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'IN THE BEGINNING...' OBSERVATIONS OF NEWBORN BABIES AND THEIR FAMILIES

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Beginnings, whether big or small, tend to be significant; the first day of school or a new course of study, love at first sight, the baby's first step, moving into a new home and, in the context of this paper the establishment of the first relationships in life between the newborn baby and his or her family.

This sense of beginning is captured in a most mysterious and awesome form, in the beautiful opening chapter of Genesis, the first words of which form part of my title. The ancient Biblical story of creation looks at the world in wonder, and attempts to explain how it came to exist, how it all started. For those who are interested in human relationships, there is a parallel experience. We observe the enormous variety of human relationships and inevitably wonder how it all started.

The story of Genesis is possibly 5000 years old. Only in the last 150 years has it been seriously challenged in the West by Darwinian theory. The systematic study of human emotions and relationships that started with Freudian thinking, is only just over one hundred years old. Our understanding of these processes is indeed in its infancy. We actually 'know' very little. Our methods of systematic enquiry are still very primitive and inadequate for the task. Nowhere is this more apparent than in the study of infant development in the family. We do not even have suitable words, as infant communication is pre-verbal and of a primitive and raw emotional nature. This pre-verbal communication can lose much of the richness of its meaning in the attempt to put it into words. Poets and artists may be more successful in describing these experiences than scientists.

The first relationships are still shrouded in mystery and awe, in the same way that the ancient scribes felt the first six days of the creation of the world were shrouded in mystery and awe. In twentieth century society, when faced with this vast unknown, it is all too tempting to create pseudo-scientific theories which actually cloud the ability to observe what is indeed a very problematic area of study. Baby observation provides this opportunity to observe, and makes every effort not to put observations into theoretical pigeon holes. This leaves the observer free to play with different perspectives of the situations that

are observed, and to wonder in the deepest sense about the mystery of what is going on within the baby's subjective experience. For parents and observers this sense of wonder and incomprehension is possibly most profound in the first few weeks of life.

The baby's arrival

Long before the baby is born, it will have been the subject of much talk and fantasising by the prospective parents, brothers and sisters, grandparents and extended family. This is a part of the baby's cultural and family inheritance, so that no baby arrives without an aura of family expectations, projections and magical wishes surrounding him or her. This network of fantasies, conscious as well as unconscious (which operate all the more powerfully), may be derived from as far back as the parents' own childhood games in which the idea of being a mummy or daddy first started to operate. Clear and well illustrated accounts of the family members' states of mind before the birth are given by Raphael-Leff (1991) and Brazelton and Kramer (1991).

The reality of what it means to bring a baby into the world may present itself from the moment of conception in terms of different kinds of bodily change, which can range from a sense of pride and physical well being, to overpowering feelings of tiredness and sickness. Some mothers may feel invaded by a greedy parasite, whilst others may feel very special because of the presence of the new life within them. The point at which the baby first starts to move inside the mother and the quality of these movements are often felt to be indicators of the baby's personality or sex. As the baby gets larger and other members of the family can feel its movements, it becomes even more real to the mother as she can then share her experience with her spouse and other children. If a scan is carried out, the baby can be seen and photographed before birth. The increasing volume of thought and feeling around the baby builds into a dramatic crescendo and climax when the baby is born. The baby who arrives may or may not match the wishes, hopes and fears of the family he or she joins.

The birth itself with all the understandable and primitive anxieties that it arouses, may leave some emotional scars on the mother and for a time affect her ability to care for her own baby. Physical problems relating to stitches, recovery from caesarian section and the after affects of drugs used in labour, may mar the mother's enjoyment and preoccupation with the baby in the first few weeks. Some mothers are

quite traumatised by a birth that was extremely painful and outside their control and may find it hard to put this experience behind them and concentrate on their relationship with the baby. Other mothers are so exhuberant and relieved that the birth is over, that they manage to forget all about its difficulties remarkably quickly.

Physiologically there is great hormonal upheaval in the first few weeks after the birth. In addition, general emotionality may be high, not only in terms of adoration of the baby, but also in the sorrow and depression that inevitably marks the passing of the previous stage of life in which the baby was not present. Whether it is a first, second, or third baby, there is a significant and appropriate emotional adjustment to be made particularly by the mother, but also by the father and any brothers or sisters, to the new baby in their midst. This constitutes a normative crisis in family life, and is a potential growing point, or sticking point, in the whole family's development. Everything changes with the arrival of the baby. The fact that such an apparently helpless tiny being can have such a profound effect on the functioning of so many large beings is a testimony to the paradoxical power that a baby exerts over it's immediate family. Bowlby (1969) argued that the powerful attachments that the baby and main care-giver form to each other, are necessary for the very survival of the species. If this process did not operate, the helpless newborn would die from lack of care. Later in this paper there will be illustrations of the kind of communication that takes place between newborn babies and their carers, and the powerful impact this has on both of them.

Establishing the observer's role

With all the sophistication of 20th century medicine, primitive anxieties and superstitions still lie very close to the surface when it comes to matters of birth (and death). Into the midst of this powerful mix of fantasies, anxieties and hopes, comes the Baby Observation seminar member, also at the beginning of an experience which frequently proves to be extremely powerful and influential in his or her professional and personal life. Anxiety runs particularly high in the period during which the observer is trying to find a family that will allow observation of them and their baby. To many prospective observers, it is hard to believe that any family could agree to what seems like such a large committment, involving weekly visits for one hour, for a period up to two years.

There is no doubt that it takes a special kind of family to be interested in having an observer visit them and there must clearly be some motivation for the family to allow a complete stranger into their midst at such a highly charged and demanding period in their family life. As the observations progress, it gradually becomes apparent why the observer was welcomed into the family's midst (an example of this is the observation of David which will be described later). Care is taken to observe a family where boundaries between the observations and any other contact with the observer's personal and professional life can be fairly readily held. One of the functions of the seminar group is to help the observer maintain these boundaries and not become an honorary member of the extended family, or resident child and health care advisor. The observer's objective is to affect the situations and relationships they are observing as little as possible. This inevitably means different ways of behaving in different family settings, and requires more of the qualities of the chameleon than those of a detached or remote fly on the wall. One of the most significant experiences that the observer will record is the emotional climate that exits within the family. This requires an opennes and receptivity to such feelings and a capacity to contain them and not act on them unless it is in the interests of the baby's or toddler's immediate safety. A detached fly on the wall will not be able to have such an experience and as a result will not have as rich a learning experience as the chameleon-like observer.

Attention to the detail of setting up and beginning the observations is as important as the care that is taken in setting up a treatment situation. This attention to detail parallels the parents' intense awareness of their baby's first communications as they endeavour to provide a good start in life for their infant. Similarly a careful and thoughtful beginning to the observations pays dividends in establishing the longer term relationship between the observer and the family. This enables the observer to demonstrate to the family from the outset that the observer truly is there to learn about the development of family relationships and not to pass professional judgement on them. By being present in such an attentive way, the observer is frequently experienced as stable, reliable and containing for the family. In the choppy waters of family life with young babies and children, where chaos and confusion are often the predominant experiences, this is a very valuable commodity. (The observation of Becky, described later in this paper, is a good example of this).

For the observer, experiencing the value of standing still and being

receptive in the midst of painful feelings and general mayhem is a valuable training experience as discussed by Margaret Rustin in Closely Observed Infants (Miller et al 1989). Mothers may also react to observers in ways which clearly indicate transference issues like those seen in therapy. Sensitivity is required when the observer is able to enjoy experiences which the mother and her family cannot due to the demands of family life. Feelings of envy towards the observer may be easily aroused in the mother in particular, when she believes that the observer enjoys freedom from the onerous responsibilities of mothering a young baby. This is most apparent when the observer takes a holiday or unavoidably misses a regular visit to the family. If these transference issues are not sensitively dealt with, they may threaten to disrupt the observations altogether. The observer may then have to work hard to re-establish a workable relationship with the family.

If it is felt that the family is suitable (and there must be room for backing out for both parties at this early stage of the process) the enormity of the transition from the before-baby state to the post-baby state in the family, can best be appreciated if the observer meets the family about one month before the baby is due. It is vital that the observer meets the father as well as the mother before a decision is made to go ahead with the observation. This is particularly important when there is a male observer. The first meeting, together with the first observation of the baby, can be as significant as the first meeting with potential clients or patients. Indeed the impact on the observer may be more intense than the impact on the family, which is usually otherwise preoccupied. Discussion of the observer's perceptions and anxieties regarding the suitability of the family and how best to behave during the visits can greatly facilitate the establishment of the observer role. This is also the time where the fantasies surrounding the newborn baby are at their most intense and may be seen retrospectively to have coloured the baby's earliest experiences. The changes in family dynamics are also highly apparent when for example, the couple moves to a threesome with the birth of the first child (Clulow 1982), or when the toddler suddenly becomes the 'big boy' overnight.

It is ill-advised to observe a family in which the observer can foresee that his or her own painful personal issues are likely to be central in the observation. For example, if issues of sibling rivalry are currently painful for the observer, observing a toddler being displaced by the baby can prove very difficult to handle, resulting in the observer having difficulty in maintaining an evenness of identifications with the family

members, and in biasing the observations because of over-identification with the toddler.

Nowadays, unlike when baby observation was first used as a training experience, many observers are not in therapy or analysis. When the observer approaches the work in as undefended a way as he or she can, personal issues are inevitably raised both from the past and from the present. The observers' thoughts and fantasies about their own experiences as infants will be stimulated. In addition, the observer is likely to reflect on his or her current life situation: an unfulfilled wish to have his or her own baby, or regrets and guilt about his or her perceived feelings as parents to their own children, particularly during the first years of life. These are painful issues which, without therapy in which to disentangle them from those of the baby that is being observed, can interfere with making balanced observations.

Gazing at the baby

In the same way that nature in her wisdom has provided nine months for the parent or parents to prepare themselves emotionally as well as physically for the baby's arrival, so must the observer get into an appropriate state of mind in which to approach the expectant family. I have tried to outline the most salient considerations and now it is time to finally 'meet' some babies. The material to be presented is a mixture of presentations given in seminar groups that I have led, other authors' descriptions, and my own baby observation experiences.

Berry Brazelton starts his book *Infants and Mothers, Differences in Development* with what he acknowledges to be an obvious statement, that 'Normal babies are not all alike'. The number of variables in human behaviour are vast and their interaction almost imponderably complex. It is not possible to study any one attribute of human emotion in isolation from all the others, although this assumption has often very naively been made in psychological studies. We are blessed with the infinite variety of human individuality and the best we can hope for is to decipher some broad trends and patterns in what is observed.

In an effort to simplify this problem Brazelton, a paediatrician, describes in great detail, three 'composite' babies and their families: the active, the average and the quiet babies (Brazelton 1983). His book documents his firm belief that 'the newborn affects his environment as much as it influences him.' His picture of the baby is not that of a passive, reactive, totally unformed being, but one of an active, sociable

and impressively powerful individual. It is this recognition of the alert, surprisingly integrated and above all relationship-seeking quality of the newborn baby that is exciting such interest in present day observers and researchers.

Psychoanalytic observers always assumed an active emotional life in the infant, but until Baby Observation started in the early 1950's, psychoanalytic theories of the infant's emotional life were based on experience with emotionally disturbed patients from whom deductions were retrospectively made about their early infancy. These deductions from emotionally troubled adults were then used as a basis for theorising about normal infant development. Whilst many clinically and theoretically useful ideas were generated, it was difficult to establish a systematic method of testing out these theories, which left psychoanalysis wide open to criticism from academic psychologists who questioned the reliability of psychoanalytic data.

Even within psychoanalysis, competing theories could not be tested out, which at times lead to systems of belief holding sway over rational thought and observation. Within the past ten years it has become possible to bring together fruitfully the knowledge that has accumulated from imaginative reserach on the newborn, paediatric experience, and baby observation combined with psychanalytic insights, to produce an exciting and much more rounded picture of infant development. This has resulted in changes in psychoanalytic theory and clinical practice as well as the generation of new hypotheses for researchers.

A good example of this comes from the psychoanalytic study and treatment of autism. Margaret Mahler, in a lecture given just before she died, renounced her concept of primary autism as a normal phase in early infancy, in the light of research evidence to the contrary. Similarly, Frances Tustin has revised her view that there is a normal autistic state that all infants pass through but in which autistic children remain stuck (Tustin 1993). Her view in the light of research evidence is that an autistic state in infancy can only be viewed as being pathological, never as being normal. However, many of her observations about the sensory level of experience of autistic children correspond very well with the world of infancy that the researchers are now describing. But autistic children for reasons she expounds (Tustin 1990) fail to use these sensory experiences in the context of human relatedness and, instead, become locked into auto-sensuousness.

Let us now do some baby gazing, starting with one of Brazelton's 'composite' babies immediately after birth. Here is his 'average' baby, in the delivery room: 'When his eyes opened slowly, he gradually tried

to focus them and though they seemed to wander independently, he finally bought them to bear on a distant, not-too-bright object. As the examiner's white mask came over him, he fixed his eyes on it and when it moved slowly enough, he was able to follow it briefly with jerky slow movements. He even turned his head to follow it to one side then the other. Up and down seemed harder to him. A fast moving object was hopeless for him to follow.'

The following is the 'quiet' baby, again in the delivery room: 'From the first moment, Laura was striking for her inactivity. She emerged from the uterus sluggishly. After delivery she lay quietly in her crib, looking round with her eyes open wide as if in surprise. Her movements consisted of rather slow, circular motions of her arms within a restricted arc round her face. All her movements were gradual, slow, smooth, and most striking of all, infrequent.

Compare this with the 'active' baby, who 'came out crying and fighting'. He quickly established a pattern during the first few days in which: 'he seemed to shoot from deep sleep to lusty and inconsolable crying with no intermediate states of alerting or mild fussing. He could not be quieted with his mother's crooning, with quiet rocking and cuddling or with a bottle alone. His crying could only be broken into by a combination of tight swaddling of his extremities, plus vigorous rocking, plus the bottle nipple held in his mouth at his soft palate until he stopped crying to breathe and felt it there.'

Clearly these three types of babies are going to be very different babies to care for. Whilst the active baby's parents are going to have a difficult time keeping up with and understanding what their baby needs, the quiet baby's parents may become anxious that she is too quiet and undemanding. They are at opposite ends of a continuum. What else can we learn about the newborn infant from straightforward observations such as these?

The 'average' baby is showing interest in his surroundings as soon as he opens his eyes. He tries very hard to keep looking at something that interests him, to the extent of even trying to move his head to keep it in sight. Although parents often doubted it, they were frequently told that babies couldn't see anything until several weeks after birth. In particular, they were told that the baby wasn't really looking into their eyes and faces, even though the parents could have sworn that they were virtually drinking in each others' souls when they gazed for long periods at the baby in their arms. Recent research has vindicated the parents - and psychoanalysis. Babies have been shown to be visually pre-programmed to be particularly interested in human faces, above

all else, in the first weeks of life. I would now like to move on to baby observation material as opposed to a composite picture.

Another new born baby, still in the delivery room, was observed 'to turn her head round to look intently at her parents whose voices she could hear coming from behind her.' This baby could not only apparently recognise and show interest in these particular sounds, but could orient her head and eyes towards them in a purposeful way. Hearing and seeing were already co-ordinated and one could readily speculate that she was motivated by the wish to respond to human stimuli as opposed to any of the many other stimuli in the delivery room.

Another newborn baby, minutes old and lying on his mother's stomach, 'stopped crying and listened as soon as his mother spoke to him. He seemed to recognise her voice.' In this instance, there is interest in human sounds as well as the liklihood that the baby had a memory of this particular and important sound, the mother's voice.

These kind of descriptions have in the past been regarded by academics as being (in a somewhat perjorative sense) merely anecdotal, not constituting real evidence of the baby's readiness to relate to other human beings. However there is now a growing baby of ingeniously conducted developmental psychology research that shows that these 'anecdotes' are indeed indicative of the profound ability and evolutionary necessity of the newborn human to elicit and engage in relationships with their carers, which will be nurturing and protective for the baby.

A growing number of developmental psychologists are involved in dialogues with psychoanalytically trained observers to discuss findings and share ideas from their different disciplines. Murray and Trevarthen (1985) place emotion at the centre of their reserach into communication between young babies and their mothers. They refer to Darwin's treatise on the expression of emotion (Darwin 1872) in which he emphasised more than 100 years ago the major evolutionary pressure on the development of communication and co-operative functions, including the expression and perception of affect... Not only did Darwin propose that the mechanism for the expression of different emotional states was innate, but more controversially, he supposed their perception to be direct: 'An infant understands to a certain extent, and as I believe at a very early period, the *meaning* of feelings of those who tend him by the expression of their features. Darwin's views were particularly helpful to Bowlby as he developed his highly influential and scholarly work on human attachment. Bowlby had returned to

this interest in his later years and, indeed, his last published work was about Darwin.

To give a glimpse of the kind of developmental psychology research that is relevant to this subject, I will list just a few of the findings. [For a more thorough introduction to this field of enquiry, see Stern (1985) and Murray (1987)]. There is now evidence that newborn infants show a preference for face-like drawings versus drawings which have the same features but in the wrong position; they can discriminate facial movements such as tongue protrusion which they can imitate (Meltzoff and Moore 1977), as well as other more posed emotional expressions (Field et al 1982); Alegria and Noirot (1978) confirm one of the 'anecdotes' above, reporting that one hour old infants will orient to the sound of gentle human speech; again in confirmation of another observation, De Casper and Fifer (1980) found that one or two day old infants will suck to produce their mother's voice; and six day old babies prefer the smell of their mother's breast milk to that of any other lactating mother (MacFarlane, 1975).

Observing individual babies over time

The most obvious difference between the way in which developmental psychologists and psychoanalytic observers approach their studies of the baby, is that whereas the psychologist looks at a small section of behavior or communication in a carefully set-up laboratory situation across a sample of babies of the same age, the psychoanalytic observer looks in detail at one baby for one hour a week in its home setting for a period of up to two years. Naturally what they observe will be of a very different, although it is becoming increasingly complementary, nature. I would now like to present material taken from three baby observations, during the very first days and weeks of the babies' lives.

David was first seen by the observer in hospital when he was one day old. The birth had been quick and painful, but mother had not required stitches and had needed little medication for pain relief. Father was present at the birth. In this first observation we meet the previously confident father 'looking dazed and exhausted in contrast to mother's extraordinary glow and elation. Father says to mother, 'Oh, Oh dear, how are you? How is he?' Then to the observer, 'I forgot you would be coming. Oh, Oh dear.' (wearily but grinning) 'What's he doing? How is he?' (leaning over the cot) 'Aw, it's all too

much.' The baby stirs and with mother's encouragement, father gingerly picks him up but quickly wants to pass him to mother, despite the fact that this is their second child and he has been faced with a newborn baby before. He says 'I'm no good at this. They're so tiny, so fragile.' He laid the baby gently in the cot. Baby coughed and he said anxiously to mother 'I think he wants you'. Suddenly the baby starts to cry, mother comes over and picks him up. The crying stops instantly as she says to him gently and lovingly 'What a little hairy monster' (David has lots of hair). 'Oh, he's got strange eyes, send him back' Later after a brief feed when David is fast asleep again, she lovingly holds him and calls him her 'little man.'

We next meet David in his home at twelve days. The observer's experience puts her directly in touch with the maelstrom of feelings and experiences that the baby and his family are now living in; so much so, that she finds it hard to pay sufficient attention to the baby as his two year old brother keeps stealing the scene and demanding that she pay attention to him instead. Mother comments that 'life with children is impossible' and clearly feels overwhelmed by the needs of her children and the restrictions they are placing on her. The two year old needs constant attention whilst she tries to feed the baby. Despite all the activity around him, David feeds steadily and eagerly, seems quite unperturbed and falls asleep on the bottle. He slowly wakes up again, but doesn't cry as mother changes his nappy. Although his brother is 'helping' and needs to be reminded to be gentle and careful, David remains unperturbed and in a dreamy state looks at the light coming through the window. Father is more confident again and the couple joke that David is mother's boy and his brother is father's boy.

By the third visit at two and a half weeks, mother is very tired and is thankful that her mother will soon be coming to stay and will be able to help her. There is no extended family living close by and this nuclear family is rather isolated in the local community to which they recently moved. This was part of the appeal of having an observer visit the family and is one of the dynamics the observer has to be careful about as it is very tempting to become friendly with the mother in a way that would confuse the observational role. Whilst mother is exhausted, the baby spends most of the observation sound asleep and, from mother's reports, is pretty settled and contented.

At six weeks, mother is seen juggling her many concerns. She is open about her difficulty in dealing with the two children simultaneously and pre-occupied with the forthcoming christening. The observer hears more about the extended family who will be coming

including a cousin who has three children and is seriously ill. David is again asleep but on this occasion he stirs a bit and ends up crying. (As this period of sleep is becoming a regular pattern his day, the observer renegotiates the time of the visit so that she also sees him awake). David was really crying heartily, but stopped as soon as mother picked him up. She held him up to her left shoulder saying 'Oh, there it is, a little pain, is it a little wind? What a little monster. Oh, my little darling.' She rubbed his back and commented on his hair coming out steadily. David's head gradually dropped onto his mother's shoulder and he was asleep in a minute. Mother said 'This is what he wants.' Eventually she said 'I can't keep holding you, there's so much to do, and I can't leave John (his brother).' She put David back in his cot.' The observer watched him 'sleep peacefully for five minutes, tongue rhythmically moving, then his face broke into a lovely smile and he stirred slightly. A few minutes later he stirred again and the lower arm stretched out till he touched the side of the pram. The other arm touched his cheek. He smiled again. I (the observer) realised I'd fallen into a reverie and as I came out of it, he stirred then closed his eyes again.'

In this observation, we see a contented easy-going baby who is unperturbed by the hustle and bustle of family life. Although his mother is clearly tired and under strain she is able to turn to her mother and accept her help in a way which indicates that a good enough relationship exists between them. This in turn is reflected in the way she cares for David. She doesn't seem to feel under any pressure to be a perfect mother and doesn't idealise the baby in a way which could lead to deflation and distress when things are tough. She talks lovingly, but ambivalently to him, telling him that he is a hairy monster, and her little darling. She is quietly devoted to him, accepting and tolerating the discomforts and adaptations that motherhood requires of her. Winnicot would describe her as a good-enough mother who manages to maintain her primary maternal pre-occupation with her baby in the midst of many competing concerns (Winnicott 1988).

Her husband, who is initially stunned by the impact of the birth, soon recovers. Unfortunately space does not permit a fuller exploration of the impact of the baby on the father, the marital relationship, and the siblings. For fuller discussion of these important issues, the reader is referred to Raphael- Leff (1991) and Clulow (1982). In this example, a reasonable adaptation is being made in the first weeks which augers well for the future. In my next example, there are marital problems and maternal depression.

