subtle inconsistencies, simplifications and confusions in the book. The following selection of quotations, although risking the danger of taking the author's words out of context, highlights what I believe are representative examples of weaknesses in style, formulation or substance which left me disappointed in the book. I will comment briefly after each quotation.

1. 'Klein asserts that the infant ego is in a state of evolving towards a wholeness and completeness that is in a sense comparable to the Freudian pre-ego state of non-differentiated unity' (1). The use of the phrase 'in a sense' is not only extremely vague in itself but in the reference to non-differentiated unity potentially misleading. There is no indication of whether Weininger is referring to a non-differentiated id-ego state or to Freud's concept of primary narcissism although the following passage in the paragraph which talks about the environment implies that the reference is to the latter. Klein did not believe in a primary narcissistic state and this was a point of fundamental difference from the Freudian and other more modern psychoanalytic theories. Coming as it does on the very first page of the exposition, such an unclear conflation of differing concepts could lead to major confusion in the minds of Weininger's readers.

2. 'The baby also phantasizes that the good internal breast is not sufficiently strong or powerful to keep the bad breast from persecution – both internally and externally' (12). The context of this sentence is a discussion of internal persecutory objects. Unless the word persecution is a misprint it is simply impossible to know exactly what the

sentence means. It would make no sense to think of the good internal breast as trying or failing to protect the bad breast from being persecuted.

3. 'Years ago Klein talked about gaining and maintaining eye contact with the baby – an aspect we consider to be so very important today: "Look at the baby, regard the baby, look into the baby's eyes, talk to the baby, and gently touch the baby"' (17). Weininger sometimes refers to Klein in this way without giving a direct citation from her work but instead substitutes a 'quotation' which in style resembles something out of Dr Spock or some other advice book for parents. This occurs throughout the book and makes it difficult to decide for whom Weininger is writing in spite of his expressed wish to address the work to a professional audience.

4. 'During the depressive position the mother should be a very adequate receptacle to contain the anxiety the baby experiences' (47). This sentence is another example of the problem illustrated by the previous one. The tone of advice giving is very prominent and even takes on a hectoring, super-ego-like quality.

5. 'During this time (the depressive position) the baby is evaluating himself, and in doing so he finds he is not bad, not totally out of control, that his feelings are not all destructive: he is effective and at times in control of his feelings. This enables him to begin to give up phantasy for reality and thus not only to investigate new ways of coping but also of changing reality ... If mother's continuous absence and return to care for him mean he did not destroy her or take too much from her, the relationship between reality and phantasy is modified' (47–8). The point here is a more substantive one. In the first part of the sentence Weininger seems to imply an either/or quality to phantasy and reality, and one is exchanged for the other as development proceeds which would be completely contrary to Klein. However, in the latter part of the quotation, Weininger clearly puts the issue in a more Kleinian way and says that the relationship between the two changes but that neither is given up. I found both types of formulation persisting side by side throughout the book, often in the form of 'imagination' contrasted with 'external reality' in a way that threatened to obscure that for Klein phantasy was psychic reality and considered as concretely real as the external world and always in interaction with it.

6. 'The manic reparation does not contain feelings of guilt and does not seem to be done to the primary object but is performed in relation to non-primary, inadequate, contemptible objects that are not experi-

enced as having been harmed by one's own destructive wishes' (53). This sentence is part of the discussion of the manic defence, manic reparation and the failure to succeed in restoring the object. The reference to 'non-primary' objects contrasted to a primary object is not one I am familiar with in Klein's work and obscures the point that in manic reparation the omnipotent control and arrogant contempt are expressed to the primary object in order to avoid feelings of depression. Therefore, the contemptible quality of the object would belong fully to a debased aspect of the primary object and not to any other one.

7. 'Self-destruction then may often take on the form of turning to drugs, alcohol, or sexual acting-out – acts representing punitive retaliation by internal persecutors' (57). This sentence also comes in a section dealing with failed manic reparation and the feeling of having destroyed good internal objects. I think the formulation is too simplistic and, for example, does not deal with the complex phantasies about the addictive substance or the promiscuity which as well as representing internal persecutors may also represent attempts to kill off internal bad objects.

8. 'In play psychotherapy it is possible to structure a play situation where children can repeatedly regain the good object and maintain a strength and stability in the ego which they are unable to achieve in any other kind of situation' (68). This quotation highlights a tendency throughout the book to apply the theory in a manner which echoes the concept of the corrective emotional experience. It is as though the play situation should be thought out in advance and certain situations made available to the child as part of a pre-ordained technique based on a psychodynamic formulation. The implication regarding the technique in this quotation and in others (below) makes me doubt whether the book would be very useful for psychoanalytic psychotherapists.

9. 'At the same time he [the oedipal baby in the depressive position] is only able to deal with these newly perceived emotional patterns of projection, introjection, and the interplay of unconscious phantasies' (82). This sentence is simply incomprehensible to me, and perhaps there is a misprint. The context, a discussion of the child's more integrated feelings in the depressive position and how this affects his relationship to the Oedipal couple, throws little light on the meaning of the sentence.