Anna, a second child, was born into a family in which there was some marital tension which increased when she was born. This problem did not seem, however, to interfere with her mother's pre-occupation with Anna and her older sibling in the first few weeks of life. Before Anna was born, her mother told the observer that when the baby moved inside her, she 'cuddled her bump'. Mother said, 'You know sometimes I just sit and talk to this baby. Richard (her husband) thinks I'm daft, but I'm just getting to know it. I did it with Kathy (the toddler) as well.' Later she said 'Having kids is what life is all about.'

In this family, at the time the observer met them, the men were marginalised by the women and children and seen as inept and troublesome. The women and children formed and their own protective society in which all the nurturing took place. This unbalanced oedipal situation is often seen when the couple has to make the enormous adaption to becoming a family whilst trying (sometimes without much success) to retain the special nature of their love relationship (see Clulow, 1982 and Raphael-Leff, 1991). Anna's mother was very pre-occupied with her baby in the classical way that Winnicott describes (Winnicott, 1956). This is Anna at eight days: 'Mother raised the baby supported on her arms to about eighteen inches from her own face. She talked gently and adoringly to the baby, noticing her tiny movements and coaxing her into semi-wakefulness. As she was involved in this intense interaction she was inviting the attention of the other females in the room (ie. observer and toddler). It was a very feminine experience and I (the observer) was aware of Richard still sitting on the sofa, next to, but hardly included with his womenfolk. Later the baby turned to the sound of her mother's voice calling 'Anna, Anna'. She clearly found her mother's eyes and seemed to focus on them. As her mum moved her head slightly she followed with her eyes. Mother noticed this and moved slightly the other way saying in delight, 'She's found me.' Anna was coaxed out of the sleepy state she kept falling into, and started to feed. After being winded 'Anna began feeding again and continued uninterrupted for some time. The vigour of her sucks diminished slowly and her eyes closed. Her hands slipped down her sides and the teat slid out of her mouth. Mother watched with satisfaction and amusement as her daughter's limbs relaxed into complete floppiness.

Here we have a picture of Winnicott's ordinary devoted mother, intensely pre-occupied with her baby, who as far as one can tell feels totally held in her mother's heart and mind (Winnicott 1956). One can

also identify with how excluded father could feel by this intense interaction if his wife continues to ignore him, whatever the root causes of this marital interaction. By the time Anna is seven weeks old, there has been a marital crisis but father is felt to be much more of a partner to mother as a result. Anna continues to appear unaffected by the turmois, very possibly as she continues to be protected by her mother's pre-occupation. Fortunately, as we have already seen from the observation at eight days, she is also a responsive and rewarding baby for her mother to look after. This continues and at seven weeks the observer notes. 'Her arms were waving rhythmically in front of her and suddenly she caught sight of one of her hands. Very carefully she brought it back in front of her face and gazed fixedly at it. Mum, turning back from the television, noticed and said, 'Look she's found her hand, I've never seen her do that before." Anna looked at her hand for one more moment, then it slipped from her sight and she appeared to lose interest. With some difficulty she turned her head towards me and looked at me (the observer). Mum picked up a rattle from her push chair and shook it at Anna, but after a cursory glance she resumed her study of my (the observer's) face.'

This is a busy and curious little baby who is learning rapidly about her environment, almost experimenting with it if it catches her attention. The observer's face is much more interesting to her than the rattle. At this early stage, her fascination is with other people. Play, with other people, is in the form of imitation of expressions and protoconversation as so vividly described by Trevarthen (1979).

Early findings from an ongoing study by Lynne Murray at the Winnicott Research Unit, Cambridge, suggest that the dynamics that we see between Anna her mother are far from unusual. In a large study on post-natal depression and it's effect on mother-baby communication, preliminary results suggest that mothers who had been identified as being at high risk of depression, were less likely to develop full-blown depression if they had a baby who was temperamentally easy to understand and rewarding. Anna's mother was depressed and sought medical help but swiftly stopped taking her medication as she felt so peculiar on it. One could easily speculate that her rewarding relationship with her baby actually helped her to hold onto something good within herself which in turn helped her to cope with her depression and, indeed, actively to seek to improve her relationships with others. This is further testimony to the two-way nature of the mother-baby relationship.

In case these descriptions of newborn babies and their families

should seem unnaturally quiet, I would like to describe a much more unsettled baby who cried a lot and was very difficult for her parents to care for. This was again a second child, but this time within a secure family setting. At five days her parents described her as much more difficult to satisfy than her brother had been. The observer wrote: 'She really screamed during the night and you had to answer, unlike Callum (her brother) who often quieted if you left him a little while. The new baby would scream louder and louder, making the parents respond, and would not be pacified until a bottle was made and she had been fed. Mother described how sometimes she was unable to find anything to comfort the baby, it was difficult to know what she wanted and she (baby) would cry and cry. Mother said that it was a good thing she had had such an easy baby as a first one. Father said it was surprising how babies control you. "She is the boss."'

Later in the observation 'Becky sucked her bottle with concentration – a frown on her forehead and a fixed gaze focussing in the space beyond her bottle. Mother commented that she always frowned during her feed.'

Becky continued to be a crying baby and her parents found it very difficult to know how to help her, although this was certainly not for lack of trying. At 14 weeks when Becky was possibly a bit unwell and was suffering from nappy rash, she cried on and off for the whole observation. Both parents tried to soothe her and father said that they felt helpless, trying to do something to comfort her and nothing working: 'Mother put Becky to her shoulder again as her cries had suddenly become loud and piercing. Father offered to take her, but his wife said that she was all right. This was the only observation in which I (the observer) had not seen father hold the baby. Mother stood up and rocked Becky, kissing her a couple of times and very tenderly stroking her across the top of her head and forehead. She seemed very empathic towards the distress of Becky and was clearly distressed by her baby's pain. Mother tried giving the dummy but Becky's cries would not permit sucking. Becky seemed to be seeking her Mum's eyes with some desperation. I had an image of her trapped in her own body and using her gaze as an expression of her wish to sink into the body of her mother, of climbing out of her body into her mother's.'

During this observation, the observer was clearly also very much affected by the baby's distress, which although magnified by possible illness, was a fairly constant factor of her personality. She was not contented despite her parents valiant efforts, and she expressed her

pain and persecution potently in a way that was very hard for the parents to tolerate. They were able to support each other and call on help from family and friends, but the observer found himself wondering how they must feel having to cope with this level of distress for long periods of time.

This observation appears to be a graphic example of Melanie Klein's description of the baby's experience of persecutory anxiety. Despite mother's evident devotion to the baby, the degree of persecution experienced by the baby for a great deal of the time is tangible. This is a seemingly good-enough mother with a baby who appears locked into persecuted experiences (internal and external) with very little to mitigate her unhappiness. Most babies only suffer in this way for short periods of time, and enjoy much longer periods of contentment than they do of pain. However some babies do have to cope with more pain than others, or are temperamentally less tolerant of 'ordinary' pain. Their parents' capacities to contain their anxieties are then sorely tested. Whereas Anna and David's mothers did not often have to contain painful projections from their babies, Becky's parents struggled to cope with the onslaught they received from their baby (Bion 1962). They did eventually settle down into a happier period of development, but parents with less of a capacity to contain anxiety may not have been able to cope and the relationship could have moved into difficulties.

These examples of such different infant observations make one realise the incredible diversity of infantile experience and how impossible it is for any one theory or approach to account for all that can be observed. Melanie Klein is talking about babies who are in mental pain (Klein 1952); Winnicott is describing babies and their mothers who are getting along reasonably well (Winnicott 1988); developmental psychologists look at large groups of babies in a state of alert inactivity, having been fed and changed and generally got into a good mood as a base line for the research (Murray 1989); Brazelton describes primitive bodily defense mechanisms which the newborn baby uses to shut out overwhelming stimuli (Brazelton 1991) and which look remarkably like a healthy precursor to Tustin's pathological protective shell in autism.

In addition, Tustin's formulation that autistic children suffered from what was for them a traumatic rift in the earliest mother-baby relationship (as suggested by the sensation-bound, relationship-less world in which autistic children are encapsulated) is given substance by Murray's perturbation studies. These studies show on video the dra-

matic impact that brief periods (one minute) of un-responsiveness in the mother can have on babies as young as six weeks old. In particular when the mother is instructed to look at the baby with a blank face: 'Within a few seconds the infant showed distress in peculiar, sneering grimaces of the mouth, increased handling of the clothes, touching the face, sucking the fingers and frowning. Efforts at communication were intensified at first. This initial reaction gave the impression of protesting or straining to reinstate interaction with the mother. This phase was followed by withdrawal, the infant averting his gaze downward from the mother's face, looking at her overall only 34% of the time (Murray 1985).'

This striking response is all the more impressive when compared with the period of intense communication with the mother which precedes it in Murray's study. Murray's research demonstrates that babies are indeed highly sensitive and responsive to their mothers' emotional states as indicated by their facial expressions. The blank face is understood by the baby to mean emotional unavailability and is experienced as being very disturbing. Babies who experience this emotional unavailability as catastrophic make Tustin's formulations about the aetiology of autism look increasingly convincing.

Conclusion

This paper has attempted to provide an overview of what is becoming an increasingly valuable integration of knowledge gained about relationships at the start of life from paediatrics, research and psychoanalysis. These earliest relationships have a profound effect for better or for worse on the way in which the individual develops. The study of these developmental processes suggests preventative work that can be done to foster good-enough relationships at a very early stage, as well as throwing light on the roots of problematic relationships in a way which aids understanding and therapeutic endeavour – all of which take me back to my starting point in which I stated rather categorically that 'beginnings are significant'. We are now at the beginning of a more integrated and creative approach to the study of infancy, in which different approaches need no longer be seen as mutually exclusive. There is every reason to hope that the co-operation that is now developing between different disciplines, will grow into a stimulating dialogue in which communication of knowledge in the pursuit of understanding will become paramount.

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THE TRUE SELF AND THE FALSE SELF: THE CLINICAL AND SOCIAL PERSPECTIVE

MICHAEL ŠEBEK

Introduction

I find Winnicott's concept of the true self and false self (1948, 1949, 1950, 1951, 1953, 1960) important not only for the clinical understanding of normal and pathological phenomena but for understanding some social phenomena as well. The self is central to Winnicott's theorizing. It is the 'I' as agent (ego) and as object. The true self is in contact with deeper layers of the person. It is close to the instincts and drives. The false self is the result of the function of the reality principle and enables us, thanks to common rules and social values, to become members of society. Some decades earlier Freud distinguished a part of the 'Ich' which is on the surface, from the deeper parts which are akin to the id (1923). So the 'Ich', ego or self are more or less spatial concepts.

The true self and false self reflect an old antithesis between individuality and society as they are represented in an inner world, as well as a contrast of strengths emerging from within a personality and those internalized from an outside world. In the past both strengths were conceptualized as positive and negative. For instance, passions emerging from the deeper layers of the unconscious may represent both the source of spontaneity, creativity, healthy vitality and those destructive forces which must be warded off by means of various defenses. It is the same with internalized social influences: they can either stimulate and promote ego and superego development, or they can cause it to deteriorate profoundly.

The true self

As we have learned from Winnicott (1960) the true self dwells in the body, and represents its own vitality which is specific to the external body. This external vital self is rooted in its own pattern of innate potential. For example, Eric Rayner (1990) mentions the true self as

the particular patterning of movements, different from all others, which each individual infant has.

For Winnicott the *drive to develop* is one of the innate potentials of the true self. This drive is more basic than infantile sexuality which emerges later. The true self develops in a smooth interaction of the spontaneous gesture and behaviour of an infant with the empathic attitudes of a *good enough mother*. A baby uses its mother as a self-object for the expression of his/her vital needs and body tensions, and in this way the infant's gesture achieves sense and becomes real. One of the basic traits of the true self is just this becoming real. Another important feature is the development of a sense of 'I am', which is the real, true self area. Perhaps the most important feature of the true self is its functioning in the *transitional area*. Within the true self the *space for inner world* develops, which involves an experience of personal *identity*, of owning genuine feelings, a world of fantasy, creativity, originality, intuition, personal tastes, interests and styles.

The false self

When a child tries to adapt to the desires of a mother who fails to be good enough, and has to suppress his/her spontaneity and his/her desires in order to obtain love and safety, then the structure of the false self is built and strengthened. In such a situation a baby uses a gesture as if it is in a vacuum. The gesture cannot achieve a *meaning* in reference to the body state and the infant become compliant. This *compliance* is a strange experience for the true self. The failing mother inhibits the development of *symbolic function* because a child cannot connect body feelings with an appropriate response to an object. Winnicott believes that mother's failures endanger the achievement of a *psychosomatic unity*. An infant may protest against being 'false' by means of feeding problems, by a general irritability pattern or by other disorders.

Here I want to add that when the needs of true-self are met by the good enough mother she reinforces the infant's feelings of his/her power, but a compliant child using a false self adaptation experiences only strong parental power. Thus the *power problem*, which has so much to do with narcissism (Strotzka, 1985) and which is present in hidden or manifest form in all dyadic and tryadic forms of human relationship, can be traced through the development of the true self and the false self.

The origin of the false self is an example of the splitting process which operates in the service of a child's adaptation to the environment. In order to explain Winnicott's ideas and problems in regard to the relation of the true self and false self, Rayner (1990) points out that, provided the infant has developed a healthy ego-organization which is adapted to the environment, *the true self has a compliant aspect*, the infant has an ability to comply and *not to be exposed*. It is then that *the ability to compromise* is achieved.

Comparing Winnicott's developmental theory with that of the classical Freudian, it is clear that the roots of the false self can be found in *the oral stage*. However, falsity and protest against the impingements contributing to the development of the false self, as well as compliance and authenticity, are crucially observable in the toddler in *the anal stage*, in which power struggles and fights between child and parent more or less dominate.

Winnicott gave us a classification of the false-self organization. In health the false self is organized in patterns of *the polite and mannered behaviours* and attitudes, which are necessary for gaining a place in society. The true self could never achieve it alone because of its closeness to the primary process. The false self is built upon *identifications* and may function adaptively when it searches for conditions which will make it possible for the true self to come into its own. When there are difficulties in finding such conditions, then a new defensive pattern against exploitation of the true self is looked for. Suicide may be the clinical result when it represents the only defence. Sometimes the false self defends the true self and the true self may exist as a potential or live a secret life. A good example is a clinically disturbed personality organization with the aim of preserving the individual in spite of bad external conditions. Winnicott believed that an extremely unhealthy pattern occurs where the false self sets up as a real self and observers assume that it is the real person showing the true self. In friendships and in important life relationships this false self may fail because in these the whole person must take part. For example, a collapse of a marriage may reveal that the wedding agreement was made largely through the false self with little respect to genuine feelings for a partner.

There are few elaborations of Winnicott's theory of self. The most important contribution was made recently by Christopher Bollas (1989). The true self is, for Bollas, the personality idiom, a person's own potential ego patterning of imagining and responsiveness. When development is rooted in spontaneity of expression of a bodily based

true-self potential in interaction with the environment, then an individual can be seen as fulfilling his *destiny*. When the true self cannot be used or is lost and compliance prevails or dominates, then the individual is *fated*. An individual who finds his destiny is actively discovering aspects of the environment and uses them creatively in the fulfilment of his potential, his destiny. Being fated means to be passively driven by forces that are outside the individual's own decisions. The true self potential encounters environment influences and forces which may foster true self development or may have deleterious effects.

The self and the totalitarian society

I take for granted that the concepts of true and false selves allow us to observe an individual in society without losing a clinical perspective. For a child the most powerful external forces are represented by his/her parents who always live in some social organization with a governing political system, rules and restrictions. For children, parents are transmitters of cultural tradition and, inevitably, of political and social systems. Totalitarian *systems* in particular are characterized by a strong pressure to make uniform all aspects of public life (politics, productions, art, architecture, clothes, upbringing of children, etc.) and pervade deeply into families, other groups and also individual minds. The totalitarian power which tries to control all aspects of life is usually introjected and reprojected, very often denied, isolated or displaced. Paranoid anxieties and fears of punishment, at least in a mild form, become a part of everyday life. Totalitarian power seeks to break individual identity and creativity and thus to suppress the true self, or it interferes with the development of these capacities. A man becomes a wheel or a depersonalized *thing* in the big state machine and there is scarcely any place for fostering the true self potentialities in individuals. On the contrary, the development of the false self structures is severely promoted. A compliant conformity is required as a proof of fidelity. Although there are certainly some barriers against such detrimental social forces like the *protective shell of a family* or a group of trustworthy friends, everybody is more or less influenced by thousands of collaborative acts which directly or indirectly support the totalitarian régime. Defensive systems then create many rationalizations, denials of reality, value distortions, identifications with an aggressor, isolations and undoings. Some projections are very typical, for example, a belief that all sorts of evil actions are done by those in

power, and a power élite projects aggression on those who suffer under oppression.

Pretence and automatic adaptive actions such as an expression of the individual and the collective false self shape a peculiar quasi-normality of the sick society. For example, in the previous communist régimes people took part in the regulated voting pretending loyality to official political power. This public 'scene' was a model used in the area of the false self of individuals. The majority of children had to learn, before starting school, the false survival patterns and attitudes towards the outer political world.

The conscious and unconscious false self

Here I want to touch upon the question of *conscious and unconscious elements* of the false self. The false self is, I believe, a structure with many layers, and furthermore the level of awareness of different facets of the false self may vary with situations and states of mind. Some aspects of the false self may be regulated willfully. Sometimes we consciously hide our *secrets* which may well represent our true self elements. This hiding makes sense as on adaptation to the environment, which might be (at least in our fantasy) critical or refusing of our inner truth or genuine feelings. Some superficial levels of the organization of the false self, for instance a pretence of some *political attitude* may be given up by a mere social revolution which brings political freedom. Then the true self part may emerge as a mass phenomenon through shared joy and elation. Good examples are revolutions in 'Eastern' Europe at the end of the eighties. These phenomena always appear when destructive war is replaced by the wished for peace. Real psychoanalytic work at such times is not possible although patients may attend their sessions. The reason consists mostly of the hypnotic denial of inner painful conflicts. *The mental set* (the useful psychological concept for the psychic attunement of the day which is mostly preconscious but with conscious expressions of many kinds) is mostly oriented to selected parts of the present and future with a tendency to idealize heroes and a strong omnipotent identification with them. The analyst, therapist and others are used as narcissistic objects which are allowed to reflect the same elation. Patients, as other people in the liberated society, mistakenly equate the inner psychic enemies with the external, defeated 'class' of enemies. Therefore, some mass depression

must inevitably follow the happy days of the revolution as patients return to their old inner conflicts and deficiencies.

Some aspects of the false self are a *mixture* of conscious and preconscious elements. For instance, the false self may respond automatically to certain new objects and situations, which are still mysterious or unknown. I might think here, for example, of a new patient who mobilizes his false self in the first interview conducted by a therapist. A patient can avoid ticklish parts of his inner experiences in order to be accepted and loved by the future therapist. It reminds me of the bisexual patient who at first preconsciously omitted his conscious homosexual longings during the first interview, then when asked by the analyst for amplification he deliberately denied any such problems. He came to the first session with strong guilt feelings about having lied. Of course, the problem of lying was also his problem in the transference. There are many situations where the true self may be defended by the false self's behaviour. *Telling lies* and *falsehood* are typical tools of the superficial layers of a false self organization where the conscious parts are mostly recognizable. If lies are a part of the false self which is in the service of the true self's survival they are usually not experienced as immoral, at least to some degree. Imaginary responses of the true self can be the following: '*it is not "me", the real I, who is lying but the other non-personal, estranged or depersonalized part of me, that is, the false part*'. *The lowered liability* seems to be an important trait of those parts of the false self which can be sorted consciously. This observation has something in common with Winnicott's statement (1950) that the result of living through the compliant false self leads clinically to a *sense of unreality*. He suggests some similarity between the false self and the *observing Ego*, a concept used by other writers. The Observing Ego can easily avoid any strong emotions and, indeed, can use isolation in order to avoid feelings of responsibility for its own actions and deeds.

Deeper levels of the false self, and thus the more unconscious, are products of early interactions with a powerful mother figure, and later with a father figure as well. We can trace false elements to early periods of life in which the child's self may come to function in the service of both parents' selves. A child is forced to fulfil the demands of parents. *Toilet training* is the classical model of parental requirements. No wonder a false self organization has *anal roots*. A child seeks to master the task set by parents by a complex process of identifications. When a parent becomes depersonalized in the child's structure of identifications, the true self does not clash with demands of a parent but

instead finds the compliantly responding inner organization of the false self. Such a peaceful resolution does not always take place and obsessive and compulsive symptoms may develop as a sign of the unconscious conflict, or the true self tries to find its own expression through protest reactions, or can find the intermediate area of play as a legitimate space for inner creativity, wish fulfilment and fantasy.

The false personality

The false self may develop into the character structure which Winnicott (1960) called '*the false personality*'. It is a rigid defensive structure with nearly non-existent true self elements. He described a person with a very successful intellect dissociated from the suffering true self. Helene Deutsch (1942) made her observations about the *'as if' personality* which has no authenticity and imitates the behaviour, attitudes and feelings of others. These people are the 'good pupils' of many teachers. They present themselves as normal. Masud Khan (1974, 1979) saw this 'as if' pattern as similar to Winnicott's false self and found some resemblance to *the schizoid character disorder*, in which suggestibility is an important trait indicating an ego passivity serving the avoidance of strong feelings.

The strong propensitity to imitate others, to play roles, may become an unfavourable aspect of adaptation. I believe that this type or types of personality represent a dangerous stratum in society because they have no serious problems in adjusting to totalitarian societies, be they fascist or communist. False personalities are prone to be manipulated and misused (through their suggestibility, imitation and superficial emotionality) for political aims. These personalities are not discovered in stable societies as easily as in countries where political systems of different (often opposite) orientations change during relatively short periods of time, and here the states of Central Europe (like the former Czechoslovakia) are good examples.

It is important to mention the false self pathology in *borderline patients*. Winnicott (1959–1964) points out the dependence of the schizoid and borderline patient on an analyst. This dependence is very much a reality and reflects or expresses the true self of a patient. This real dependence is often a burden for an analyst. I have observed in some borderline patients their painful awareness of the split between their false-pseudonormal ego functioning in their jobs and outer world and their real, immature, and highly vulnerable true self. They describe

their false mental functioning as some automatic activity being split from their emotions. They must very often hide their tremendous anxiety and rage which are the infantile parts of their true selves. Sometimes they worry that their true selves are dead and that they will never find their authentic experience.

False objects

The theory of the true self and the false self would be incomplete if *true and false objects* were not included in the theory. 'Good enough' parents are the basic true objects of a child. A 'Stalinistic' mother, depressive father or a brutal leader are examples of false objects faking being 'good enough' but representing the external trappings or undecipherable double-bind figures. Social life in a communist régime has involved an interaction with many false objects which create a false world: for instance political meetings confirming the dogmatic truths of Marxist ideology, temporary jobs directed to the artificial improvement of socialism, unnecessary institutions and organizations which were for a long time faking their 'effectiveness' and usefulness, and so on. This false external world was used for an acknowledgement of the false self organization. There are false objects in all sorts of societies, for example the world of advertising has strong false characteristics in that it sets up artificial needs and attempts to persuade people that they are their genuine needs and wishes.

The conflict

Let us think of the *conflict* of split parts of the true self and the false self. It appears when the true self is endangered too much by false self expansion, and when the price of the true self's survival would be too high. In some individuals the true self (fixed by strongly cathected values) cannot bear some of the demands of the power system on the false self. The true self has too high a narcissistic value to be reduced to silence. These individuals may become heroes, dissidents, and might prefer self-destruction rather than become traitors of themselves and others.

The internal conflict that was and is typical of the lives of individuals under the oppressive social system can be expressed as follows: 'Should I say, express, feel, be conscious of my inner truths, opinions or

genuine feelings, or is it better to be silent, to pretent, to play a role, to lie, to suppress my own spontaneous responses?' The first choice leads to personal freedom with risks of persecution and destruction. The latter means some form of psychic death, the loss of individuality, the loss of freedom, self-dignity and self-respect.

The protective functions of the false self.

Although the false self seems to be a not very happy solution, it plays an important role in protecting the true self organization in totalitarian surroundings (Šebek, 1990). In order to share the true self elements people usually establish some underground groups or an underground subculture, where oppositional and free thoughts, ideas, and artistic creativity can take place at least in a limited space. Intellectuals and artists especially could preserve their creative selves in some sort of an underground movement. Such movements have an historical tradition in Central Europe, and in the Czech country especially, because the Czech nation had to live for 300 years, until 1918, under the Habsburg Monarchy. This underground tradition was renewed during the Second World War and later during the Communist régime. I believe that some important cultural values as well as a democratic tradition can be preserved when the false self works adaptively for the protection of the true self. Also psychoanalysis has survived the last totalitarian régime in the former Czechoslovakia in the underground subculture. Of course, in the false world of this régime psychoanalysis could rarely be mentioned publicly but some other terms were used like *deep psychology*, *uncovering psychotherapy*, or individual psychotherapy. The psychoanalytic institute could not exist officially, and secretly was called 'the little school'. These examples illustrate that language is an important part of the false self structures which protect the secrets of the true real world.

Although the true self and the false self are based on the underlying splitting process, further ego development is responsible for *the new synthesis and integration* of those aspects which promote the complementarity of both parts. Thus some parts of the false self structure are indispensable for sublimation of true self tendencies and the development of the true self's potential. Some values and cultural interests learned or acquired through identification with important figures or objects represent no conflict with elements of the true self, on the contrary, they exist as an integrated whole.

One of the important features of the false self is to minimize or prevent a conflict with the outer reality but the price paid for it may be an intensification of the conflict between the true self and the false self.

The destiny of the true self and the false self in the post-totalitarian society

The question could be raised as to what is a destiny of the false and true self in post-totalitarian society, for example in the Czech Republic, where I live. It is an observable reality that the development of the true self was highly stimulated by attaining freedom in social life. In particular, private initiative in the development of new groups, associations, clubs, political parties, private enterprises and so on is proof of the urge to find an activity which would fit some inner longings and more genuine and diverse tendencies. This development is characterized mostly by sublimation of inner drives, but it is not a smooth path. Attempts to disregard authority and laws, mobilization of primitive cannibalistic and tribal forces, growing envy and resentment, characterize present day tensions in post-totalitarian societies. The tendency to disregard authority and laws is probably a consequence of the general devaluation of totalitarian authority which was experienced as oppositional and totalitarian laws being understood mostly as hostile. Envy and resentment were in the past régime partly suppressed by the fact that the majority of working people had approximately the same incomes and salaries. This situation has been radically changed in the post-totalitarian period and the new differences among people create a new ground for painful, envious attitudes and emotions.

The character of the true self elements

True self elements, I believe, should not be in any way idealized because they mediate *destructive* and primitive sexual urges as well as a *creative* developmental search. Briefly, the inner potential of the personality consists of *tendencies of different qualities* and *diverse developmental levels*. The so called 'good enough mother' can fail easily when being confronted with destructive aspects of the infant's tendencies, or when she is not able to initiate the development of the flexible false self structure in an infant or toddler. When the system of social

authority is shattered or weakened, then the suppressed or repressed destructive forces may be revived together with longings for restoring the lost grandiose position of an early true self. These forces can be retained by political movements and misused for nationalist aims, aggressive ecological attitudes, or even wars. In this way an individual patterning of inner states, drives and longings can take the shape of group false self identifications which are regulated not by the individual but by group pressures or a leader's decisions. The individual pattern is overwhelmed by the collective or mass movement and the true self is not recognizable any more, at least not in its creative form.

The therapeutic dialogue

Winnicott emphasized that an analysis uncovering the patient's genuine feelings and true self experiences is not possible without an activation of the true self of an analyst. Spontaneous processes in the patient and in the analyst are responsible for the *creative work in the analytic situation.* Affective truth is manifested in the spontaneous utterances and metaphor and illusion become real agents of a psychoanalytic cure. Winnicott tells us that the true self interacts with the reality within *the transitional area* which is defined as an *intermediate area of experience* that bridges 'the me' and 'the not me.' *Play* and *illusion* are typical examples of this. Adler (1989) points out that an analysand's utilization of free association is a part of his/her experience of transitional phenomena. Kris (1982) observed that the analysand may experience free association as a satisfying aspect of the treatment. It might be inferred that *the play of free association* provides this special sort of satisfaction. On the other hand, we often meet with patients who behave as if some task put upon them by the therapist should be fulfilled and there is really no pleasure in any 'play'. They use their false selves to serve some imagined or expected needs of the therapist. When they recognize, for example, that the therapist is pleased with their dreams they bring them every session or whenever they think they are expected to do it. Or they use their false selves as protective barriers against imagined expectations and interests of therapists so that they avoid dreams or some other aspects of their affective experience, which must be hidden to sustain feelings of safety.

Patients often project onto analysts their false internalized objects. For example, they can see in therapists some double-bind figures who

are not or cannot be sincere and who in the therapy play only their professional (depersonalized) roles. Such patients seem to be afraid that in allowing themselves spontaneity they will be destroyed or ridiculed. Some of them keep secrets for a long time before they reveal them, and some may think that the therapist has an ideology which is directed against the rest of the identity he or she had preserved.

Clinical illustrations

Some fragments of cases treated by psychoanalysis and psychoanalytic psychotherapy in our cultural conditions may illustrate the functioning of the true self and false self and their developmental vicissitudes related to the totalitarian and post-totalitarian social conditions.

Vignette 1

Joan was a young woman, a clerk, married, with three children. She asked for psychoanalytic therapy during the Communist régime. She felt herself unsuccessful, and inadequate in her adult roles as mother, partner and worker. She said that she mostly did things which she saw others do. For example, she married because it was expected by her family and friends. She never felt any strong feelings for her husband and she was far from being sure that the marriage was really her choice. She did not experience orgasm in sexual intercourse and she had doubts about her femininity. She felt dependent on the responses of other people and lacked an inner measure of what was right or wrong in different everyday situations. She was afraid that any activity of her own could mean destruction of others and her guilt feelings were the strongest emotions she ever had experienced. Her anamnestic data were relevant. She was brought up in a Communist family. Her mother was a dominant Stalinist feminist who preferred her own career to any intimate emotional involvements with her three children among whom the patient was the youngest. She was breast fed for only four days because her mother then had a breast infection. As a six months old baby she was sent to a day nursery (it was the usual practice in the fifties). Her mother used to apply a military drill in her educational practices. Father was weak and also suffered under the totalitarian family atmosphere. The patient is identified with him to a larger extent

but never got the wished for protection from her father. The patient's main memories were centered around her desperate fight with her mother. The patient was obstinate, negativistic and she often felt like a naughty girl, believing she could not get closer to mother. She often had dreams in which she stayed in a hilly landscape with feelings of loneliness and helplessness because she could not find her way (to the analyst and life as whole). She knew two positions: a compliant one through which she was very successful in school and a negativistic, critical attitude to others, especially the authorities. She had the infantile true self which inclined to the grandiose rejection of others and at the same time felt lonely, helpless and worthless. She had strong longings for closeness with the ideal mother figure but at the same time she did not trust any object and avoided intimacy as being a dangerous enterprise. Her false compliant self helped her to adapt partly to her adult roles but she paid for it by feelings of inadequacy, insecurity and doubts. Her transference developed into a long fight with the analyst whom she experienced partly as a totalitarian object (similar to her mother) trying to control her by means of the *psychoanalytic ideology* which she decided to reject, although her false self did much intelectual work in 'understanding' the analyst's interpretations. She was afraid of erotic fantasies and feelings towards the analyst (male). She reasoned that the analyst was 'certainly' married (as father was) so that it was useless to have any fantasies about him. In fact, she was unconsciously terribly afraid of penetration of any kind. She also refused sublimated forms of penetration (intellectual influences, beliefs of authorities and psychoanalysis as the special sort of 'ideology' for her). She had problems with free association; telling stories was much easier for her. After some time she revealed that the analyst's attitude to her was helpful but it had to be only professional because it was paid for. In fact, she did not believe in any relationship and in any help. She was in contact only with her false objects and this was evident in the transference. The political changes in her society had not touched her inner problems. She felt some triumph over her Communist mother but it did not bring her any real satisfaction. She observed that when other people started private businesses she became envious, not having enough courage to be more independent or rely more on her own strengths. Her way to her own feelings of being a woman was rather complicated and accompanied by a still strong experience that she was more a 'child', 'a nasty girl', who could not be loved, and if she obtained proof of being loved, it had to be a false proof (perhaps a mistake on the part of the lover).

Vignette 2

This fragment involves a situation in an introductory interview. I was listening to the life story of a woman who can be called Eva. She talked about her previous psychoanalytic psychotherapy and about her childhood which she spent as an only child of a divorced and rather dominating anticommunist mother. Mother was, for her, the only person she could love and hate. Mother was severe and wanted her to be a well-bred girl. Eva was a rather negativistic child who was often physically punished in her preschool and school years. In her adult life she suffered from not being able to marry, or even to fall in love with a man. She feared closeness in her relationships and she was afraid to take over the feminine role and feel a woman. When finishing our first meeting and drawing up a contract I mentioned a simple rule that when she was late her session could not last longer than the rest of the agreed time. She responded with surprise; she was usually on time everywhere. For some ten sessions her false self worked well and she was really usually on time. She was rather productive and brought into the sessions a flood of her sadistic fantasies which were turned against me in a playful way, testing my tolerance and conveying her fear of sexuality, aggressive defenses and her ability to use an intermediate space. Her observing Ego could at any time switch from her fantasy level to the hard reality of judgement and everyday rules of her personal and interpersonal world. Gradually she came late for some sessions, trying to provoke a punishment as a part of her transference needs. Although she was always able to use her observing and judging Ego to some extent, some decline of this capacity occurred and her Ego became flooded with manifest aggression. She was able to experience her true self as a highly sensitive, vulnerable and also endangered part of herself which needed to be defended by a never well integrated mixture of good manners, identification with the aggressor, escapes, refusals, negativistic actions and projections. Some political context may be interesting: her mother was a severe anticommunist believing that bad things in her life were caused by 'them', meaning the Communists. Eva was fully identified with her mother's attitude and used the same projection. Furthermore, she had a tendency to blame her non-present father as though he were the enemy as were the Communists. Just as she had rejected the communist régime, so she was highly critical of the democratic government after the revolution in 1989. She needs to project bad aggressive parts of herself

blindly attached to some pieces of outer reality. When she was in her second year of psychoanalytic psychotherapy (twice a week), she decided to marry but she only told me about it several days before the wedding. She said she had been afraid that I could prevent her marriage as her mother would have done because her mother did not like men and did not like her father. She decided to marry her partner (whom she had known for several years) in a situation in which she was afraid of a landlord who was pressuring her to move to another flat. She resisted, was very anxious, hated him, but needed the protection a partner could give her. She was also proud of being married because she thought it was a proof that she was healthier and stronger. Step by step she became less under the pressure of her anxiety and her massive projections of bad objects were changing into the sadness of realizing that it was too late to think of having a baby; a natural focus of her emerging feminine creativity.

Discussion

Both cases have a similar background: a totalitarian upbringing which bore down on the spontaneous behaviour of children, stressing the compliant aspects of the child's responses and a strong emphasis on power which inhibited the proper development of the true self in both cases. Joan could not find her femininity and her true self was fixated in its patterns of anal resistence against the power of the outer world. She did not believe that she could gain genuine affection and love and was suspicious of any signs of it in her interpersonal relations. She conceived of her analyst as a false object with only professional and not genuine interests. Her false self was a powerful agent in her everyday adaptation where only people close to her could recognize her disturbance.

Eva activated her false self struggle in the first interview because she wanted to be accepted for therapy but she bravely attacked the analyst with her primitive aggressive and sexual phantasies from the beginning of the treatment. Her primitive true self repeatedly tested the analyst's capacity to contain her impulses. When she was almost sure that her phantasies were bearable not only for the analyst but for her too, she tested him by acting out aggressive impulses (for example by being 'terribly late' in sessions, and then by marrying her partner). She believed that the therapist had to be a false object who only

pretended sympathy towards her. She tended to expect 'punishment' from the therapist.

A common social background during the childhood of both patients illustrates that extreme political attitudes – both communist and anti-communist and probably any other ideological extremes – represent some resolution of *the power conflict* which is transmitted to children by their parents through a prevailing educational style. Put simply, therapists cannot afford a clinical 'sterility' in their understanding of psychopathological phenomena although it is in the tradition of the biological model in medicine. The old concept of trauma which represented the bridge between outer influences and the body and the inner world in the earliest stages of psychanalysis is not suitable because it refers to confined events and experiences whereas the totalitarian social structure brings about a permanent anxiety at all possible developmental levels (destruction, separation, castration, humiliation, a loss of dignity, identity, etc.). The concept of the false self involves a psychic structure which may function as a survival behavioural pattern that serves as the link between the outer unfavourable environment and the inner world, and also as the buffer modifying inhibiting and filtering the impinging outer world. The false self may function as an adaptive and also as a defensive structure, furthermore, it can be a compromise formation as any other symptom of a complicated nature. The pathological false self is a character structure which keeps the true self elements in their infantile fixation.

Both clinical cases are good illustrations of this development. Joan used her false self adaptively in her social behaviour but she could not reach real satisfaction and she felt false and inadequate. Her false self structure had superficial and rather deep unconscious layers, which were used for defensive and inhibiting purposes. She projected the false elements believing that the outer world was full of false and more or less dangerous or unreal objects. The experience of a gratifying femininity was a difficult task for her infantile true self.

Eva had a much more plastic, superficial and weaker false self and her adaptation in her social life was consequently not very smooth. She was ready to express herself much more directly and spontaneously but with more interpersonal conflicts in her everyday life. Although her true self was infantile and her feminine identity seemed to be a difficult developmental task for her she proceeded quickly in psychoanalytical psychotherapy by means of constant and intensive testing of the therapist's capacity to contain her primitive impulses and his ability to be empathic with her.

Conclusion

Winnicott's concepts of the true self and the false self are useful for understanding clinical and social phenomena and their relatedness. Perhaps they illustrate the social nature of the clinical phenomena. People can find similarities among themselves through their false selves while the true selves as personality idioms are the source of differences and individuality. Totalitarian and institutional powers lead to restrictions of true self development and to fostering false self structures which suppress or defend true self elements and structures. Problems of identity, a limited ability to recognize one's own feelings and needs, loss of creative capacities and lack of spontaneity, obsessive control of responses, feelings of being exposed to the demands of others, excessive conformity, emptyness, and experiences of depersonalization are the most frequent symptoms of the false self pathology.

The false self has conscious and unconscious layers and involves older infantile structures as well as later developments involving experiences in adulthood, too. False self and true self experiences may exist also as mass phenomena during overall social oppression, violence and social revolution. The world of false external and internal objects is contrasted with true objects. The false self pathology is much broader then Winnicott's false personality concept. We can find it in borderline, narcissistic and neurotic patients. Patients often project on to the therapist their false internalized objects. These objects are very often similar to dictators, ideological leaders, emotionally distant persons and professional authorities who do not possess empathy, who are not able to give real sympathy and love and who pretend to behave with affection.

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BOREDOM AND THE THERAPEUTIC PROCESS

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In our clinical work, I believe that boredom, even more perhaps than 'antisocial impulse', may constitute the most severe 'clinical challenge', both to patients and therapists. When we look at the etymology of the word, it appears to have two seemingly unrelated meanings: (1) To pierce so as to form a hole and (2) To weary or annoy with tediousness (Chambers Dictionary). At first, I thought these were two distinct meanings, especially as the latter dates only from the mid-eighteenth century. But then I wondered if they could be two aspects of the same experience, as for example in the experience of emptiness or non-existence when being 'talked at' or 'looked right through' rather than properly related to. Either way, the psychic subject, or self, is irrelevant to the procedure, and either way a hole or gap is experienced in the self-structure, whether as a result of impingement or of sheer neglect. The usual consequence is an urgent striving to find something to fill the gap, either by claiming the other's attention through protest or pleading, or through withdrawing into an inner phantasy world, for as Jung pointed out we cannot stand a meaningless existence.

Of course, the state of boredom varies in degree. In the more confident (because 'ego-related') person it can be resolved by *claiming* attention by normal natural self-assertion; or by a little sage advice, as when A.S. Neill explained to a child that everyone is bored while making up his mind. Recently, I advised a father whose son complained of boredom, to sit it out with him, rather than 'inject' a meaning or purpose from outside his son's experience. On the other hand, where an individual has experienced long periods of boredom and emptiness in early life the result is much more serious: What Laing called 'ontological insecurity', a crucial doubt as to one's reality and stability as a person, in some cases so severe as to preclude any claiming of what is needed: the individual can only wait. Thus Winnicott, when asked by social workers when they should put a client in touch with a psychotherapist, is reported to have advised them to do so if they found their client bored them: the sign of a deeper problem beginning to emerge.

One might further speculate about a connection between 'boredom' and 'border': 'on the margin or edge of things', and so with 'borderline',

the term used to describe states on the border between neurosis and psychosis; states which are often associated with a hole or flaw in the self-structure (Balint 1968), which patients describe as 'tipping over into blackness' or 'falling endlessly in space'. Rycroft, in his definition of 'borderline' points out that its use as a diagnostic term is based on a false assumption 'that neurotic and psychotic states are mutually exclusive, while clinical observation shows that they are not' (Rycroft 1985); a view supported by Guntrip (1968) who writes that 'neurotic conflicts are so often thrown up out of the struggle to keep going over the top of a hidden deep core of isolation, emptiness, lack of reality as a person, feeling weak, inferior, a nobody, of no value; and also the feeling of being out of touch, cut off from people, not belonging'. He adds that 'the real problems are not about instincts and impulses, but about personal reality experienced and grown in the medium of personal relationships. This view was confirmed recently by a female patient in her early thirties whose 'hurt and vindictive practice of self-cure' (Masud Khan 1974) was a finely-tuned ability to discover the expectation of the other and comply with it, chameleon-like, whilst secretly hating and having contempt for that person (negative transference from her father) whom she would seek to control by her cleverness. Although it was an important gain when she could openly express how she hated being with me, and how glad she was to get away etc., this only revealed how 'empty' she felt and how 'cold' beneath the 'heat' generated by hate. Then, on one occasion, when I, in an attempt to respect her privacy, remained silent, she experienced me as critically disapproving of her for failing to interest me. Noticing her hostile expression, I said, 'You seem to feel angry with me for failing to give you a lead'. She replied, 'No, I'm too empty to feel angry. I'm afraid you'll see what a nothing I am.' She was beginning to sense the deeper problem: the lack of what Kohut (1977) has called 'a life sustaining matrix', at the point where her 'false self functioning', by which she attempted to manufacture meaning in a meaningless existence, found nothing in my response to sustain it: only a gap, an emptiness. In the transference I had gradually ceased to become her difficult father to compete with, and had become instead her non-relating mother who had been unable to recognise and nurture her, and had avoided physical contact with her as a baby. The 'neurotic' struggle with the contentious father had become her sole means of struggling free from the underlying 'psychotic' void with her cold mother, and as such had come to characterise her relations with men in general, and with myself in the 'transference neurosis'. From this point, it was no longer the

neurotic struggle which preoccupied her, but the need to remain quiet and to be steadily emotionally accompanied and supported in the therapeutic relationship. The underlying emptiness ('boredom') had to be addressed and tolerated before she could begin to recover.

Not all psychoanalytic writers see boredom from this point of view. For example, Fenichel (1954) argues that the state consists of instinctual tension from which the instinctual aim is absent, and that, because of this, the bored individual needs the therapist 'not to receive the impact of his instinctual impulses, but rather to help him find the instinctual aim that is missing'. In my patient's case, this would have meant warding off the deeper problem of unrelatedness and non-existence by reinstating in the transference the battle for survival with father; surely a retrograde step, when she was needing to find not so much a 'missing instinctual aim' but a *missing sense of relationship and of 'self'*, in short an interpersonal context for her dissociated 'instinctual aims' to function in. As Kohut (op. cit.) has put it, 'the therapeutic aim is not to confront the patient with a now supposedly fully uncovered drive. . . . the deepest level to be reached is not the drive. . . . but the experience of a life sustaining matrix'. It seems to me that if the individual is basically unrelated, the 'drives' function in disparate and unconnected ways because the 'ego' or 'self' whose 'property' they should properly be is still only a psychic potentiality. Thus the 'drives' can only find their true context when the patient/child can experience himself as securely related to the therapist/parent, in *real terms*, and not only in 'transferential' terms. This requires of the therapist that he alter his therapeutic emphasis from sensing the repressed conflicts of his patient, to sensing his undiscovered personal potential.