10. 'Young children in play psychotherapy do not state that "My mother has orally incorporated my father's penis." This is the deep, underlying, unconscious phantasy and is expressed as seeing the

mother as having taken something away from the father and as containing important things. For example, the child will take the "Mummy purse", fill it with marbles, pegs, coins, pencils, and small pieces of folded paper, and then clasp it to herself, saying, "Now I have everything I need," and smile' (86). By page 86 of a book which has sought to explain the whole concept of unconscious phantasy I found it surprising to come across this remark, presumably addressed to a readership that might still think that children literally expressed the unconscious phantasies to the therapist. The illustration of the phantasy is a good enough one, but I simply do not understand the need for such a literal introductory sentence at this point.

11. 'The phantasy is a very active one: the boy wants to enter his own penis, not into the body of the mother, but into the father's body' (104). This sentence might be amusing if it did not come in the middle of a section in which Weininger is attempting to explicate the very complex phantasies concerned with the primal scene and the combined parent figure. In his Foreword Grotstein highlights Weininger's discussion of these primitive Oedipal phantasies as one of the main contributions of the book. The infelicitous phrasing 'to enter his own penis' in this case suggests an unintended and completely different phantasy which does not fit in with the major theme, and I think this is an example of the far from elegant style in which the book is often written.

12. 'At about this age, many parents wonder how they are going to stop their little boy from "playing with himself", although they realize that "he plays with himself" when he seems worried or when he is alone (perhaps phantasizing)' (107). In a book which purports to describe the constant and inextricable interaction between phantasy and external reality, it is surprising to come across the formulation 'perhaps phantasizing'. It led me to wonder whether the fundamental importance of the activity of phantasizing was being effectively communicated to the reader.

13. 'For example, in one play session a seven-year-old boy began to draw a map very quickly, when suddenly he became very angry and began to "scribble out" the map. He said that he didn't know where he was going and that "his map was bad". I suggested that he might be able to make his map using masking tape.' (108). This is one of the passages which illustrates the author's technique. Although the wider context shows that Weininger was fully aware of anxieties in relation to sadistic impulses experienced by the patient, he seems to

adopt a non-interpretive position and to function in the transference as a 'good object'.

14. 'Projective identification is the projection of certain parts of the ego into the parent – in this case the mother – and forcefully controlling and at the same time identifying with her. This form of communication serves to make the child become more aware of his projection because of the dangers of retaliation from the mother, thereby creating a form of interpersonal relationship (Crisp, 1986)' (136). I have not seen the Crisp paper but this passage does not sufficiently distinguish between projective identification for purposes of evacuation, attack, control and communication. Klein herself did not consider the latter function; and her formulations regarding how the splitting-off and projective identification of hated or unwanted parts of the self can lead to the development of a hostile object relationship do not envisage an awareness that such hostility from the object is a projection. On the contrary, the projective identification distorts perception of both self and object.

15. 'At about this point tears were streaming down her cheeks, and I told her that her feelings were not going to hurt her Mummy and Daddy, and it was safe to show them in the room: that I would not get angry with her or throw her away, like she wanted to throw away the dolls' (144). I think that this is another example of how Weininger's technique often involves reassurance when persecutory and depressive anxieties flood the material and blur the boundary between the internal and the external worlds.

For elegance and clarity, as an introduction to Klein, Segal remains first choice. Compared to Weininger, I believe that all the authors listed above offer clearer, more concise and (especially Ogden) challenging explications and interpretations of the theory. Recent books edited by Spillius, Anderson and Steiner, as well as Hinshelwood's thorough discussion, anchor the concepts in clinical psychoanalysis which will be of greater use to psychoanalytic psychotherapists. Of course there is always the work of Melanie Klein herself.

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JOHN GORDON

Mothering Psychoanalysis: Helene Deutsch, Karen Horney, Anna Freud and Melanie Klein

By Janet Sayers. Penguin 1992 Pp 319 P/b £6.99.

Over the past thirty years the scope of psychoanalysis has broadened into treating a wider range of problems than previously and this has been due to the increasing emphasis on pre-oedipal issues. In a sense this shift has been due to the foundations laid by the work of the four women described in Janet Sayers' book: Helene Deutsch, Karen Horney, Anna Freud and Melanie Klein.

Gradually, there has been a focus on the mother-child attachment and a reduction of the importance of the centrality of father. This does not detract from Freud's genius and his amazing discoveries, but we need to chart the evolution of psychoanalysis from Freud's triadic view with its core concern with the Oedipus complex, to a pursuit of capturing an infant's earliest psychological unity with its mother.

To this end, Janet Sayers, an experienced University lecturer and a trainee with the BAP, has outlined the lives and theories of four of the female pioneers of psychoanalysis. Her aim has been to make the ideas of Deutsch, Horney, Anna Freud and Klein accessible to as many people as possible – students, patients and professionals.

Although recent biographies have been written about all four women, it is good to have both the biographical and theoretical information in one book. It is interesting to read about Deutsch and Horney whom we do not hear so much about, while Anna Freud and Melanie Klein have particular relevance to the development of the opposing schools of child psychotherapy in England.