It is precisely here, when the therapeutic experience shifts in emphasis that the *boredom* of the therapeutic process is apt to become apparent. The patient's resistance will be extreme, since the fear of re-experiencing the gulf prevents him from believing in, let alone attaining the relation he needs in order to recover. He can only shut the therapist out and his potential self in. And yet his greatest need is that the therapist remain attentively with him. The danger *for the therapist* seems to me to be that he may end the analysis at or around this point, since 'transference analysis' and 'transference neurosis' seem to be over, and that he may 'analyse away' the consequent 'boredom' as depression at the prospect of ending analysis. Or again, the therapist may analyse the patient's 'emotional withdrawal' as resistance to the uncovering of further instinctual drives. In doing so, he will find a

willing participant, for as Winnicott (1965) has pointed out, 'The patient's false self can collaborate indefinitely with the analyst in the analysis of defences, being so to speak on the analyst's side in the game. This unrewarding work is only cut short profitably when the analyst can point to or specify an absence. . . .': that is, a hole or flaw in the personality of the patient about which the analyst can somehow let the patient know that he, the analyst, knows and accepts as the deeper underlying problem. Only by patiently relating the patient to the deepest area of this psycho-pathology can what Guntrip (1968) described as the 'schizoid compromise' and the 'psychotherapeutic stalemate' be overcome. The well-mapped territory of the 'neuroses' having been traversed, therapist and patient pause before the unexplored region of undeveloped personal potential, undeveloped because unrecognised as a possibility. Small wonder that analysts have wanted to insist upon a border, separating mutually exclusively, neurosis and psychosis, for, as Neville Symington (1968) has pointed out, 'the psychotic (in the) patient will burrow away until he finds what is in the analyst's heart', since he requires for his 'cure' something of the analyst's true self, which by definition has no antecedent.

I wish to suggest that boredom can represent the patient's way of signalling, conveying and 'transferring' to the therapist the original experience of emptiness which gave rise to his neurotic symptoms, the maintenance of which costs him no small effort. He will feel exhausted, listless and very vulnerable and dependent as he lays them aside. He is unable to gratify his analyst's need for 'progress' since he needs 'regress', of which he is nonetheless very afraid since he feels that regression involves the loss of whatever independent status he has built up. The therapist may therefore feel acutely alone, and uncertain, since little or no reflection of his significance will be forthcoming from his patient. And yet, failure to respect and feel concerned about his patient may invalidate whatever gains the latter has made. On the other hand, by what can only be described as a *faith or belief in his patient*, based partly perhaps upon his perseverance in attending sessions, and also partly upon an *intuitive perception* of the 'basic human heart' of him derived from the analytic uncovering of his struggles in his relationship with his bad objects – and by a further sensing of the infinite possibilities for him to experience living, the therapeutic relationship may become the matrix for his personal development. For me, the whole point and purpose of analytical psychotherapy is to arrive at this point; analysis prepares the ground by equipping the therapist with the 'emotional information' about his patient, so that the latter may

feel known and valued as a person, perhaps for the first time, and begin to grow. One patient, a woman in her twenties, born into a grossly disturbed family, deserted by her mother, and exploited and abused by her father and brothers, had no sense of herself when she entered therapy. On one occasion, when I remarked upon the severity of her circumstances and how hard she must have found them, she merely replied 'I *am* my circumstances.' Her existence felt automatic, mechanical. After the deeper phase of her therapy had passed, and a new sense of self began to grow, she felt moved to review the process. Referring to herself in the third person, she wrote of her sense of unreality thus: 'Only a thin parameter lay between her and the world of everyday objects. She would look down inside her outline, viewing what she thought they might be seeing when they looked at her; head bent inwards, she would turn about and then, exhausted momentarily, resume her nothingness.' She described her experience of therapeutic intervention as follows: 'She had. . . . blown a single breath upon an ocean and miraculously a living man (therapist) had said he heard the air expel from her lungs and that she was real. From then on she. . . . listened to him, dreamed her poetry aloud, and fought above an ordinary strength to be here next day, and then the next, rather than do what her tired soul willed of her when despair enveloped totally. . . . Over the years the bargain beame apparent. She would trade her sovereignty of the huge waste acreage where she had found a frozen quiet, for his vision of a touchable, ordinary world, full of flaws, but with the thread of honesty running through it. . . . As far as he could, he stretched the depths of his soul to reach her, and they had agreed a common tongue . . . so that each might have understanding of the other.' She entitled her account 'Journey Back' meaning not the reductive analysing of the past/internalised present, a necessary stage, but the 'journey' back to the surface of life from her profound retreat in the face of an uncaring world. Just how profound was revealed in one of the poems she 'dreamed aloud':

> You may be entering the cold
> room where I was born
> Cold-limbed at birth,
> Lying there, unknown.
>
> A vast cavern
> empty
> a world once closed, sealed off,
> an unknown place then
> And at the heart,
> nothing.

The starkness of this level of experience has sometimes been regarded as inaccessible to psychoanalytic therapy. But as Guntrip (1971) has put it: 'The psychotic transfers to us his experience that no relationship exists, and hopes that we will see it and get through to him'. He is needing the therapist to reach him in his empty world, and if this need is not met, we do not receive anger as we would at a later stage of development, but only a mute acceptance: described by Winnicott (1975) as 'only a reproduction of the environmental failure situation that stopped the process of growth .... and we witness the original cause of a sense of futility .... in a world devoid of relationship'. Back to boredom again.

Thus the above mentioned patient was inarticulate verbally for a very long time, and there was no eye contact for the first three years of sessions. Later she wrote of herself: 'She was always trying to explain. Yet as soon as the first words left her mouth, she caught them in mid-air, and stopped, crystallised, *containing the awfulness of not being understood*' (my emphasis). I emphasise this phrase, because, at this level it is not 'technique', but the therapist's capacity to relate personally and empathically to the patient, his essential humanity, 'full of flaws but with a thread of humanity running through it' which is indispensable to the patient. If the therapist is too keen to make a success of the treatment, concentrating only upon clearing up the patient's pathology by a flawless technique, he will certainly avoid awareness of boredom at the cost of failure to meet the patient, whose need is to be waited for. With the patient mentioned above, I was on the borders of sleep one afternoon, when I heard the quite unmistakable 'arrival' of her 'true self', not that I was ignoring her, simply waiting, as so often before, allowing my imagination to conceive of *how she would have been* in an affirming world. I am indebted to a Jungian colleague for the following quotation from Adolf Guggenbuhl-Craig in his book *Power in the Helping Professions* (1982) which expresses helpfully what I am trying to convey. He wrote: 'To encounter a person creatively means to weave fantasies around him, to circle around his potential.... Even if they are not expressed, fantasies also influence the other person, awakening living potential in him.'

A similar experience occurred with a male patient in his mid-twenties. He described a bleak childhood with a hard, disinterested mother who had had three abortions before he came, and did not want him. His father had deserted her, and she went to live with her own mother and three sisters. The patient had been brought up as a girl. He was very pale and tense and markedly lacking in 'personal

presence'. He described his behaviour as 'automatic', though he was aware of 'forcing himself to behave like a person' at the cost of continual back and head-aches which concealed a strong need 'to withdraw completely'. He was a talented singer and actor, but reported a growing sense of impotence and futility, and a strong sense of inferiority. Although he could show no emotion he was aware of a deep yearning for affection which he experienced as dangerous: as he put it 'When the desire for love gets too hungry it's too great to be contained'. His attempted solution was to remain unconscious of this desire; by 'withdrawing completely', but in doing so he felt unreal, and in one session cried out, 'Where is the essential me?' Quite early in our meetings he went fast asleep in his chair for the entire session. I let him sleep and gently roused him at the end. This set the pattern for future sessions when he would draw the chairs into what he came to call 'the partnership position' and lapse into a semi-doze, often making sucking noises. The 'partnership position' was with the chairs side-by-side, so that we had an awareness of each other's presence, but direct eye-contact, though possible, was unlikely. I co-operated to the full with what I felt to be his great need for 'vegetative rest' (primary identification), and out of this atmosphere he eventually reported a sense of personal reality which was 'distinguishable from the senses'. He explained that he had always felt 'his senses were him' so to speak, that 'he' was an assemblage of organs. I was reminded of Winnicott's (1965) statement that the psyche is not simply a reflection of somatic experience, since it may be only loosely connected to the body in the first months of life, but that it would gradually *integrate* somatic experience if environmental adaptation to the infant's needs was adequate. Clearly this had not been so for my patient, but I was led to the possibility that he may be using the therapeutic relationship for the integrative process. I should add that it was only at this stage that he was able to use part of our sessions to re-experience the starkness and cruelty that pervaded his early life. His perseverance in attending sessions was impressive, especially when he was obliged to move 200 miles away for work. However, one result of finding himself in a different environment was the formation of a friendship, his first, he said, with a work colleague 'who did not make the same judgements as other people'. His friend was Persian and the value of their friendship for my patient was expressed in a memorable dream: 'Someone was introducing me to a map of Persia and as I studied it, it became animated and friendly, and it was the real world and I was part of it'. This development went along with a gradual sense of new life in the

therapeutic relationship. Little was said. External problems were discussed briefly and having dealt with them he would relax into a silence, which I came to associate with 'introjection of a good object', since he reported feeling 'much stronger inside', and that he could 'take me for granted' as a personal background to his increasingly satisfying outer life.

In all the examples I have mentioned, the sense of being in touch with another person, for whom this had been a long-awaited need, facilitated the evolution of a new sense of purposeful self-feeling, and was enormously satisfying and enriching for *both patient and therapist*. One cannot be involved in such a relationship and remain static, for as Guntrip (1975) has pointed out, in such an encounter the therapist grows as well as the patient and in fact, it seems to me that it can only be a growing sense of *mutual* significance which can both facilitate the patient's growth, and also sustain the therapist to tolerate and respect the area of boredom, the 'psychotic transference', as a 'potential space' for his patient's unilateral development. There is much that the therapist can *give* his patient by reason of accumulated experience and developed understanding, but the developing sense of their relationship as persons can only be the gift of each to each, the sole province of neither. To quote Symington (op. cit.) 'Each new patient challenges the psychotherapist to further his emotional development ... It is when analysis is a rich emotional experience for both parties that it enables the patient to grow.'

Summing up, I would suggest that the 'transference-self' which the patient brings into analysis is a 'falsely-reactive self' manipulated by his internalised bad objects, and therefore ultimately predictable and 'boring'. He brings it into analysis because it feels false and reactive, as distinct from 'true', creative and responsive: no creative self-expression, just reaction. The working through of this area is the business of 'transference analysis', and as the patient comes to see the extent to which he has been reacting instead of living, he is likely to sense the deeper problem: an extreme weakness or a void where the true sense of self should be. The original purpose of analysis has gone and there seems to him to be no point. I am suggesting that he can only discover the creative self expression that is living if he can experience a non-reactive resting in an 'accompanied space' in which he can dream, so as to allow the reactive distortions into which he has been split to cohere in a new unity of purpose. And he can only realise this potentiality if the therapist can sense this possibility in him and wait for him to develop it. It is imperative for the patient that the therapist

see the point of 'being with him' in these moments when the 'therapeutic *process*' is not (yet) able to be experienced as a 'therapeutic *relationship*', because neither patient nor therapist has been able, so far, to relate from their true or natural selves. If the therapeutic process were to end at this point without the therapist having met the patient the process would remain static, non-dynamic and ultimately 'boring' since the patient would know only who and how he is not, and not who and how he is, or 'has it in him to be'! My point is that he can only experience himself as a whole person when the *other* person, the therapist, senses that possibility in him, thereby transcending the influence of his 'bad objects'. For me, this is psychotherapy, 'mind-healing,' for which 'analysis' prepares the way: in other words the whole purpose of analysing is to facilitate a therapeutic relationship, without which it would be a 'boring process' like any other purely intellectual, introspective process, producing a feeling that 'real life' is going on elsewhere. Two further points need to be made. The cases I have mentioned were severely 'schizoid' in nature, with 'psychotic' experience very near the surface, beneath a very thin neurotic defence. But even when the 'presenting problem' is expressly 'neurotic', for example where parents actively provoked rage and guilt in a more developed ego or 'self', I have found that at the *core* of the 'neurosis' lies an experience of being *un*-related. To put it another way, when a parent maltreats a child, that parent also *fails* to relate to his true nature, and both the maltreatment and the child's *reaction to it* serve to obscure the non-related feeling. Consequently, any 'analytic treating' of the neurosis which goes far enough will eventually uncover the deeper problem, and with it, 'the psychotic in the patient' which requires for its resolution a personal relationship with the therapist.

The second point concerns how the therapist sustains himself through the long hours of waiting. A colleague told me that he had to leave his first analyst because he 'gave *too much* relationship'. 'In that case', I replied, 'it can't have been "relationship",' for two reasons: first a sense of relationship can be discovered or 'evoked', but it cannot be 'given'; and second, the precondition for relating is a *moment-by-moment sensing* of the other person's state including, especially with the 'schizoid' patient, sensing when one is 'too close' or 'too much'. The schizoid in the patient is more afraid of love than of hate, since loving stirs such dangerously hungry needs, hence my respect for my last-mentioned patient's need for the 'partnership position'. What is true for the schizoid in large measure is true in some measure for all

patients at the schizoid level so to speak: the therapist must observe the 'pace' of his patient, just as a mother with a child at the breast.

It would be my guess that the analyst referred to by my colleague had not acknowledged his own loneliness during the therapeutic process. If so, it would be his *own* need and not that of his patient that caused him to flood the latter with his attentions. It is very important that we can acknowledge boredom and loneliness when they exist in the 'counter-transference'. In my own experience failure to acknowledge these feelings can lead the therapist unconsciously to visit his own 'neurotic need' upon his patient. Perhaps I might propose that just as the patient, by reason of being a patient and therefore manifestly 'in need', has '*a deep craving*' for object-relations' within him (cf. Fairbairn 1952), the therapist, to the extent that he is well and whole, will have a basic human capacity for, and interest in, reciprocal personal relations, and a *conscious hope* that, through the medium of psychotherapy this may sometime come about between himself and his patient as emotional equals. If this is the case, the therapist will be certain to experience a 'normal' and natural *loneliness*, when sitting, for a long time, juxtaposed to someone whose defences repeatedly preclude such relations in one way or another. Whereas, for the patient, his defences are assembled against awareness of his isolation, for the therapist, only his insight can sustain him in his loneliness, by enabling him to conceptualise the isolated psychic heart of his patient and to wait for its gradual development, an eventuality to which his own experience of analytic psychotherapy will hopefully have introduced him. If as therapists we deny our 'natural loneliness' with the defended patient we cannot allow him to mean anything to us and he cannot recover. I must emphasise that I am not denying the possibility of 'neurotic loneliness' in the therapist. It is certainly not impossible that he may experience this, and it is appropriate that he deal with it in supervision. But I believe his patients need him to know what it feels like to be in a state of true relation with another, and that it is the indispensable medium for ego-development, that his patient is sick because of its lack, and that it is an innate human capacity, and that it must be waited for.

Over many years I have come to look forward to 'boredom' in the therapeutic process, as the prelude to creativity, and to accept it as a necessary stage, an accompanied space in which the other person is gradually integrating his experience, developing his purposes and, in the deepest sense, 'making up his mind'. I have been very far from disappointed.

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TECHNICAL DIFFICULTIES IN THE TREATMENT AND CONTAINMENT OF VIOLENCE WITH PARTICULAR FOCUS ON TRANSFERENCE AND COUNTERTRANSFERENCE ISSUES

JUDITH EARDLEY

Introduction

I was stimulated to write this paper as I became aware of the various technical issues and problems raised in the treatment of a particular patient. As therapists we are accustomed to treat and understand unconscious fears of violence. However, I found complications when I was treating a patient whose fears were grounded in reality. In her case, although the fear was rooted in the past, it was directly connected to events in the present because of her associations with political organisations. Imprisonment, assassinations and murder were a current reality for people close to her, thereby implicating her, albeit at one remove.

I found myself considering the technical issues around the treatment of violence, as well as the dilemmas and problems of a therapist working with a patient whose underlying psychopathology was compounded with some degree of combat neurosis or post traumatic stress disorder (Figley, 1978). I refer here to the trauma incurred by this patient by her experience as a prisoner and guerrilla.

'When the intensity of a traumatic event reaches overwhelming proportions the internal parental images that are unconsciously relied upon for safety become helpless before the onslaught of massive terror. The good enough environment is replaced by a life of threatening unpredictability that reawakens the most primitive fears and aggression' (Schwartz, 1984).

The main areas I shall be discussing are the ways in which anxiety moves around in the treatment setting, the qualitative differences between the anxiety related to unconscious sources and anxiety related to the present real fears of violence, and also the difficulties inherent in making these connections.

Due to the defences and resistances mobilised in an endeavour to cope with or deny these fears and anxieties, the transference and countertransference issues are also a central theme.

I should mention that the conflicts my patient demonstrated between her loyalty and allegiance to the political group, which was one of unquestioning obedience, versus her commitment to psychotherapy, which was of a questioning relationship, often made me feel that I was dealing not with an individual but with a large group. I was reminded of Freud's 'Primal Horde' in which there is an expectation of utter dedication to the group ethos, a situation where individual thinking is not allowed. In my countertransference I was experiencing the terror that my patient felt in opposing the group thought. At times the difficulty of her thinking as a separate person was also conveyed. I could understand my patient's need to pull me into 'their camp', to get me to lose my separateness and join her/them, and thus not to have my own ideas and mind in the same way as she felt she had not been allowed them herself.

Freud in 'Civilization and its Discontents', said that Groups formed not only to combat forces of nature, but also to combat psychological dangers, primarily to bind the destructiveness of man against man. He comments, 'we can love one another in a group provided there are outsiders whom we can hate'. Groups also bind and contain psychotic phantasies, anxieties and defences. (Bion, Jaques, Menzies, Yalom).

I found some interesting comparisons whilst reading 'Hitler's Children', Jillian Becker's clear, well documented study of the origins and development of the Baader-Meinhoff gang. Most of the key members of the group lost one or both parents through death, war or a religious cause. The evidence suggests a deprived group whose various losses played a strong part in their impetus towards becoming a radical, and, later, dangerous criminal group. Their deep unhappiness was projected into society as if it were society's fault. Blindness to their motives and to the group dynamic allowed the violence to escalate and get out of control, and at the same time represented an escape from threatening depression and despair. In her paper, 'Silence is the Real Crime', H. Segal quotes Fornari: 'War is a paranoid defence against depressive anxiety', in that the hated/bad aspects of oneself or of the group can be projected into the enemy/nation, and so can ease the internal conflict of love and hate.

A backdrop to the Baader-Meinhoff gang was the building of the wall separating East and West Berlin, a situation that shocked and confused the world. The wall also concretely created a barrier 'not to see, not to think'. The split was geographical but also psychological for individuals world-wide who did not wish to know or see the horrifying face of reality. In this climate, hysteria, hatred and terror

were rife, awaiting a climax. I mention this because in my work with this patient, 'the turning of a blind eye' to the horrors in her life played a powerful and significant part in our work together in the transference and countertransference.

Heinrich Racker explores the complicated issues around transference and countertransference in his excellent book on the subject. I quote; 'the first distortion of truth in the myth of the analytic situation is that analysis is an interaction between a sick person and a healthy one. The truth is that it is an interaction between two personalities, in both of which the ego is under pressure from the superego and the external world; each personality has its internal and external dependences; anxieties and pathological defences; each is also a child with his internal parents and each of these whole personalities, that of the analysand and the analyst, responds to every event in the analytic situation. Besides these similarities between the personalities there also exists differences, and one of these is "objectivity"'.

Family history

Mrs P is an attractive woman from South America. She is the second daughter in a family of two girls. Her father is described as a somewhat withdrawn man with a violent temper and an inability to talk about or to cope with strong feelings. His silence, combined with the fear he instilled within the family, mainly in a non-verbal way, appears to have contributed powerfully to my patient's life difficulties in coping with strong emotions.

Mrs P described her mother as beautiful, feminine looking but uneasy and 'guilty' about sexuality. There were fights and quarrels between the parents with Mother giving in to Father. P remains angry that her mother was never able to make a stand against Father for herself or the children. Mother was felt to be a vulnerable woman whom my patient tried to protect from Father's and her own anger.

Mrs P's memories of her childhood seemed to be full of separations and disappearances of one parent or another. There are accounts of returning from school to find the door locked, no-one at home and running to the care of two female teachers. She is unable to remember or account for these absences and initially seemed to 'take it in her stride'. The image I frequently had was of a 'little girl lost'.

L, her elder sister, is presented as a noisy, bullying seductive person, who over-shadowed P and tried to encourage her into sexual games

and experiences with herself and with boys. P was confused and frightened by her.

After entering university P became involved in civil rights movements and guerilla activities against the reigning political party. She was arrested and imprisoned. Her interrogators played the 'good guy, bad guy' roles. At one stage she was brutally treated and led to believe that she would be hanged, a fear she had to live with for some months. After a successful appeal P was released a year later and left the country. She married soon afterwards and has one son of 16. The marriage broke up after seven years.

P is a skilled professional worker and is valued in her field, holding a responsible management position. Her team admire and respect her. She came to me for help in trying to separate from a difficult and violent relationship.

Clinical presentation

During the first few assessment sessions P demonstrated considerable anxiety and apprehension under a surface of charm and denial. The initial months of the work were spent on her elaboration of the term of imprisonment and her relationship with her interrogators. She spoke in a flat affectless way. Contrary to this at other times I felt flooded by massive amounts of disconnected material. I felt exhausted trying to follow her until I realised that it was not the content of the words so much as the quality of the feeling in the room. The content was a smoke screen to keep me at a safe distance. When I was able to articulate this it enabled her to give us both some space. My memory of her at this time was of a brightly plumaged bird, that I occasionally caught glimpses of, as it flew, dartingly around.

The transferences relationship was her experience of me as one of the interrogators, fearing that I was trying to get information from her, to use against her. There was material to suggest that unconsciously I was the father whom she felt could not allow any real emotion to surface. The anxiety at this time was persecutory and paranoid, although there was some external reality to this.

Prior to one session P had seen a helicopter circling around and the session was full of her need to hide from the 'all seeing eyes of the helicopter/therapist' and fears that I was trying to get information out of her before she was prepared to divulge it. I was reminded of Primo Levi in his book, 'The Drowned and the Saved' who quoted Jean

Ameray 'anyone who has been tortured remains tortured. . . . faith in humanity already cracked at the first slap, is never acquired again'.

P let me know that her parents could never discuss her political involvements with her and had avoided this for 20 years. On the contrary she forced me to become aware of her political self first and only then could she begin to allow me to see the private person. There had been a major investment of herself into the political aspect of her personality, without which she felt inadequate, empty and worthless. Her main identification has been with the angry secretive father and the heroic fighting men of the 'cause'. This was a defence against her feelings of inadequacy as a woman. Her maternal instincts were not available except for a fierce protection of her child from being patronised as a child rather than being seen as a coping adult. This was linked to her need to hide her own child self which was felt to be damaged, weak and denigrated. I was able to interpret her more unconscious feeling about her vulnerable self, through the material she brought from her relationships to the damaged children with whom she worked. She was able to apply herself with great dedication to the management and care of these children in a way she was unable to do for herself. Beneath the skilled professional self, I could catch glimpses of her despair at repairing a very 'dead' part of herself.

At this time my patient became deeply disturbed by news of a rapist in London and was terrified that it was the man from whom she was trying to separate. The split in the transference at this stage was an idealisation of me with the fears and suspicions of rape and battering focused on to the boyfriend. From her experience of fighting parents and associations of the political/violent 'cause', the intimacy she so desired was of a violent, fighting kind. I was aware that part of her wished to draw me into discussions and fights about her political allegiance. A defence against the needy self was operating. The anger with me was also funnelled into denigrating me as being politically naive. Jokes of this kind were made against me. Whenever we came close to her vulnerable self, there would be a passionate move to the 'fighting group'. The difficulties I experienced at this time were very intense and her fears were contagious as there had been a recent spate of assassinations of her political colleagues. The horror of the actual happenings was so great that I felt pulled into the shock of death and mutilation. On the one hand she was requesting me to be her 'sister in arms', but was also fearful that I would lose my analytic stance. I found my position one where it was extremely hard to think and the numbness I felt in the countertransference gave me insight into how

terribly difficult and frightening it was for her. I felt almost intolerably burdened by an overwhelming sense of hopelessness and helplessness. I felt she desperately needed me to be the mother/therapist/container as opposed to the men/terrorists and there appeared to be very little space for sanity and attempts to repair damage. If P sensed me to be weak she would become the aggressor; if I were perceived as strong she became more passive and compliant. I felt she was requesting the right balance of good father and mother from me, to be strong and sensitive, otherwise she would be aggressively denigrating or fearful of my counter-attack. This was similar to the internal dialogue within herself. She was ruthlessly merciless to her own needs. Frequently it was difficult for her to leave the sessions and she would say, 'you are like the house arrest police, I can't leave you'. I did indeed feel as if I were damaging her by ending the session and had to contain my own guilt and pain in the countertransference as the persecutor.

I would describe the quality of my patient's anxiety as annihilatory. This was subjectively felt to be a fear of going crazy and disintegrating. She would have fantasies of collapsing on the floor of my room and would say, 'if I went mad, would you certify me, what would you do?'. Her fears of not being held by me were related to her lack of a secure holding (failure of the protective shield – Winnicott). P described her mother as someone whom the patient had to protect from her own feelings and experiences.

The manifest content of the annihilation anxiety was primarily related to the actual violence being perpetuated in the present. The quality and quantity of this was such that I had great difficulty in separating it from the preconscious or unconscious anxiety content and therefore it was difficult to explore and interpret. In the countertransference I was able to recognise that my own resistance to interpreting was related to fears that I would cause her to collapse. It was as if I were the cruel tyrant/father. As well as this there were my own feelings of guilt that I had not suffered in the same way. The displacement of violence onto the 'political group' and it's action in such an intense and current way made it extraordinarily difficult for me to get hold of the violence in the transference and countertransference. Just as she at one level used the political fighting as a defence against her own murderous rage and depression, within the treatment setting, the enemy could so easily be the assassins out there and disguise the fear of annihilation within. Harvey J. Schwartz in his book, 'Psychotherapy of the Combat Veteran' writes about the power of the primitive trans-

ference. 'It seems that the regression induced by actual trauma leads to an inability to symbolize. Without this ally of the therapeutic alliance, transference becomes real. This results in the common finding that traumatised patients rapidly and concretely perceive the transference object to be actually malevolent and threatening. The therapist's recognition and successful management of this state poses significant technical and emotional challenges'.

Another difficulty in technique was my uncertainty about whether to interpret conflict laden material or to stay with non-interpretative interventions of empathic understanding of the feelings. Quite often I may have wished to interpret in the hope that it would take away the problem of terror, whilst to stay with the anxiety in the countertransference sometimes seemed impossible, cruel and torturing. The sense of being flooded by anxiety content at this time was excruciating and attacked thinking and the space to reflect.

I found it difficult not to intervene when she spoke about her conflicts; whether to become active in the 'party' again; guilt that she was not doing enough. She also informed me that her son was thinking of training in the guerilla camps. I began to wonder about the moral problems and the conflict she demonstrated between her maternal role and her unconscious murderous link with death and destruction. I felt safer ground when I could examine her difficulties in being able to criticise me as a parental figure and her perception of me as lacking care and understanding of her fears. I too had difficulties and these were in trying to isolate the paralysed silent self from the tyrant. Connected to her anxieties were P's fears of damaging me if she demonstrated her intense demands for safe holding. At one time P would show her aggression to the outside world but soon after would suffer a reaction of fear of violence being done to her.

I found myself reacting to her fear of being 'blown up in a car bomb'. This induced in me fears of being attacked myself and I found myself locking the door after P left and then having fantasies of whether my car was being **set up**. I realised that I was experiencing her unconscious violence towards me, as well as experiencing what it must be like in her position with her great anxiety about her inadequacy to protect herself and her child.

My patient's defences against insight in relation to both internal and external reality, due to the fears that she would collapse or be overwhelmed by anxiety can be demonstrated in the following material. (H. Segal in her paper 'Silence is the Real Crime' mentions 'the turning of a blind eye' described by Freud as disavowal. In this split we retain

intellectual knowledge of the reality but divest it of emotional meaning.)

I will use examples of two dreams which disturbed P soon after an embattled colleague arrived in this country for surgery and physical treatment. Her first dream was of seeing the bloody, mutilated body of her friend and lying near to it was his mother who was encapsulated inside a red, mucousy sac, which sounded to me like a placenta. Her associations were about her resistance to seeing his mother as she could not bear to look at the pain in the mother's face. At this time P was presenting a caring, factual account of the tragedy and her own pain and horror was defended against in an idealisation of their fight for the freedom of oppressed people. I felt in the countertransference that I was required to be the placenta/therapist, to process and cushion her against her own pain, thereby allaying her anxiety that it would overwhelm and paralyse her ability to cope. I found myself struggling against a paralysis of thinking, especially of the formulation in my mind of her infantile equivalents. Her childhood had been an experience of domination by a bullying and excitable sister and a father whose aggressive silence paralysed her ability to resist, or to find her own freedom to think and act as an individual. Secondary to this were her own experiences as a prisoner. These feelings went underground and her memories are of herself as a gentle and good little girl who did not complain or react. P looked intently at me throughout most sessions and I was aware of her need to reassure herself that I could cope with this material, as indeed she had in the past when protecting her mother by hiding her own feelings.

The second dream was about her struggle to get to a blackened stump on a small island in the middle of a lake, the waters of which were ugly, black, dangerous and threatened to drag her away. From the associated material it became clear that the dangerous waters were the terror of the feelings that prevented her not only from caring for the cripple in herself, but also from really caring about her colleague. P told me that she was able to put on a 'good act' of visiting and concern, but that she felt guilty about her sense of repugnance and hatred of mutilation. In our work together both anxieties were apparent, her fear of being swamped and drowned in these feelings, but also fears that I could not tolerate the burden and would leave her, as her mother had done on various occasions in her childhood. From emerging material it was also clear that P felt she had driven mother away by not being good enough.

At this time her defences against pain, projection, splitting, denial

and 'turning a blind eye' were breaking down, so that my countertransference fears were of hopelessness to alter the situation.

The wish not to see as a defence, also manifested itself in other ways. At moments when P was threatened by seeing or feeling there would be a hopeless, helpless shift and she would appear to have gone dead; a sense of utter despair prevailed. When I was able to contact her in these experiences, she would sometimes break into deep heart-rending sobbing and rub her eyes and ears, as if she were a little girl again trying not to see or hear upsetting things. She would also have disturbances of vision and squint feebly about the room. At these times I was usually very moved, but also quiet, sensing she needed a mother to 'hold' her in compassionate silence. These experiences were part of the transition from not seeing, to beginning to see and feel and were sad and painful for us both.

Soon after this P came to a session looking vulnerable and apprehensive. Awkwardly and slowly she told me that she had often wanted to say something to me; that she wanted to crouch down in the corner of the room with her arms over her head and just be there, quietly hoping that I could understand her. These sessions were quiet, sad and heavy with non-verbal communication. They were powerful and valuable times, giving space for the vulnerable aspects of herself to grow and develop. I felt also that an earlier trauma of not being understood and not being able to demonstrate her needs was being enacted in this way. (Winnicott's 'Corrective Emotional Experience').

These depressed states preceded a move from the fears of violence to an erotic attachment, which though a defence against her fear of her murderous rage in the transference, also contained elements of a shift in her poor image of her feminine self.

Throughout the first year of treatment I became increasingly aware of P's love/hate relationship with her lover. He as well as P jealously guarded an exclusive relationship in which they terrorised and idealised one another. It was not a sharing relationship, but a controlling one. The formula was of the changing positions of 'strong' adult and vulnerable child. At times I quailed at the prospect of her feelings entering into the transference.

Gradually a change occurred and my patient developed a strong erotic attachment to me. My countertransference feelings were of fear that I would not be able to cope with P's fluctuating moods of elation and despair. Also I was concerned about her demand for an exclusive, idealised, fantasy relationship with me, which she considered to be the reality. P was hurt and then furious when I interpreted her need to

control me. Thereafter for a while she refused to share her fantasies about me, lest they be destroyed. In retrospect I believe it was important for me to contain my anxieties about this idealised position. The need to interpret was thus more to service my anxiety and perhaps technically was not appropriate. Despite the tyranny of P's demands to be loved in an almost battering way, I was ever aware of the desperate quality of her need for my attention and of her terror of losing me.

Sessions at this time were overflowing, with little space for me to gather my thoughts. In some instances I was active in stopping the torrent of anxious words. I also felt a need to gain control which may to some extent have been 'acting out'. I found formulating an interpretation difficult as it in some sense was quickly swirled away with the current. My experience of this difficulty was that I had to be pushy to function and be heard.

Intertwined with the forceful demand for love, was a quite different experience, that of a 'blissful togetherness'. I would catch myself in a dream-like state, mesmerised by P's 'love potion'. This was a pleasant numbing experience. Guiltily I would pull myself out of the 'trance' which was so powerful, I had fears of becoming lost within it. Searles writes of his erotic and loving experiences towards his analysands during the analyses of most of his patients in 'Oedipal Love in the Countertransference'. He described these experiences as akin to those feelings he experienced during the resolution of his Oedipus Complex late in his own analysis.

C. Bollas in his book 'The Shadow of the Object' writes about the 'sensational' way in which the hysteric possesses the therapist, through the senses. 'Hysterical patients believe that the only way they will ever be known by anyone is if they can compel the other to witness them, because of their unconscious conviction, based upon cumulative experience of the mother, that no one thinks about them. If we realise that the hysteric's externalization of psychic states occurs because of her adaptation to the mother's failure to internalise her child, then I think it becomes clearer to us why hysterical patients bring with them an urgent need to become an event in our presence, so that it is exceedingly difficult to forget them. We are witnessing the infant's desperate effort to implant an image of himself or herself inside the refusing mother.'

P's desperate need for reassurance that she was in my mind was demonstrated by her giving me or sending me cards which were revealing and memorable. For example, one card was of a Russian peasant mother giving her child to the 'Political Cause'. The scene

depicted encapsulated her unconscious maternal conflicts concerning her son's decision to join the guerilla movement. It also revealed her difficulties in discussing the matter with her son and also with me. Similarly the card highlighted P's fears that instead of my accepting her in a personal way, I was giving her up to the psychotherapeutic relationship. Another card demonstrated her ambivalence and derision. It was of an Egyptian goddess whose head-dress was of a snail whose two feelers were positioned in such a way that it appeared the goddess had four eyes. It was P's way of complaining that the therapy was too slow and that she wished I had four eyes to see with and thus could go faster, thereby reducing her pain. During phases when P felt overwhelmed with fear and anxiety she would often ring me in the middle of the night just to hear my voice on the ansaphone. She did this at weekends and I was aware that despite her heavy demands, she endeavoured not to impinge on my free time. I felt that this showed a combination of a developing ability to contain some of her anxiety, but also that it revealed a fear of her depleting my resources, thus rendering me unable to help her, in other words in the service of her narcissism.

I was able to understand more about P's intense jealousy, when during a session she told me how upset she had been while watching an episode of 'Neighbours', an Australian series on television. A young couple had been embracing, oblivious to the fact that the pram in which their baby was asleep, had begun to run downhill out of control. At the same time a car came around the corner. The suggestion was that the car would hit the pram. P burst into tears and said that she could not get rid of the memory. Her acute unhappiness and despair was connected to her terror that if she (the baby) could not have mother/therapist's exclusive attention, a terrible disaster would occur.

Eric Brenman ('Hysteria', 1985) discusses the use of the external object relationship which appears as a relationship to a whole object. It is essentially narcissistic and an ostensible whole object is used as a part object to prevent breakdown. His view is that the hysteric's use of the external object involves an attack on psychic reality. Brenman also suggests that hysteria is a defence against overwhelming anxiety.

Separation anxiety

P had great difficulty in coping with separation anxiety within the session, over weekends and at holiday breaks. She had various ways

of trying to ensure against the reality of the separation. Within the session words were sometimes used to connect us. During gaps and silences P would become very anxious and feel as if she didn't exist. She had difficulty in thinking. I realised that my usual technique of allowing spaces and silences was inappropriate for this patient, as her level of anxiety would increase dramatically and prevent the understanding of her predicament. It was important that I could put words to the anxiety and make it knowable. I also realised that P equated depressed and unhappy feelings with a fear of collapse and going mad. After a session when this had been apparent, I spent some time talking with her about depression, acknowledging how painful it was for her, but also conveying that I felt it was a necessary and important experience. This was a fruitful intervention and I was surprised by how much this contributed to her ability to begin to hold herself together during breaks. Another example of separation anxiety was during the time when P was separating from her lover. 'Remember', P said, 'I couldn't conjure up R's face last week, well now I can't conjure up anything, there is nothing, just blackness and a hole. It is terrible, all around me, I feel that if I stop talking it will envelop me. . . . Talk to me'. I replied that she wanted me to be connected to her in the sessions and also when she was absent, because of her terror of losing me. Linked to this was her fear of losing herself and falling into the black hole. P began to have difficulties remembering me at weekends. When I explored this it was apparent that each time she lost me, it followed an angry exchange with or thought of a friend or colleague. I was then able to interpret the displaced anger towards me being experienced in this way, a 'killing me off' in her mind. This understanding helped and she did not need to reassure herself that I was alive by ringing me. We were able to do some work on her terror that for her separations meant a successful killing off of the object.

Technique

Other areas for discussing technique came up in relation to my patient's repeated attempts to get me to drop my psychotherapeutic self and join her in a private relationship. I realised that interpretations along the lines of her need to have me with her, outside the treatment situation, because of her terror that otherwise I would either leave her or be killed off in her mind by her unconscious rage towards me, and the connection to her fears that she could not protect me as a good

internal object, were useless at this time. This was primarily because P attacked psychic reality. It was as if her belief in the possibility of our personal relationship obliterated all else. Finally in some desperation I made a clear statement of my position and spelt out her attack on the treatment and how the anger was being used in this way. This firmness in defining the boundaries seemed to get through to her and she was able to accept to some degree the difference between her fantasy and the reality of the therapeutic relationship. For the first time P was able to experience the sadness of the loss in a way that she could tolerate and which made sense. This situation remained volatile throughout the difficult working through period.

Summary and conclusion

I have endeavoured to convey the difficulties in working with intense emotion particularly in relation to problems around containment of anxiety within the transference and countertransference, and the technical issues it raises.

In relation to the handling of actual fears of violence in the present, I found a number of difficulties:

1. I felt I was being involved at a reality level. My ability to think was attacked which I feel was a combination of my powerful countertransference reactions to her fear, but also because I felt precipitated into a split between my therapist self and my own personal reactions to actual violence, which made me want to act.
2. As a consequence I felt defenceless as if I was without my usual therapeutic skills which increased my difficulties in staying with my sense of powerlessness. My response was to want to organise, to argue and to provide a solution. This was related to my understanding that my patient desperately wished me to 'take it all away' because of her sense of helplessness and terror.
3. I was also aware that my own social, political, moral judgements and criticisms came to the fore and I had to work hard on myself in order not to allow this aspect of myself to take over in the various crises.

I have demonstrated the use of more active interventions which were twofold. (a) In order to help myself think and function. (b) As a management/technical problem when working with patients in

regressed states or highly excitable states when interpretations may not be heard and thus were unable to be taken in or digested.

Other difficulties were in making the connections from the present real fears to the past unconscious in particular:

Timing: My countertransference feelings had to be worked through and understood before I could interpret the meaning of my experience in the light of my patient's dilemma, otherwise my interpretation would have been hollow of meaning and my patient would have picked it up as a weakness in myself.

At what level does one interpret? Some psychotherapists would say that to focus on adult trauma would be a resistance to the earlier experience. Others go further to the opposite and declare that any effort to look at an individual's childhood is done to avoid the present. What I found useful was the use of a bifocal therapeutic perspective as past/present, real/fantasy are always dynamically present. With my patient it was difficult to feel sure when childhood memories might be a resistance to terror filled events in the present and vice versa.

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THE FLIGHT FROM HEALTH*

JOSCELYN RICHARDS

Introduction

In his book *Impasse and Interpretation* (1987) Herbert Rosenfeld describes the problems 'the narcissistic omnipotent self' creates for the patient in psychotherapy who is attempting to understand his/her difficulties in sustaining attachments, especially as they are manifest in the relationship with the psychotherapist. In his view this self secretly influences and imprisons the libidinal or object-relating self and attempts to prevent the patient from forming and sustaining a working relationship with the therapist. Rosenfeld suggests that the structure and methods of the narcissistic-omnipotent self change from being seductive and persuasive to being denigrating and belittling as the patient's capacities for understanding and relating develop. This is because these capacities undermine the previous internal power relationship in which the narcissistic self has dominance over the other self. In Rosenfeld's view the narcissistic-omnipotent self wants either to have complete control over omnipotently created objects which are expected always to be present to gratify desires or, when this expectation is not met, to be completely self-sufficient.

He suggests that an early splitting of the ego takes place during the period of absolute dependency in infancy resulting in two agencies or selves. Rosenfeld describes one of these as the omnipotent-narcissistic self and the other as the libidinal self. He sees the latter as a self who wishes to and is capable of forming a realistic attachment to the need-fulfilling object. In some respects his model is similar to that of Bion's who describes the co-existence in all human beings of a psychotic personality and a non-psychotic personality and emphasises the importance of differentiating between them. Both Bion and Rosenfeld were aware of two different modes of mental functioning which co-exist and alternate within the one human being. They both observed that

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the personalities underpinning these modes could claim to be the senior partner and could intimidate the other. However, neither were completely consistent in their conceptualisation of separate personalities, e.g., sometimes Bion spoke of parts (Sinason, 1993) and sometimes Rosenfeld wrote of the omnipotent-narcissistic self as a phantasy of the ego. Sadly, I think Rosenfeld died before he could think through all the implications of his final model. It is not possible in this paper to explore the inconsistencies in Rosenfeld's and Bion's models and the areas of similarity and difference.

The point I want to make for the purposes of this paper is that, once the psychotherapist is aware of profoundly different and seemingly autonomous modes of mental functioning within the one human being, then it is necessary to develop a conceptual framework which best helps a patient understand and contain these differences.

Before discussing the conceptual issues further I would like to summarise some of the features of the psychotic state of mind or personality which have been observed ever since the frontiers of psychoanalysis have extended to working with patients with borderline, narcissistic and psychotic disorders.

Some of the main features are a hatred of reality, of thinking and of dependence. The thinking that does exist is absolutist and concrete and the main defences are splitting and projective identification. All human relationships are considered to be exploitative which rule out the possibility of creative intercourse (literally and metaphorically). There is extreme narcissistic sensitivity and retaliation is assumed to be the only method of dealing with slight or major injuries. There is an incapacity to learn from experience. The non-psychotic personality can, of course, learn from experience, can think symbolically and flexibly, enjoys the mutuality of relationships and values the capacity to make differentiations and to recognise and negotiate internal and external realities.

Conceptually the issue is whether these two different states of mind or personalities represent an early splitting of a single ego or whether they represent a predisposed structural duality from birth which may be aggravated by an adverse environment. Until recently the concept of splitting of the ego has been the preferred concept though at times Freud also used the concept of disavowal to account for the two different 'psychical attitudes to reality' (1927, 1940a). The problems with concepts which imply a rift or split in the ego have been fully described in a recent paper by Sinason (1993) and have technical implications for the aims of psychoanalytic psychotherapy and the

nature of the mutative interpretation, as these aspects are influenced by the model of the psyche employed. The concept of splitting implies that one or other personality is subsidiary to or is a split-off part of the other and is essentially under the control of the main ego. Consequently, the precise aim of the psychotherapy is then conceptualised as helping the patient to experience, own and integrate the split-off part. This involves helping patients understand why a part of their ego has been split off, the damaging consequences of the split and the methods and defences employed to sustain it.

In his paper Sinason introduces his concept of internal cohabitation or co-residency of two autonomous minds or personalities in one body to account for the very different modes of functioning. This concept has evolved at Willesden Centre in the Workshop on Psychotherapy with Manic-Depressive Patients and seems to provide a more adequate basis than that of splitting for understanding the clinical phenomena that emerge in the transference and countertransference. In another paper (1993) I have described in detail clinical experiences with a number of patients with a range of diagnoses which led me to seek a more satisfactory framework than that of ego-splitting and to use the concept of cohabitation for understanding the negative therapeutic reaction.

If the human being is considered to have two minds which are separate from birth the main analytic aim is differentiation and not integration. This involves the patient and therapist working together to recognise, understand and contain the misconceptions, misperceptions and mal-adaptive solutions of the patient's omnipotent-narcissistic or psychotic self or cohabitee as they emerge in the patient/therapist interaction and of differentiating them from the views and solutions of the object-relating or non-psychotic self. This joint enterprise inevitably involves a sense of mutuality and interdependence between the patient and the psychotherapist which in turn inevitably threatens the status quo of the narcissistic/psychotic self. Rosenfeld thought the narcissistic self experienced threat in two areas: the wish to feel in control of the omnipotently created object and the wish to be in control of the thoughts and intentions of the object-relating self.