Anna Freud's papers are scattered and it is not widely known how moving her work has been, pin-pointing the effects of separation on her war nursery children. Also, how it led to influencing John Bowlby and James Robertson and in turn many child care policies.

Also, Sayers makes Klein's ideas on the death instinct seem less ferocious and off-putting and more manageable to the uninitiated reader.

Sayers brings an interesting perspective to the lives and difficulties of these four vigorous women. They were all born towards the end of the nineteenth century in pre-Nazi Europe and they all fled to America or Britain in order to do their work. They each had complicated relationships with their own parents and intense yet varied reactions to their own mothers: Deutsch detested hers, Horney adored hers, Anna Freud seemed to have ignored hers and Klein appeared to have

been highly ambivalent to hers. In fact, Anna Freud was so involved with her own father that she did not marry. But the other three women, despite their own analyses, did not manage to remain satisfactorily with their partners or perform well as parents: Deutsch was abandoning, Klein was both abandoning and intrusive and Horney was unavailable to her children. Indeed, Anna Freud in sharing her friend Dorothy Burlingham's children, seemed to have been the most maternal and empathic of them all.

Each woman used her own experience to formulate her theoretical stand. Deutsch stressed the importance of identification with others but particularly maternal identification; Horney, primary femininity and men's envy of women's mothering potential; Anna Freud and Melanie Klein formulated their respective theories of infant development in such different ways that they nearly split the British Psychoanalytic Society in two. Klein went straight for interpreting the child's unconscious phantasies and held firm that this was the best way to contain anxiety; while Anna Freud, having witnessed the detrimental effects of maternal separation and loss in the war nurseries, believed in a softer approach, building up a relationship with each one of her child patients, advising the parents and allaying anxiety by soothing a child in more concrete ways.

From Sayers' book we see how Freud's concern with the three-body world has been edged out by the primacy of the two-body relationship of mother and infant. It is not surprising that this contribution has come from women. These four women see that an infant's awareness of self is formed through a gradual separation of its sense of fusion and identification with mother. Relief from this merging, a state which is both desired and feared, can be obtained from getting a different view of mother by sitting on father's knee. Here it can be seen that the three-person situation affords relief unlike Freud's three-person world involving murderous feelings of Oedipal rivalry. So it can be seen that instead of Oedipal competition, penis envy and castration anxiety, we have regression and problems of separation and identity.

Sayers wonders if the swing to mother has gone too far and has obliterated father completely. Certainly Winnicott, extending the ideas of these women pioneers, considers that finding father is not essential for an individual's experience of self and selfhood. However much feminists may find this a cause to celebrate, I agree with Sayers that psychoanalysis must find a way to include the importance of bonds to both mother and father.

JUDY COOPER

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THIRD IPA CONFERENCE ON PSYCHOANALYTIC RESEARCH
London, 12-13 March 1993

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UNDER THE CHAIRMANSHIP OF ROBERT S. WALLERSTEIN

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Bertrand Cramer, Geneva: *Mother-Baby Interactions: In Reality and in Fantasy*

Gloria Endres de Oliveira, Wiesbaden: *Babies' Capacities to Capture Emotion in the Human Face*

Barbara Fajardo, Chicago: *Conditions for the Relevance of Infant Research to Clinical Psychoanalysis*

Juan Miguel Hoffman, Buenos Aires: *From Initiative to Experience: A Contribution to the Understanding of Integration*

Linda Mayes, New Haven: *The Child's Emerging Understanding of Other Minds*

Lynne Murray, Cambridge, England: *Prevention of Adverse Effects of Parental Depression on the Infant with Brief Psychotherapy: A Treatment Trial*

Each presentation will be discussed by an experienced psychoanalytic clinician and there will be adequate opportunity for discussion by the Conference participants.

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The language of the Conference will be English, and the number of places will be limited.

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The names of the Discussants will be announced later

JOURNAL OF CHILD PSYCHOTHERAPY

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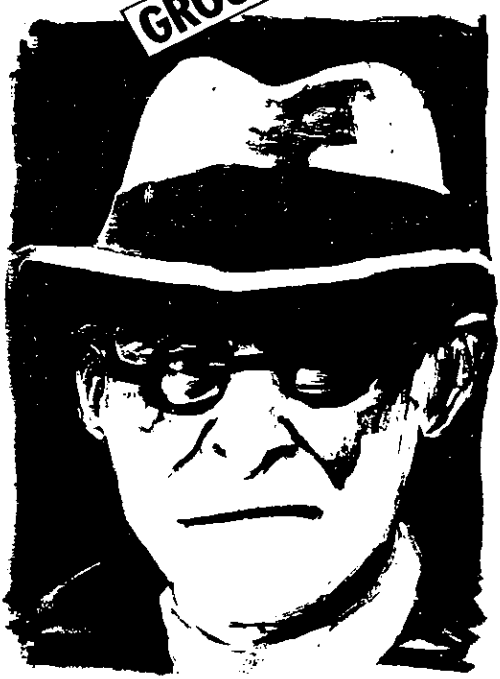

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James, H.M. (1960) Premature ego development: some observations upon disturbances in the first three months of life. *International Journal of Psychoanalysis*, 41: 288–295.

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

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