Thus, from the point of view of the concept of cohabitation, there is a self who perceives the whole therapeutic endeavour as a threat to his/her existence and automatically reacts in ways that are intended to protect that self but which undermine the patient in carrying out the investigative tasks of psychoanalytic psychotherapy and from remembering the insights gained. As a result the patient is continually

undermined in his/her wish to sustain both the emotional and intellectual attachment to the therapist and to the analytic work. The consequent wish to leave the psychotherapy can be described as a flight *from* health. Such a concept is in contrast to the more usual concept of a flight *into* health which seems to have been first used by Fenichel in 1945 and later elaborated by Train in 1953 and Oremland in 1970. Fenichel's concept comes from a single ego model whereby a patient's intention to leave therapy prematurely, because he or she feels better, is conceptualised as the ego's defence against facing and thinking about the return of repressed material stirred up by the psychoanalytic work. The flight is seen as an avoidance of psychic truth which the patient perceives as unpleasant. If psychic truth is equated with health then of course the fleeing patient is not really fleeing into health but away from it. At the same time if the psychic truth is perceived of as unpleasant then it is understandable that a patient may wish to take flight from the psychotherapy. However, from the point of view of a one ego model it can be confusing to conceptualise that the person who seeks psychic truth also decides to avoid it. It may make more sense to conceptualise a patient having two personalities who cohabit within the same body and which have different reactions to psychic truth: one of the personalities may value it in order to change and develop and the other personality may feel threatened by it and prefer the status quo.

The patient

A patient of mine (Mrs L) who successfully terminated her psychotherapy after six years, experienced during the first four years a recurrent, urgent and dislocating impulse to end her therapy suddenly. It would occur in reaction to almost any change, positive or negative. If she felt she was making progress she would immediately assume that as she was better she had better stop therapy now, or if she felt she was worse she would immediately assume that as she was getting nowhere she had better stop coming. Sometimes she would be in the middle of exploring and conceptualising something complex and important to herself and then suddenly stop, look at me suspiciously and say she would like to leave therapy now!

The urge to stop particularly seemed to occur as soon as Mrs L felt settled and felt she could understand and contain some of the assumptions that lay behind the urge to leave therapy. As she herself said, 'as

soon as I feel all right I change over so dramatically' or 'as soon as I get things clear it all goes wrong again'. This reaction initially made her feel that as she always returned to 'square one' she had better accept that she was incapable of change and that therefore therapy was pointless and she had better stop; 'that's how I am - there is no point in talking about it', she would say.

Just about every method possible was used to communicate the necessity to end the sessions. Messages were left on the answering machine at the NHS Centre where I saw her and letters were written to say that she was not coming again. Announcements were made in sessions that she was going to stop or that she had had to get up in the middle of the night to write to inform me of the termination of her therapy. The way I was informed always conveyed to me that I was being pushed away forcibly because of some terrible thing I had done but at the same time there was usually a denial that I had done anything and hence that there was anything to explore. She would often say to me in a superior tone of voice, 'what is there to talk about'; or 'does it really help to explore that?'

Other ways of conveying that she might have to end her psychotherapy were provided by fantasies of turning up to the next session covered in bandages or of getting her husband to ring to say she was in hospital or had been badly injured in a car accident or had committed suicide. Sometimes the fantasy was that the husband would just ring up and inform me that she was dead without further explanation. In reality she hardly ever missed a session and never appeared in bandages! Of course, we came to recognise that the fantasies reflected a view that I was an injurious therapist.

These fantasies and the recurring impulses to stop therapy abruptly were also accompanied by a recurring difficulty in remembering sessions. Mrs L often reported that she had tried to remember a session but had been quite unable to do so. She would often say 'my mind's gone completely blank'. As with the urge to leave therapy, she would often 'feel dried up' after a session where she had been particularly able to explore the assumptions, motives and fears that lay behind the flight from health. Initially Mrs L was bewildered by this wiping out of her memory as she felt she normally had good recall e.g. in her work as a teacher she was relied on to remember many personal details about the children she taught.

In fact Mrs L felt bewildered, distressed, and undermined by all these reactions she could not control, especially the intense urge to

discontinue her psychotherapy, since at other times she was very clear about her wish to continue.

Background

Mrs L was in her early forties when she was first started therapy, was married, had one teenage son and taught young children. She grew up in the north of England, a middle child in a family of 9. She left home in her teens to come to London to train as a teacher. She remembers this as her own decision, made unilaterally, as she assumed her parents were not interested and would either not notice her departure or be pleased to see the back of her. Because she assumed total indifference on their part she was surprised when she moved to London to find that her mother had organised a relative to meet her and arrange suitable accommodation. This concern was noted and then dismissed. Thus she assumed her parents were not interested in hearing from her and so she was again surprised when her mother made efforts to find out how she was getting on.

The patient's essential experience of her mother was that she provided good material care but was too busy to provide emotional care and had no time for the patient's personal needs. There was a conviction that her mother's busy-ness really meant she (the patient) was essentially unlovable. She felt her father cared about her but he was often away. At times she described her husband as supportive and good natured but at other times saw him as someone who did not understand her and whom she wanted to leave.

Mrs L was referred by her GP for psychotherapy some months subsequent to her son taking an overdose after leaving home to go to college. She found herself worrying about him all the time and became very depressed and anxious. She had to take time off work and was on mild tranquillisers. At times she felt suicidal.

Clinical illustration

I would like to illustrate, by presenting a whole session, the way in which it seemed necessary to work with Mrs L in locating who wanted to leave therapy and why and who wanted to continue and why. Firstly I will describe some features of the early sessions.

Mrs L attended twice a week, on Mondays and Thursdays. The

setting was a psychotherapy clinic in the National Health Service. The room had two comfortable chairs and a low table. There was no couch.

Early sessions

Soon after she commenced psychotherapy Mrs L found it almost impossible to leave when the session had ended. She would say she could not go, tears would come to her eyes. She would look helpless, anguished and like a child. She would then make a supreme effort and heave herself out of the chair, turn and scrutinise my face, her eyes would harden and she would abruptly turn away and say good-bye in a cold, dismissive voice and walk out without a backward glance.

As soon as she looked anguished, I would experience an intense pain and feel a tremendous urge to continue the session. Every time she turned from me with her hard cold eyes and cold voice I would feel that I had been terribly cruel to send her away and was being terribly punished and rejected for doing so. I thought these counter-transference reactions reflected the patient's pain in feeling she was being brutally thrown out and the consequent wish to hurt back and cut all connections.

At the beginning of sessions I would invariably have someone in the room with me who could neither look at nor speak to me. Sometimes there would be some attempt to speak (shown by quick glances and opening her mouth). Later in the session she would say she had been surprised to find herself so immobilised as she had been thinking of things she wanted to say prior to the session. Thus I would have the alternating experience of being with someone who wanted to speak and someone who did not or could not.

As already stated Mrs L was puzzled, embarrassed and distressed by all the reactions she could not control, i.e. the difficulty of starting and leaving sessions, the pain at the end of sessions, the consequent hatred of me, the intensity of the conviction that she must never return and the vividness of the fantasies of me being informed of her being ill, injured, dying or dead. I too was initially puzzled and startled by the intensity of these reactions and the speed with which a change would take place from someone who could remember, think and speak, to someone who was often mute, could remember very little and was driven by assumptions and impulses.

Gradually we began to recognise that there was a Mrs L who was interested in understanding why she found the ends and beginnings of

sessions so painful and difficult and who seemed to see me as someone she could rely on to be interested in exploring the assumptions and perceptions underpinning the reactions which distressed her. We began to recognise that she was different from another self who seemed to see me as either an eternally available maternal object (who in the patient's words wanted 'twenty four hour care') or, when this fantasy broke down at the end of sessions, saw me as an enemy who ruthlessly rejected her, was utterly indifferent to her fate, and never remembered her between sessions. This self could see no point in exploring anything and seemed either more interested in demonstrating how cruel I had been or informing the patient that she was mad to have returned to a session for further ill treatment from an abusive therapist. This self thought leaving therapy was the only sane thing to do.

Terminology

We used different terms for these selves at different times and I tended to use the terms the patient chose. She tended to prefer the term 'non-all right self' for the one who thought I was brutal and who wanted to end therapy. Sometimes she referred to herself as the 'all right me'. These terms evolved through the patient considering how she never felt all right once a persuasion had taken place that I was 'powerful, remote and calling all the shots' and had dropped her out of my mind at the end of the session. Once these thoughts had taken hold she would feel 'terrible' i.e. would be unable to sleep, would drink too much, would feel isolated and convinced that everyone had turned against her. On exploring these views and interpretations of my motives and attitudes she would reconsider the evidence for them and decide that they were 'all wrong' and not consistent with how she saw me at other times. Hence, she found it helpful to think of someone in her mind who got it 'all wrong' and decided to refer to that self as 'the non-all right self'.

At a later stage we began to realise that there were some problems with this terminology because it implied value judgements. But at the time of the session presented below this term seemed adequate.

The session

I am going to present a Thursday session which occurred about four years after the commencement of the psychotherapy.

P (Looked at me, looked away; said nothing)
silence
P (Looked at me and looked away again; said nothing)
silence
T I think there is a you who can look at me as if you expect to find a me you can talk to but there is someone else who looks away because she sees someone she cannot or must not speak to.
P (a bit tearfully) I've been struggling not to ring you all week.
silence.
P I wanted to ring and then kept feeling I shouldn't but then it seemed so long until Thursday. In a way I didn't really want to speak to you, just the machine, it seemed I wanted to just hear your voice [my voice was on the office answering machine]. But then I would feel I shouldn't. I've had a terrible week thinking about whether to ring or not ring. It just seemed so long until Thursday, like it would never come. I would feel I must ring and then I would feel it wasn't right.
T It seems as if there has been and still is an intense tug of war going on inside, between a longing to make contact and a view that you shouldn't. The conflict seems to have started with a persuasion that you were cut off from me which then made Thursday and me feel a long way off. It seems as if you felt so sure you were cut off that you urgently felt you had to check to make sure you weren't, and to see if I still existed and was available for making contact with.
P It is an urgent feeling: something inside said don't go on Thursday - ring up and say you are not coming any more. All week I've been feeling I have to ring up and say that.
T I think you've been indicating that the urgent feeling of wanting to ring and just hear my voice was in reaction to an even more urgent feeling to ring up and say you weren't coming any more. I think that 'something inside', as you put it, that has been urging you to ring to say you're not coming is your non-all right self who interprets the gap between Monday and Thursday as a sign of my having rejected you.
P Yes (seemed thoughtful as if she understood and then looked away as if withdrawing).
T (after a silence) it seems that as soon as you thought we could link up and work out what has been happening inside you, there is a pressure to pull away.
P (Crying) I fear that as soon as the session is over it'll all be gone again. As soon as I go I'll feel terrible again. I'll never be able to hold on (crying).
T I think the you that wants to hold on is frightened that the non-all

right one will keep on taking over and insist that the only way to deal with the gap between sessions is to cut off from me permanently.
P Yes, my non-all right self keeps saying 'to finish with you is the right thing to do, the only thing to do' (calmer) it's so odd because at the same time I had the thought 'Thursday is far away'. So in one part of my mind I've had the thought 'Thursday is far away', and in the other I'm thinking 'ring up and say you're not coming'. It's as if I'm split down the middle.
T I think you are noting how there are two different views about how to deal with a break between sessions. I think there is a you who feels interested in recognising how you want to remain in communication with me and so, however difficult the waiting is, you want to wait and come to the session so we can work out together what was happening inside you during the week, but the non-all right self says it's best to cut off from your therapist and that will solve the pain of waiting.
P I think what's happening is that at the moment I'm terribly aware of the two sides, and that whatever one side thinks the other side is in opposition. In the past the opposition was always buried, it was one or the other side which was always in charge and I didn't know anything about it. I didn't know about one or other winning. Now it's a battle and I'm always aware of it, I don't want any of these two sides. Why can't I have a side which totally ignores everything (tearful and angry).
T There's a view that ignoring the two sides and the conflict between them would help.
P I can't really ignore it can I? Really I want to be aware of the conflict. In fact I have to be because I need to know when my non-all right self takes over, I have to be aware which part of me is influencing a decision. I get to feel so unall right, so awful that I have to think what's happening; in a way I've come to see that as soon as I've begun to think I should or shouldn't do something, that's a sign that my non-allright self has taken over (pause), I'm finding that I'm trying to work out whether I should or should not ring you when I get to feel terrible. I'm not sure which side is in charge when I think either I must or mustn't ring, there's this terrible thought to cut you out – but that's the non-all right self that wants to do that – to cut you out is not what I want; I want to be aware of what the cutting out thought is all about and recognise it as coming from my non-all right self. I think I have to acknowledge that there are two sides of me and that they think in two completely different ways except when

one takes over and then there is only one way because I don't know about the other side then.

T I think you are working out that when you are aware of the two sides and their different points of view you have a chance of working out which point of view belongs to you and which to the non-all right self and which seems the most accurate and I think you may be still be trying to work out who it is that urgently wants to ring me between sessions either just to hear my voice or to tell me she is going to end therapy and who it is that finds sessions a long way off but wants to maintain contact even if this involves a wait.

P I think I'm understanding it now, I've realised that it was my non-all right self that wanted to ring up and say I wasn't coming but somewhere I recognised that and didn't do it because I recognised that I don't want to end therapy, not suddenly like that and yet, I wanted to ring up to hear your voice and felt I shouldn't. It seemed wrong.

T Perhaps your non-all right self longs to ring because she just wants to hear my voice because she thinks that's all she needs from me but is then convinced, because she thinks in absolute terms, that I would judge you for doing that rather than be interested in understanding why waiting for Thursday had become almost impossible or why there was a longing to just hear my voice.

P Mmmm. I'm thinking why I feel I shouldn't ring; it's the non-all right self saying I shouldn't bother you when you are not on duty. See it says 'on duty', it says 'you are impatient and fed up and not showing it because you are doing your duty'. Now I see you're not like that. It's awful to keep thinking you are.

I'm always in a state of conflict at the moment; on the outside I seem all right to others but inside there is a such a conflict. All week I felt terrible and I kept having a feeling of wishing everyone knew what was happening inside.

T I think the wish is especially for me to be in touch with that conflict and the arguments that go on inside. I think that when the non-all right self builds up the pressure to persuade you that as I have rejected you, you had better cut off from me. Then you feel convinced that it is certainly me that has done the cutting off and so then you feel there is no me who can be in touch with the struggle between the two sides.

P I know from my all right self that you are in touch with my conflict. I know that you are very much in touch and that you understand what the battle is about but my non-all right self, she just sees you as she always has, she is so stubborn in her opinions, she's in a time

warp, she still thinks she's a baby and mother is too busy for her, that's all she sees, will that side ever see you as caring, I can't get that part to change her mind.

T You seem to be drawing attention to your observation that, no matter what you think of me, there is someone else who takes no notice of your evaluations. Rather, she seems keen to re-assert her views whenever she gets the chance. She always sees me as the mother who is too busy for her.

P I used to feel that I had to get rid of her and change her or change her mind but I sort of see that what I need to do is to keep recognising her and what she thinks; it may not be what I think. I notice her there all the time now. She wanted me to ring you up in the week and say I wasn't coming to any more sessions. I'm quite clear about that now. It was her and not me that wanted to do that.

T I wonder if you are noticing her now and that at this moment she is quite sure that you should not be trusting me to remember you between sessions though you think you can. I wonder if she's busy trying to tell me that she is still quite sure she knows what sort of person I am.

P Non-caring; she's saying now 'if someone seems caring do not trust them because they are not really caring and they will only let you down and you will get hurt'.

T I think she is very sure I'm a hypocrite.

P (laughed) yes, she does. I'm laughing because I feel different now but I do get convinced that you do terrible things to me. I know now that you don't but all this week I really thought it was best to ring you and say I wasn't coming any more; it felt the right thing to do. I'm remembering now that I felt all right when I left the Monday session and felt good about the session but very soon after I felt silly for talking to you so openly and I felt quite sure you were laughing at me. But I didn't think that at the time, it was only after. I think in a way it is because I left last session feeling all right because I could see that you are interested in me but my non-all right self thinks that's too rational; she thinks the ending means you are getting rid of me and then she says you must have been laughing at me. I don't know why I so much wanted to ring you though. I so much wanted to ring.

It's all the hurting I'm thinking about. I know that it's not you that hurts me but if I'm really honest there is a part of my brain having the thought, 'how can I know whether you speak the truth', and yet I'm sure you do, I don't think you are the sort of person who would laugh. This is what I mean when I say I am so aware of the two sides

all the time. I recognise the non-all right side and what that part of my brain thinks but every now and then I get completely taken over, so much so that I'm thinking the way it thinks and I can't weigh up any more.

I think you understand these two sides of me. I keep expecting you to not understand and to get fed up but you don't and then I feel a sort of hurt inside that I have thought of you in the way the non-all right me says you are; that I have thought such awful things about you and really wanted to cut you out (became tearful).

T I think you want me to know how sad you feel at recognising the extent of the damage done to me in your mind when you are governed by the views of your non-all right self.

P (Nodded) and to me; it damages me too.

T It's time to finish.

P (Sighed) this is the test; I always hate this moment. I know why because she says – she says you are pleased to get rid of me because you think of me as a nuisance. I've been feeling close to you, and that's when I feel silly.

I think I can go and not feel terrible. I can see more clearly what's been happening.

(Patient left without the usual cold turning away)

Discussion

One way of thinking about this session is that the patient is preoccupied with the psychotherapist almost to the exclusion of everything else. From the perspective of the more usual one ego model the above session could be described as an illustration of 'acting-in' (Sandler, 1973) meaning that the patient is treating life as equivalent to the relationship to the therapist. There is only the relationship and nothing else. From this point of view the session could be seen as the patient's defence against examining both the relationship with the therapist and the relevance to past and present relationships. As the therapist, in this session, only makes minimal links with other aspects of the patient's life it could be thought that the therapist is colluding in this defensive strategy.

However, what I have tried to illustrate is the value to the patient in working with the therapist in making clear the views and reactions of the omnipotent-narcissistic self or cohabitee and differentiating herself from these. The cohabitee is completely absorbed in living out

the relationship with the therapist but Mrs L is capable of observing and thinking about this obsession. The ending of the previous session was perceived as evidence to the cohabitee that the therapist had not been genuinely engaged but had in fact been laughing at her. Whilst waiting for the next session the conviction grew in the omnipotent-narcissistic self that the therapist must be informed how brutal she had been and that ringing to announce the end of therapy would be the best method of doing this. At the same time it was thought that cutting out the therapist would end the pain of waiting. There was also a hint of wanting to ring to re-establish a symbiotic merging with the therapist. These convictions led to an urgent pressure to ring the therapist between sessions which led to a further conviction that if she did, I would respond disparagingly.

In the session we were able to explore not only what had gone on inside the patient during the gap between sessions, but how the views of the omnipotent-narcissistic self were present in the session and how they were so powerful that the patient could nearly lose her own knowledge of the therapist and become convinced that she was with someone who was mocking and/or hypocritical. This exploration enabled the patient to clarify the views and solutions of that self and recognise that she did not agree with them, especially the urge to end therapy. She could establish that to leave therapy was a flight from health, i.e., a flight from an opportunity of developing further her understanding of the misconceptions and mis-perceptions of the narcissistic self.

Central to this exploration was a recognition that the therapist knew about both selves and had not turned into a judgemental therapist who had forgotten that Mrs L has an internal cohabitee and the difficulties this cohabitation causes. When she realised that the therapist had not forgotten, Mrs L began to think less in terms of an internal battle and more in terms of wanting to understand the narcissistic self, e.g. that she is caught in a time-warp and sees herself as a baby with a mother who is too busy to remember her. Differentiating herself from the assumptions and solutions of this self resulted in the patient being sad at the hurt and pain that happens to herself and her objects when she cannot make this differentiation but also enabled her to leave the session without feeling convinced she was being thrown out by a ruthless mother/therapist.

In this session Mrs L was more able to sustain her thinking than usual, perhaps because she was beginning to reap the rewards of

persevering with the attempt to recognise and understand her cohabitee. Unlike other sessions Mrs L did not get taken over when she realised that she had been mistakenly agreeing with her cohabitee about my cruelty and hypocrisy. In previous sessions, once she had realised that she had misjudged me she would immediately feel ridiculed and condemned for 'getting it wrong again' and would once again feel hopeless and that she should leave therapy. This time she took an interest in recognising the cohabitee's readiness to transform understanding an internal process into an abusive process of condemnation and ridicule of errors.

In this session too, Mrs L built on the understanding she had achieved in a previous session that her cohabitee did not want me as a psychotherapist because 'she thinks she has found the mother she always wanted and wants to be with you twenty four hours a day and is hurt and angry when the session ends'. The assumption that the therapist was a maternal substitute who was offering to mother the patient because she was a deprived baby is a profound misunderstanding of the purpose of the psychoanalytic psychotherapy relationship and is an example of what Hanna Segal describes as a concrete symbolic equation. To the cohabitee there was no 'as if'. She was a baby; I was a mother and as such I was providing brutal treatment because a baby cannot survive on only two fifty minute sessions a week with mother. A baby needs twenty four care! To end a session could only mean I was 'bored', saw her as a 'nuisance' and was 'glad to be rid of her'.

Although there were often take-overs by the narcissistic self following the above session, Mrs L demonstrated a growing capacity to differentiate herself from her internal cohabitee. Thus the quality of the sessions began to change so that more and more Mrs L could arrive at a session and speak to me and could then leave without feeling thrown out in the cold. During the sessions she became more able to free associate and to explore other aspects of her life. She especially began to think about the links between our relationship and that with her mother, husband, and son and to recognise those attitudes from her cohabitee which had distorted her perception of them and had impaired her capacity for mutual enjoyment. Eventually she began to feel she had sufficient understanding of her cohabitee and felt sufficiently satisfied with the rest of her life to begin to think of leaving.

It was important to Mrs L to leave in a way that was different from

that of the narcissistic self. She realised that she had left home as a young woman under the influence of that self and had assumed she and her mother were dead to each other. Finally a date was set six months in advance. Inevitably the narcissistic self objected and either tried to leave before the six months were up or wanted to stay for ever. Mrs L sometimes lost her understanding of this self during the ending phase and we had to work through again and again how this happened and why a planned separation made her vulnerable to the cohabitee's views. The claustro-agoraphobic dilemma of the internal cohabitee became clearer than ever during this phase.

Mrs L was anxious that she might be taken over by her other self and end her therapy in a state of hurt anger but because she remained alert to this possibility she was able to leave in her way, i.e. with a mixture of sadness and gratitude, hopeful that she would retain her memories of the work done and insights gained. At her last session she said she was sad at leaving as she knew she would miss me but she felt this would be a good experience as it was a 'part of having a meaningful relationship'. She saw the ending as marking the beginning of a new phase in her life. She contrasted these thoughts with the attitude of the other self who saw the ending as 'total rejection – death' and intended never to remember me or the therapy work.

I think Mrs L was enabled to reach the position of being able to plan an appropriate ending by differentiating herself from the omnipotent-narcissistic self who was characterised by alternating wishes for permanent merging with the therapist or permanent self-sufficiency. The total preoccupation with the therapist which this self had is symptomatic of the claustro-agoraphobic dilemma of the borderline patient and can lead to a patient prematurely leaving therapy or getting stuck in an unalysed or unanalysable transference if the therapist and patient cannot recognise the existence of two separate personalities with their different modes of functioning. Getting to recognise and understand the narcissistic self's automatic assumptions or misconceptions about the nature and purpose of therapy, my cruel motives, her infantile status and the retreat into self-sufficiency and retaliation, enabled Mrs L not to be taken over so readily by these reactions and assumptions. When she did get taken over she was more able to recognise that this had happened and work out whether she agreed with the views or not. Thus, she became less ready to agree with the internal pressure that she should end her therapy at every turn. The flight from health could be understood and contained and eventually an appropriately timed ending could be planned and worked through.

Conclusions

This paper explores, through a clinical illustration, a model of the psyche which conceptualises the cohabitation of two autonomous personalities or selves. It provides a framework for understanding a patient's recurring and urgent impulse to end her psychotherapy. For the narcissistic-omnipotent self who hated the ends of sessions and the gaps between sessions, the impulse to leave therapy was felt to be a necessary flight from a brutal and rejecting therapist, who should have been offering twenty four hour maternal care. The paper aims to show that when Mrs L was able to differentiate herself from the convictions and perceptions of the narcissistic self she could re-evaluate the urgent decision to leave and then decide that she did not want to end her therapy, as to do so would deprive her of further opportunities to understand and contain the reactions that could make her feel isolated, depressed and cut-off from good objects. From this perspective the urge to leave therapy was a flight from health rather than a flight into health.

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BOOK REVIEWS

The Undiscover'd Country. New Essays on Psychoanalysis and Shakespeare.

Edited by B. J. Sokol. Free Associations Books, 1993 pp. 260 P/b £15.95.

The creative intercourse between psychoanalysis and Shakespearian literary criticism is now a firmly established link. It began with Freud, Jones and Ella Sharpe and has continued ever since, with psychoanalytic writers returning again and again to Shakespeare to enrich our understanding of the plays and to be enriched by Shakespeare's profound and remarkable grasp of the fundamentals of the human mind. The interest of Shakespearian critics in psychoanalysis is of more recent origin, dating back perhaps only twenty years, since when a lively industry of psychoanalytic Shakespearian studies has arisen. This volume of essays is a contribution to the dialogue between psychotherapists and Shakespearian critics; two of the seven papers are by clinicians, one is by a theatre director, and the remaining four by critics.

The editor, in his Introduction, states that the essays in this collection 'employ Freudian, Jungian, Kleinian and Winnicottian perspectives' to the '"undiscover'd country" of human motivation' (the title refers to this usage, not to Hamlet's reference to death). Sokol outlines an argument whereby the characters of a play can be viewed as equivalent to internal objects enacting an unconscious phantasy, so that the play and it's action can be understood as a depiction of the internal world of the central characters. Some of the essays do attempt to apply some aspects of Kleinian thinking about internal object relations to Shakespeare, though the results are quite varied in quality.

For example, Sokol's own paper on 'The Tempest', which he describes as 'a Kleinian reading', details how Prospero battles with internal rebellions and conflicts in his emotional movement from omniscience and omnipotence to 'base humanity', which involves the owning and integration of Ariel and Caliban as split-off parts of himself (representing manic and anal-erotic elements respectively), as well as the capacity to accept his incestuous wishes towards Miranda in order to relinquish his control over her. The play is thus seen as dramatising a genuine process of synthesis, as its central character struggles to integrate hate and bitterness with forgiveness, love and

tolerance. This is one of the better essays, being well-argued and taking an appropriately complex view of the text; what it has to say about the play is not especially new nor is it especially Kleinian, but it is clear, interesting, and alive to the contradictions of the play. In contrast, 'Hamlet and the inner world of objects' by M. D. Faber, one of the pioneers in this field of criticism, is a disappointingly muddled account of Hamlet's disordered internal world. He argues that, 'the deepest urge of the Western tragic hero is to resolve the mystery of maternal ambivalence', and that Hamlet, like all such tragic heroes, resolves this mystery by splitting the maternal image into good and bad. Hamlet is seen as constantly pulled internally between his attachment to idealized internal objects (his father), which evoke admiration and submission, and bad internal objects (Claudius, Polonius) which evoke disgust, contempt and hatred. The women of the play, Gertrude and Ophelia, both representations of 'maternal ambivalence', move rapidly from good to bad. Faber has some sharp observations on Hamlet's use of sarcasm and verbal cruelty, and on his death-wish as a return to a blissful union with mother, but I was confused by the central thesis of the paper and by whose ambivalence was being referred to, the mother's or the son's? I was also surprised that, in what is a long and detailed paper, there was no place in the author's thesis for Hamlet's manifest conflicts in regard to separation.

The conflict evoked by ambivalent feeling towards the maternal object is also explored in Angela Sheppard's paper on the representation of Cressida in 'Troilus and Cressida'. The writer, a Canadian psychoanalyst, argues that audiences of the play are too inclined to accept Troilus' view of Cressida as a soiled and treacherous woman as fact rather than distortion, and that this 'angry devaluation' is in part an inability to face the necessary disillusionment and mourning that comes with a mature awareness of mother as part of a sexual couple and not the infant's first love. This is discussed with reference to the formation of the female ego-ideal and the part it plays in the developmental task of the girl to both identify with and separate from mother. This essay is a good example of the use of a text to inform our understanding of psychoanalytic theory, rather than an application of a theory to a play, like a template, to show how neatly the play fits the theory.

The other psychotherapist in this collection, Lynn Stephens, looks at three characters from 'The Merchant of Venice', Antonio, Portia and Shylock, in an attempt to account for the 'savagery and ruthlessness' of this bitter play, and to address why its apparent resolution of

mercy in place of revenge fails to convince. She sees a perverse and narcissistic bond between Antonio and Shylock into which both are equally locked, and for a similar relationship between Portia and Shylock of hatred and vengeance, rooted in a paranoid and destructive father-daughter transference. This paper makes for quite difficult reading as it does not follow a particular line of argument or pursue a coherent thesis but moves rapidly around the play and around psychoanalytic ideas, mainly Kleinian and Jungian, nonetheless it contains some useful insights and new ways of thinking about a difficult and troublesome play.

Ruth Nevo investigates 'Pericles' strange, obsessive, dream-like quality and understands it as symptomatic of its hero being haunted by the terror of enacting his incestuous impulses towards his mother, re-evoked in his relationship with his daughter and symbolised by his complex preoccupation with the sea. I found this paper difficult to assess as I am not sufficiently familiar with the play, which also applies to Phillip Brock's piece on the poem 'The Phoenix and the Turtle'. I imagine I am in good company in being unfamiliar with this poem by Shakespeare, but then that begs the question of why it was included if it pertains to a rather obscure text?

Jonathan Miller's piece on 'King Lear in rehearsal' is taken from a talk he gave to The Squiggle Foundation in 1989 when he was directing the play at The Old Vic. Although nothing that Miller has to say about Shakespeare could be uninteresting, there is little in this talk to engage a psychoanalytically informed reader. He is in fact more concerned with the play's relation to Christian myths than to unconscious processes, and his ideas about the relation of Lear to the Fool and to his daughters has been described in his other writings at greater length (eg 'Subsequent Performances') and the interested reader would be advised to seek them out there.

So, to conclude: is this book a worthwhile investment for the psychotherapist with an interest in Shakespeare? Inevitably such a collection of essays will be something of a mixed bag, but on the whole, at least for this reader, the essays disappoint more than they enlighten. I would direct the interested reader to two other recent volumes, (Schwartz & Kahn, 1980; Simon, 1988) which contain more substantial and satisfying contributions to psychoanalytic Shakespearian criticism. Despite these misgivings, it is hoped that the present volume will serve to continue the lively and necessary dialogue between these two disciplines, as they have so much to learn from each other.

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NOEL HESS

The Doctor, The Patient and The Group

By Enid Balint, Michael Courtenay, Andrew Elder, Sally Hull and Paul Julian. Routledge 1993 pp. 162 Pb £11.99.

The sub-title, 'Balint Revisited', provides an admirable summary to this almost compulsively readable book. For it is indeed an invitation to current workers and readers to re-examine the pioneering work of Dr Michael Balint, himself the son of a GP from the Tavistock Clinic in the early 1950s. He set out to look in depth at the relationship between general practitioners and their patients with a view not only to increasing the awareness of doctors, but actively to contribute to their pleasure, satisfaction and competence in their work.

These days we seem to take group work for granted but in the 1950s this was a revolutionary process. The formula was deceptively simple: the same group of doctors, meeting in the same place, for the same length of time each week, with the same leader, a psychoanalyst, and keeping changes and interruptions to a minimum.

This current book arose from the ideas generated by a group of doctors set up as a research project from 1984–87, to look at developments in this field since the 1950s. They asked probing questions: 'What is still useful?' 'What should be discarded?' 'What can be offered that is new?' Their first task was to find a way of studying the work of general practitioners *then*. In the 1990s, general practice is changing fast. There are new contracts of employment. Members from other professions are being brought into the team: counsellors, for example, and clinical psychologists. What contribution might a psychoanalyst now have to bring?

The essence of Balint groups has always been the sharing of experiences and enabling doctors to reflect upon their relationship with patients. The focus is always on the intimate, crucial dynamics between two people.

Enid Balint and her co-authors look evaluatively at Balint work in the 1980s and 1990s. This could be interesting but dry. That it, emphati-

cally, is not, derives from the rich illustration of their ideas from clinical examples. They confine themselves to an in-depth exploration of a small number of cases. Both the doctors and the patients come remarkably to life and speak vividly.

As I started to read this book, I felt that interesting though it promised to be, it would be confined to a limited audience of concerned GPs and possibly medically trained psychoanalysts interested in Balint groups. Rapidly I found myself revising this preconception. Many relevant questions arose. I found myself examining the overlap between doctor and therapist, 'counselling' and 'good medicine'. Also I was more tempted than usual to study the bibliography and seek out references. Indeed, there are some gems there. I do urge you to explore them. For me, an especially fascinating one was Balint and Norell's, 'Six Minutes for the Patient'. 'Six minutes?' I found myself wondering, 'Six minutes!' And I sometimes feel that three sessions of three 50 minutes each week is woefully inadequate! But I am not a GP; nor is a GP a psychoanalytic psychotherapist.

This book should really not be confined to GPs. What members of a Balint group may gain from an intuitive, imaginative, unthreatening yet rigorous group leader, as Enid Balint undoubtedly is, throws into relief what we might experience from putting ourselves in the place of those GPs in a Balint group who feel safe enough to explore in depth, with their peers, exactly what went on in the consultation.

For the reader, an added bonus of this book is the emergence of the personalities of the GPs in the group. They present their cases, look at the interactions between themselves and their patients, (often very moving and highly charged ones) and face painful, hitherto unacknowledged, feelings from their own early experiences. They are, by turns, supportive, critical, putting down, out to score points, 'anti-analysis' and delighting in 'surprises'. At times, they dig holes for each other to fall in – and delight in helping them out. In short, they are a very human, indeed lovable, group of people, who very much come to life in these pages.

My final thought is that this book is a wonderfully clear exposition of one of the most successful endeavours, both by Michael Balint in the 1950s and Enid Balint and her team in the 1990s in the field, as yet largely untapped, of applied psychoanalysis. Undoubtedly, it will prove to be a very valuable tool of the trade for anyone involved in group work.

At times, I found some of the ideas and language in a book written by doctors for doctors slightly daunting. Should I have reference to a

medical dictionary? Or be content to allow the doctors their own specialist body of knowledge? However, on finishing it, I felt content to be part of my own discipline, and respectful of theirs, proud to have GPs as colleagues, and entertaining, I admit, a sneaking hope that my own GP has access to a Balint group.

PAMELA MANN

Female Perversions

By Louise J. Kaplan. Penguin 1993 pp. 580 Pb £7.99.

Can we all agree as to what constitutes aberrant sexual behaviour? Does homosexuality indicate deviant development, and what about oral and anal sex? There would certainly seem to be a wealth of difference between needing to employ a fetishistic object for sexual excitement and the compulsive urge to use a child, animal or corpse for sexual arousal.

Since our sexual lives are governed almost entirely by fantasy, do fleeting bizarre images mean that we are sexually disturbed? Not so. What distinguishes the perverse psychological strategy is not wayward thoughts, odd behaviour or 'kinky sex' but driven, repetitive, stereotyped fantasies or actions based on unacceptable unconscious wishes. There is no *choice* about perverse activity and there is hatred and vengeance hidden behind erotica.

Dr Kaplan is a psychoanalyst with a compelling awareness of the social and economic structures of Western Society: 'Perversion is a social transgression that regulates aggression and thereby protects the structure of the social order – most of the time' (126). She argues that by the end of the nineteenth century sexologists started to investigate the incidence of unusual sexual activity and found that this type of behaviour was displayed by men. It would seem that this has changed little over the past century. However, Kaplan reveals that this information is definitely misleading. It does not show moral superiority or highmindedness in women. It merely indicates that women, whose anatomical sexuality is more hidden than men's, also employ more indirect ways of expressing their perversions.

In brief, Kaplan states that society's expectations shape what is a perversion, in that a society's gender regulations define what is seen as deviant behaviour. Thus, perversion is a device for deceiving, based

on society's norms, against what are unacceptable gender identifications: for a man, his unconscious striving to express the despised feminine aspects of himself; and for a woman, as a screen for her forbidden and frightening masculine wishes. The perverse act is an attempt to contain 'the desperate hatred and vengeance and utter madness beneath it' (33). In this way the unconscious mind meets the social order and prescribed norms.

Kaplan's premise makes sociological sense of Estela Welldon's interesting conclusions that men act out their forbidden sexual wishes on others or on objects, while women tend to act them out on their own bodies (anorexia, bullimia, self-harming), the products of their bodies (their children), or as Kaplan adds, those close to them (husbands, lovers, neighbours), or on commodites (shopping, kleptomania).

Although Kaplan emphasises society's role in defining what is behaviourally unacceptable, she follows this through to its psychoanalytic origins in an individual's earliest history. She is clear that all perverse behaviour is an attempt to allay infantile anxiety and implies unconscious rage at feelings of loss and abandonment from early emotional life. It involves an attempt to steal what was not freely given.

Kaplan gives a wealth of examples from research, clinical material and literature (particularly Madame Bovary's perversity), highlighting the hidden pressures towards sexual normality and gender conformity. But I found her book somewhat over-indulgent and too long. Her important message would have been better received in a book half this length.

JUDY COOPER

Being Homosexual: Gay Men and their Development

By Richard A. Isay, New York: Avon Books. London: Penguin pp. 159 Pb £5.99.

This book challenges existing psychoanalytic theory and sets out a path of normal development for gay men. The writer's conclusions are based on his clinical work, which is classical analysis, or analytically-oriented therapy, with forty gay men, and the researchers of others in the field.

The author states, 'The expression of their sexuality is both normal and growth-enhancing for gay men'. Homosexuality is seen as consti-

tutional in origin. His views are a return to Freud, who never lost sight of the importance of biological factors. Also like Freud, he disagrees with organised psychoanalysis' general exclusion of homosexual candidates from analytic training. 'We do not on principle want to exclude such persons. We believe that a decision in such cases should be reserved for an examination of the individual's other qualities.' (Letter from Freud to Ernest Jones). And in 1903, Freud said 'I am of the firm conviction that homosexuals must not be treated as sick people.'

Sixty years later, two American analysts are quoted as saying 'I do not approve the attempt by organised homosexuals to promote the idea that they are just another minority, since their minority status is based on illness' (Bieber) and 'The homosexual is ill and anything that tends to hide this fact reduces his chance of seeking and obtaining treatment. If they were to achieve social acceptance it would increase this difficulty' (Socarides).

In trying to explain the difference between Freud's view of homosexuality and Bieber's and Socarides's view, the author suggests that social values became confused with health values, the social bias of a society in which psychoanalysts worked interfering with their ability to conceptualise a developmental path for gay men, and thus 'impeded our capacity to provide a psychology that is neutral and unbiased by cultural expectation'.

Many European analysts fleeing Nazi persecution settled in America. Some felt particularly threatened during the McCarthy era in pursuing their radical intellectual interests. During this time there were purges of homosexuals from government and a consolidation within psychoanalysis of the theory of the pathological adaptation of homosexuals, and the exclusion of homosexuals from analytic institutes became customary.

Homosexuality is defined by the author from the contents of a person's erotic fantasies rather than from behaviour. Some studies by psychologists are cited to support the author's view that, 'There is no greater psychopathology in gay men than in heterosexuals.' In support of this view the Kinsey report (1948), the Wolfenden Committee (1954) and the recommendations to the American Psychiatric Association, which led to the removal of homosexuality from its Official Diagnostic & Statistic Manual of Mental Disorders (supported by Marinor and Stoller) are quoted. However, psychoanalysis remains committed to the pathological model. Why? Freud implicated some environmental factors in the development of homosexuality (as he did in the develop-

ment of heterosexuality). After his death, psychoanalysts became intent on removing Freud's ambiguous ideas about homosexuality, and settled on a pathological model. Rado was the first to discard Freud's idea of 'predisposed bisexuality'. He saw homosexuality as a phobic response to anxiety caused by the mother. Bieber, Ovesey, and Socarides elaborated Rado's theory of anxiety caused by an intensive attachment to the mother. They considered homosexuality to be profoundly pathological and all homosexuals to be seriously disturbed.

In contrast to the above writers, Isay states 'My clinical work with gay men for more than twenty years has brought me to the conviction that homosexuality is a non-pathological variant of human sexuality.'

The traditional theory of possessive mothers who bind their sons to them because of their own needs as being important in the aetiology of homosexuality is disputed. The writer claims that many heterosexual men have similar mothering experiences; however, these men, like their homosexual counterparts, share similar difficulties, which are identity diffusion, self-punitive tendencies, and difficulties with intimate relationships, due to early injury to their self-esteem.

Effeminate behaviour of homosexual men is seen as springing from the wish to attract their fathers, just as heterosexual boys imitate their fathers to attract the attention of their mothers. 'These identifications of homosexual children appear to follow the manifestation of the sexual orientation and the erotic attachment to the father, and not to precede them.' He goes on to quote some empirical evidence that there is a heredity basis for homosexuality, as is generally assumed for heterosexuality.

Many homosexual men report having always felt different from their peers, 'being on the outside'. The author sees these feelings as a screen which hides the same-sex erotic fantasies which are usually present in homosexual men from at least 4–5 years of age. This period of development is seen as similar to the Oedipal stage for heterosexual boys, except, 'the primary sexual object of homosexual boys is their father.'

The majority of gay men in therapy report that their fathers were distant, and that they lacked any attachment to them. The author became impressed by the similarity between gay men talking about their fathers and heterosexual men talking about their mothers. He interprets these memories as being 'distortions against early erotic attachments to the father.' He concludes that 'while most analysts consider these distortions, caused by repression, to be important with heterosexual men, the same importance has not been applied in working with gay men; which has led to the unwarranted conclusion

that a constructive, supportive, warmly-related father precludes the possibility of a homosexual son' (Bieber).

The acceptance of gay men's memories without an awareness of distortions and the assumptions of homosexuality as pathological has led to an inadequacy of conceptualisation and a distortion of clinical perception as the result of the heterosexual bias of our society, which affects most clinicians in their work with gay men. On perceiving their son's need for closeness and erotic attachment fathers may withdraw from their sons due to their own anxiety. This withdrawal of the father lowers self-esteem, arouses feelings of rejection and inadequacy. This withdrawal is an important reason why some gay men have difficulty in forming loving and trusting relationships. The interpretation of these early repressed erotic feelings towards the father lessens conflict and arouses more flexibility and responsiveness in sexual fantasies and behaviour.

As opposed to the manner in which gay men describe their fathers, relationships with mothers are depicted in a variety of ways. The author has found that men who have a positive sense of themselves and their sexuality usually describe their mothers as being 'good enough'. However, gay men may also be envious of and competitive with women, which originates in the rivalry with the mother for the father's attention. Often the description of gay men's mothers as being overbearing or binding, or keeping them from their father, can stem from anger at and envy of her closeness to the father. Often, gay men have an underlying bond with women, which is based on their mutual attraction to other men, a bond which initially was shared with the mother in pursuit of father as a love object. A homosexual child of 4 or 5 may even assume some of mother's attributes and characteristics. The mutual bonding and closeness sometimes continues into adulthood and extends to other women.

The gay adolescent has more sexual guilt than his heterosexual counterpart, because, having perceived his sexual feelings and impulses as different from those of his family and peers, his self-esteem has already been injured by the withdrawal of the father, the rejection of other boys, and his own perception of himself as being 'different'. Additionally, his self-esteem is lowered because of the internalisation of society's prejudices and bias. The belief that adolescence provides a second change to put aside homosexuality and to work through early developmental experiences that have been held to thwart heterosexual development is, in the author's view, clinically harmful to the gay adolescent's self-esteem.

Homosexual boys experiment with heterosexuality similarly to heterosexual boys experimenting with homosexuality. However, what feels 'real' has a strong affective element, that is, falling in love or longing for love is consonant with the erotic fantasy-life of the individual adolescent. One is made aware of the difficulties experienced by these boys in first of all 'coming-out' to themselves and acknowledging their own homosexuality. Coming-out to themselves can lead to coming-out to other gay men; relationships, mutual and loving, sexual and non-sexual, are formed and are essential to the healthy integration of a homosexual identity, promoting a positive self-image.

Isay refers to this as homo-socialisation, and states that little attention has been given to this by psychoanalysts. Those who have spoken about it usually see it negatively. However, social psychologists are quoted as arguing that the consolidation of a normal identity of a homosexual requires a total, or nearly total, involvement in a gay community. The inability of the gay man to come out to his parents is seen as a failure to integrate his sexuality and a need to keep his parents at a distance.

This chapter on adolescence is the longest and most sensitively written chapter in the book. It shows the author's deep concern and understanding of the internal and external difficulties of the homosexual adolescent. For the psychoanalytically-oriented psychotherapist it raises theoretical and social issues.

The analytic neutrality, acceptance, and respect given by the author to adolescent and young gay men's relationships could pose problems for psychoanalytic therapists in the UK, where the age of consent is 21.

In writing on AIDS, it is shown how healthy young men who are not at risk from unsafe sexual practices, both heterosexual and homosexual, can use a fear of AIDS defensively. Rage is expressed against the parents by inhibiting their own sexual development and spitefully withholding pleasure from themselves: 'If I suffer, they [the parents] suffer.' The unrealistic fear of HIV infection can hide masochistic trends, whilst the unrealistic anxiety about passing on the virus to others may mask sadistic fantasies. In writing about AIDS, the author describes his only deviation from usual classical psychoanalytical technique when he refers to 'educating a patient about safe sex – but these are not usual times'. This didactic approach may arouse fantasies and conflict in the analysand, but provided they are analysed they do not seem to evoke further conflict or self-defeating behaviour during periods of negative transference.

The fear of passive sexual longings, internalised social prejudices,

and the vicissitudes of early development are all seen as contributory factors to the 'homophobic' attitudes in society. However, the author believes that hatred of what is viewed as 'feminine' in men by all men is a much more important factor. Homophobia is found in institutions that recruit because of their masculine qualities. Examples given are the CIA, FBI, Army, and athletic organisations. Also, in institutions where high value is placed on feminine qualities, but where 'being a man' is highly prized within the institution, or as part of the institution's image, homophobia is also seen to exist. The examples are given as: the Catholic Church, which excludes women from the priesthood; and organised psychoanalysis, which excludes gay candidates from training, simply because they are homosexual.

Gay relationships are described as: long-term (lasting one year or longer), short-term (two or more nights to one year), and anonymous sexual encounters. Anonymous sexual encounters are sometimes used to provide diversity for some gay men who are also in a stable relationship; and also as a sexual outlet for 'closeted gays' and bisexual married men. Usually, no emotional bonding occurs in these encounters, but considerable affection may be expressed.

Some gay men, like some heterosexuals, tend to avoid intimate and emotional attachments. The rejections, from father and peers, in childhood and adolescence, are seen as contributory factors in gay men's anxiety about relationships. Some gay men try to recreate with their partners the rejections they felt as children, forming spiteful and revengeful attachments. Whilst these vindictive attachments are not characteristic of all gay relationships, and are not exclusive to gay relationships, they are on the other hand seen as frequent.

Researchers have found that men in close couple relationships are more adjusted and happier with their sexual orientation than those who are not. These researches are confirmed by the author through his clinical findings. The chapter concludes by saying 'It is only through mutually loving relationships that gay men can ameliorate the wounds of childhood and those caused by society. The rest is, at best, temporary comfort – in all likelihood illusory and futile.' The author suggests several ways of distinguishing between heterosexual men who use homosexual fantasy defensively and homosexual men whose fantasies are part of their personality.

In heterosexual men the fantasies usually start in late adolescence, motivated by threats inherent in aggressive 'masculine' strivings, and usually linked behaviourally to inhibited sexuality and work. In gay men the fantasies date from a much earlier period in life, usually from

the age of 4, and are not linked to inhibition in sexual or vocational endeavours. In gay men, the homoerotic fantasies have the aim of becoming attached to a man; whereas in straight men there is little or no interest in becoming attached to another. In homosexual men the fantasies seem natural, whilst in heterosexual men they are experienced as alien. In heterosexual men, the homosexual fantasies either disappear, or are greatly mitigated, in 'any therapy that is conducted in a neutral, or non-manipulative, coercive manner.' In the gay man the homosexual fantasy and behaviour become less conflict-ridden during similarly-conducted therapy, and the strength of the sexual desire, and the potential for sexual intimacy with another, becomes enhanced. In heterosexual men, homosexual fantasies become activated by conflicts centring on aggression and competitiveness, where in gay men the same sort of fantasies remain constant and strong throughout.

This is one of the very important clinical parts of the book. To distinguish between true homosexuality and defensive homosexuality is obviously important. The author acknowledges that there are men whose erotic fantasies are more or less equally divided between homoerotic and heterosexual. These men feel a need for emotional and erotic attachment to both men and women. However, in the writer's experience these men are relatively rare. He feels that many men who appear to be bisexual, and are labelled as such because they are married, are in fact gay. When true bisexual men (whose fantasy lives are equally distributed between heterosexual and homosexual fantasies) come to therapy, it is usually because the homosexual component of their sexuality is presenting other internal or external difficulties. 'The most important therapeutic task with these men is to make the homosexual impulses conscious and tolerable.'

The author bases his psychotherapy of gay men on two firmly held convictions: one, that gay men can live, as homosexuals, well-adjusted, productive lives, with gratifying and stable love relationships; and, secondly, that the effort to change the sexual orientation of a gay man is harmful to him. Freud is quoted in support of his conviction: 'In general, to undertake to convert a fully developed homosexual into heterosexual does not offer more prospect of success than the reverse, except that for good practical purposes the latter is never attempted' (Freud, SE 18, 151).

The author stresses the need for neutrality and affirmation of the patient as being essential for the treatment of all patients, 'not just gay men'. However, 'no technical deviation from a customary thera-

peutic alliance and positive regard is indicated in the psychotherapy of gay men.'

While these statements might be taken as obvious, it does however differ from other writers who advocate that analytic neutrality should at times be abandoned, in case the homosexual patient might misunderstand neutrality as permission for him to 'act out homosexual behaviour' (Kolb & Johnson). These analysts advocate that under some circumstances therapists should terminate treatment if homosexual behaviour persists. Ovesey suggests that the patient should be given an ultimatum if he is not making sufficient effort to perform heterosexually, and states, 'There is only one way that a homosexual can overcome his phobia and learn to have heterosexual intercourse, and that way is in bed with a woman.'

Socarides suggests that the gratification of a homosexual should be spoilt by interpretation and that he should be counselled in how to engage in heterosexual sex. The danger that some patients might show a willingness to attempt to change their sexuality as a manifestation in the transference of a childhood desire to please and be loved by the father seems to be ignored.

The author feels that there are some issues that are particular to the therapy of gay men, of which the therapist ought to have some knowledge.

These issues are problems deriving from paternal rejection, social discrimination and stigmatisation; internalised homophobia; and the coming-out process. The author feels that the therapist or analyst cannot be analytically neutral if he believes that the normal developmental endpoint is a heterosexual one. Isay suggests to gay men seeking psychotherapy that, for their own benefit, they should have a therapist who regards them as capable of 'gratifying and loving relationships as homosexual men', and that their homosexuality is for them normal and natural. He believes that such an attitude can only be convincingly held by the therapist who holds the theoretical perspective that homosexuality is a normal developmental endpoint for some men.

In summary, this is a thought-provoking book. It challenges orthodox psychoanalytic theory, i.e. the too-binding mother and absent father; homosexuality is seen as constitutional in origin; the expression of their homosexuality is both normal and growth-enhancing for gay men. The importance of the father-son relationship is stressed, and the devastating effect of paternal rejection is emphasised. The dangers of societal, institutional, and theoretical bias affecting analytic neutrality are referred to many times in the text. The author also describes

the path of normal psychological development for gay men. He sees no good reason for excluding homosexual candidates from psychoanalytic training other than the wishes of analysts to fit in with society's mores and prejudices. It is written very clearly and sensitively, with many case-studies illuminating the text. This book would be of benefit to psychotherapists, social workers, and gay men, and candidates in analytic training will also benefit by becoming aware of a differing theoretical viewpoint.

The book was written to enable clinicians who work with gay men to work more effectively, and with greater empathy and understanding, and to provide gay men with a richer understanding of their own development.

Having read the book, one feels the author's hopes have indeed been realised. Perhaps in conclusion it is best to remember the author's words: 'Like all forms of love, homosexuality remains mysterious and eludes our total understanding. Like all forms of love, it is a longing for a lost attachment. That longing, for gay men, is usually for the father.'

DANIEL TWOMEY

The Harvard Lectures: Anna Freud

Edited and Annotated by Joseph Sandler. Karnac Books 1992
142 pp. Pb £10.95.

In 1950 Anna Freud lectured to students of Harvard and Radcliffe Universities in the United States. She was invited back in the autumn of 1952 and over a period of 4 weeks gave 10 lectures which she described as a 'Summary and Introduction' to psychoanalytic theories about child development. All but the first of the lectures were recorded at the time. They were delivered without notes and Joseph Sandler has transcribed them with minimum interference. He allows us to be in the room with Anna Freud, giving us first hand experience of 'Her great love for children and her concern for the problems of parents and caregivers' as well as her 'down-to-earth uncommon sense that is characteristic of all her work'. His annotations are equally unintrusive but very helpful in putting some of what is said into historical context and pointing out some errors arising from oversimplification.

There are oversimplifications such as an equation in one lecture of the unconscious with the id, or too clear a distinction between imagery used in primary process thinking and words in the secondary process of the ego. However, these are a price to be paid for a remarkably clear exposition, in a very limited time, of the instinctual stages of childhood development and the structuring of the personality.

Anna Freud's purpose is to help parents. She aims, by increasing understanding of the process of human maturation, to encourage parents to provide an environment allowing maximum instinctual development within the confines of reality and society's expectations. She gradually unfolds for her audience a picture of the struggles within the infant's own psyche, as well as with the outside world, which may result in partial defeat (regression or fixation) or may lead to growth and self fulfillment.

The course begins with an account of the id and its workings according to the pleasure principle; the 'reservoir of force' within us which supplies motivation for most of what we do. The speaker describes its autonomous, illogical state, only changing because of an inborn sequence of wishes and only within the influence of parents, in so far as they can gratify or frustrate.

The parents' part in the development of the ego is vital. At first they must take over ego functions which the infant cannot perform but gradually they must let go, allowing the child to struggle with conflicts set by reality and to tolerate frustrations by himself. (Much of what is said to parents might equally apply to psychotherapists but she is not addressing them in these lectures).

In an effort to counteract the belief that in order to save their children from neuroses parents should also save them from anxiety, the speaker emphasises the importance of the role of anxiety in strengthening the hand of the ego and thus saving the child from fears which may lead to neurotic symptoms. She explains the development of the superego, helping parents to understand that too much rigidity is not the only hazard in child-rearing. Over-permissive parents may deny children the opportunity to feel or express aggression safely, leaving them no alternative to self-attack. Parents who are too tolerant may therefore find themselves with a viciously self-punitive son or daughter.

Alongside her description of the developing structure of the personality, Anna Freud sets forth with the same brevity and particular clarity, the phases of infantile instinctual development. Although she spend much time observing children, the author reminds us that her

theories are psychoanalytical. Knowledge of infantile sexuality originates from the analysis of adults; it has been further confirmed by the direct study of children. She shows how Freud's theories of infantile sexuality altered our ways of looking at sexual deviancy, formerly thought to be either organically determined or a sign of depravity, instead of the end product of a long and hazardous period of growing. Sexual excitement must not be equated with genital sexual feeling and is present from the oral stage onwards. Nevertheless some of the author's attempts to trace adult sexual behaviour back to the vicissitudes of childhood instinctual wishes are perhaps too oversimplified to be useful; for instance her explanations of bisexuality and homosexuality in chapter seven.

The lectures prompt us to remember that object relations theory has been given increasing recognition over the last forty years. It is a dimension that Anna Freud largely omits except in recognising the parental role in modifying instinctual desires. The vital significance of this however, is brilliantly summarized in chapter six which confronts us with the complicated interrelationship between narcissism, object constancy and the capacity to identify. Quarrelling, absent or multiple parent figures are recognised as potentially damaging, a view endorsed two years later by her example of a Jewish girl separated from her parents in the war and unable to establish a sense of herself.

At the same time as trying to understand the view point of the orally or anally dominated infant, the writer makes many observations about parents' difficulties in putting up with their children's behaviour at these stages. She observes that love and involvement are a help in this and are never present in the same way between children and unrelated caretakers who may find it harder to be tolerant. However, her emphasis in the last chapter on over-indulgence of children as a cause of anti-social behaviour may be an attempt to set a balance to Bowlby's belief that delinquency could be traced unequivocally to prolonged separation from the mother.

The speaker repeatedly tells her audience that her lectures are not a blue print or guide but a gateway to further thought and reading (and perhaps, for some, analysis for themselves but analysis as a treatment is not the subject matter of these talks). There are several references to changes in the public mind brought about by knowledge of psychoanalytical ideas and the most obvious of these is an acceptance of the unconscious. We are reminded, however, that these lectures are addressed to a largely unanalysed audience who may find it 'difficult to imagine that the unconscious is really unconscious' and 'cannot be

reached by goodwill and effort' but only by certain methods, of which psychoanalysis is one. Anna Freud points out that psychoanalysis is a method of research and treatment and its influence on society's ways of thinking and behaving is an unplanned by-product. She considered this by-product to be of great importance to the prevention of mental problems, and thought that psychoanalytic ideas should be made available to parents, schools and any establishments dealing with children; hence the focus of these lectures.

She was, however, deeply concerned that some of these ideas had been misunderstood; the swing away from rigid pre-war upbringing had gone too far. In the lectures she emphasises that parents must not only care for a child's id and instinctual freedom but also for his ego and superego which enable him to function at an optimum level in the society in which he lives. 'Each drive should be looked at and treated on its merits' which is to say on how acceptable or useful it might be in adult life: for instance, oral drives can for the most part be fairly well accommodated by eating, smoking (times have changed!) or kissing, but most of the anal ones need to be transformed in order to serve the ego. Her brief description of some of the ways these transformations could take place, by sublimation, reaction formation or other defence mechanisms, is a tantalisation which once again urges her audience towards further exploration of psychoanalytic thinking.

These lectures must be read in their historical context and I found them stimulating because they encourage the reader to look backwards as well as forwards. There are several references to changes in Freud's own ideas and hints about development of psychoanalytical thought for the future. For instance in her discussion of the oedipal stage, Anna Freud makes it clear that she does not regard the instinctual life of the infant as functioning on its own and describes vividly the fate of the child whose parent fails to admire or appreciate. Her Hampstead Nurseries were financed with American money and speaking in the States she may have felt no need to justify her emphasis on the influence of the environment on the development of children which was largely challenged by Melanie Klein in Britain. At the same time she seeks to lesson the rift between them by stating her belief that innate qualities contribute to the personality of any child so that the instinctual life of each will be dealt with in different ways.

The lectures were given at a time when the ideas of Bowlby and Winnicott had become popular. Their positioning of the father as mother's support and the family's contact with the outside world is delicately challenged by the speaker. She considers the child's different

relationships with mother, father and siblings (chapter seven) but concedes that the roles of the parents and therefore the child's relationship to each, may be seen as more interchangeable than in the past.

Anna Freud thought that over-protection and too much indulgence led to poor parenting in the post war years. Nowadays she might have been concerned about other forms of neglect. However she has much to tell us about bringing up children within our society today and as both a psychotherapist and a parent I have been left with many ideas as a result of reading this book.

ANNE TYNDALE

The Psychotic: Aspects of the Personality

By David Rosenfeld. Karnac books 1993 pp. 318 Pb £21.95.

Dr. David Rosenfeld's book presents a selection of papers, some published previously and some new, encompassing both clinical and theoretical issues encountered when treating patients with borderline and psychotic disorders. The author describes his clinical work and his observations with different pathologies, and at the same time, he postulates some hypotheses which contribute to our understanding of the etiology of the mental apparatus. Dr. Rosenfeld's technical approach and theoretical premise comes closest to what in Britain would be considered the Independent School, with its emphasis on object-relations and use of the countertransference.

The book is divided into three sections, covering a wide range of psychotic conditions, describing transference and countertransference issues as well as the technical management aspects of their treatment. He introduces the reader to his concept of 'primitive psychotic body image', and his use of Tustin's concept of encapsulated autistic nuclei. Dr. Rosenfeld oscillates throughout the book between these two phenomena to assess the extent of ego deterioration in the cases he presents.

The most salient contribution Dr. Rosenfeld makes is the concept of the 'primitive psychotic body image, (PPBI)', which, according to his observations, appears to be at the basis of the primitive mental apparatus. Dr. Rosenfeld distinguishes between a neurotic type of unconscious body scheme and a more primitive and psychotic one. In a regressed or psychotic condition, patients lose their 'psychic skin' that warmly protects and envelops. According to the author's obser-

vations, this 'psychic skin' liquefies in the sense that it lacks any sense of solidity or protective membrane and, therefore, the ego disintegrates and becomes destructured. In these states, patients experience their bodies as made of pure fluids contained by a flimsy sack and clinically they express these experiences as fears of their body being emptied of vital fluids. When in the paranoid schizoid position, patients often experience anxieties about being drained of blood, perhaps by vampires or other similar persecutors.

The concept, 'encapsulated autistic nuclei, (EAN),' is a primitive defensive organisation aimed at preserving a precocious integration of the personality, which has been too hastily integrated. In the face of great trauma, 'EAN' is an alternative to ego-splitting, thus being an attempt by the individual to maintain their inner objects intact. This is differentiated from more disturbed instances in which the individual defends by ego-splitting leading to a total loss of self.

The first section of the book, 'Psychosis and psychotic part,' describes the author's main ideas in the understanding of the psychotic processes through the vivid accounts of the treatments of a schizophrenic patient, a patient undergoing cardiac transplant treatment suffering from schizoid depersonalisation, a manic depressive, and a semi-autistic child.

In the first case he illustrates how, through careful continuous monitoring of the countertransference, containment of the patient's rage and bizarre projections can be achieved allowing the patient to create a mental space. The author shows how, as the treatment progresses, the patient begins to alternate the more psychotic part with a healthier part, thus permitting integration slowly to take place. In another case study, a very disturbed patient undergoing a heart transplant projects massively into the therapist feelings of rejection and deprivation whilst defending in an omnipotent and manic way. The therapist's self analysis of these very intense emotions enabled the patient to get closer to the depressive position.

Dr. Rosenfeld next illustrates a case where encapsulated autism is used as a massive defence. At each phase of great resistance in the analysis, the cause is almost invariably a countertransference phenomena requiring a deeper self-analysis on the part of the analyst. The author recounts the analysis of a patient who would not remember past experiences including her own treatment with Dr. Rosenfeld some years previously. In this extreme case, Rosenfeld illustrates the interesting observation that some disturbed patients do not disavow unwanted parts of the Self but instead, they encapsulate a nucleus of

their true infantile experience to shelter it from unbearable pain, just like an autistic child.

In the chapter 'Identification and its vicissitudes in relation to the Nazi phenomenon' Rosenfeld shows how patients who suffered severe trauma tend to either lose their previous identifications with their objects by splitting with the resulting personality disintegration and fragmentation, or alternatively they encapsulate them in a defensive effort to preserve them, resulting in a personality which has a functioning ego and is capable of reality testing but is incapable of emotional involvement. Either way, the victim does not have these internal objects available to mourn or work through. This differentiation has important implications in assessment of analysability since patients with the latter mode of defence have a better prognosis than the former.

In chapter five, 'Child analysis: technique and psychotic aspects of the personality' Rosenfeld describes sessions with a 15 year old boy with an extremely deprived and traumatising background. The need for projective identification in a mind which is fragmented and lacking a container is highlighted. Interestingly, most of the analysis was carried out through drawings as means of communication. This account of a child's initial inability to comprehend, and his eventual progress through the careful handling of the non-verbal communication illustrates and reaffirms the conceptual development of the mental apparatus developing from a uni-dimensional mode of functioning, passing through a two dimensional mode, reaching eventually a three dimensional one.

The second section of the book called 'Psychosis, technique and body image', comprises three chapters presenting clinical vignettes serving to illustrate how the psychotic patient resists by drawing the therapist into acting in, in order to avoid change. In 'Hypochondria, somatic delusion, and body image', Rosenfeld describes the various ways in which hypochondriac pictures become manifest in clinical practice. He discusses hypochondriacal phenomena based on different conceptions of body image, differentiating those based on projection onto the outer world where projective defensive mechanisms predominate, from those where either an autistic encapsulation exists as a method of defence or where a primitive psychotic body image related condition exists, with no sense of boundaries. These models have important clinical implications. For example, the author shows how, as a patient begins to improve, the primitive body image changes from being based on a liquid phantasy to being semi-solid and finally solid.

Symbolisation comes about as the psychic apparatus develops; the mind needs a 'psychic skin' to symbolize and think. An inner space can be created and also a mental space between the internal and external worlds and therefore the thoughts can replace the concreteness of the body. Dr. Rosenfeld sees these hypocondriacal expressions as gradual manifestations of the stage of development of the mental apparatus and its accompanying sense of self and existence of ego functions.

The third, and final section of the book entitled, 'Drug addictions, impulsions and linguistics', is perhaps the most interesting. In it, Rosenfeld emphasis the interrelationship between very early disturbances in terms of basic mental organisation and the development of addictive behaviour and/or impulsive sociopathic functioning. Chapter nine, 'Drug abuse and inanimate objects', describes the treatment of several cases of drug addicts and offers a very clear and useful delineation of the pathology involved, the stages in the process of change, and the corresponding dynamics. Dr. Rosenfeld's model of the primitive mental apparatus and the primitive psychotic body image help explain the internal world of some of these types of patients.

The drug addict persistently wants to have an inanimate maternal object which is unconditional and disposable. This according to Dr. Rosenfeld is predominant in severe cases where the original 'psychic skin' was missing due to a lack of physical contact with early carers. As a result, the patient cannot differentiate between live or inanimate objects and is seeking to create a 'skin' in order to substitute non-existent primary relations. In the countertransference, the author reminds us that the most important task is to stop being the 'drug' or the 'inanimate object', since this is the role these patients continuously force upon the therapist.

The remaining two chapters present accounts of two analyses; the first, a man with sadistic perverse behaviour, illustrating how the patient defends against psychic disintegration by acting out. The second presents the clinical history and treatment of a patient suffering a psychotic episode, characterised by delusions, hallucinations and particular verbal dysfunctioning of speaking fast with no interruption. The case shows clearly how the patient, when operating in a state where a primitive psychotic body image is predominant, needs to evacuate, through fast talking, uncontained, 'fluid' parts of herself. The containment offered by the therapist permitted the gradual development of a differentiated language.

Dr. Rosenfeld, follows a pure phenomenological approach in his

work, faithful to the psychoanalytical method of scientific investigation, as initiated by Freud. He succeeds in formulating his theoretical concept of the primitive psychotic body image, which is a useful contribution and can only enrich our psychoanalytic understanding. Dr. Rosenfeld's writing is, however, at times confusing. His ideas are disseminated somewhat indiscriminately throughout the book, and it is left to the reader to try to find a clear pattern in the author's thinking.

The book's strengths lie in its clinical focus rather than in its metapsychological approach. It raises issues which are relevant to clinicians, trainees and practitioners wishing to understand the workings of the primitive mind. The case material presented is stimulating and interesting, permitting the reader to be closely in touch with the treatment. I was, however, disappointed that the author does not attempt to offer a coherent theoretical construction of the many valuable themes that are raised.

Perhaps the greatest value of Dr. Rosenfeld's book lies in conveying to the reader a hopeful and optimistic view of the use of the analytic method in treating not just some forms of psychosis but also the psychotic type of transference and defence mechanisms which make their appearance in every patient. One is reminded of M. Klein's recommendation that an analysis cannot be complete unless primitive early psychic phenomena are analysed.

DR. R. STRAMER

Slouching Towards Bethlehem and Further Psychoanalytic Explorations

By Nina Coltart. Free Association Books, 1992 pp. 200 Pb £15.95.

Dr Coltart is a well known member of the Independent Group of the British Psycho-Analytical Society. This collection of her papers can be said to be an introduction to and a summing up of our hopes, fears and expectations in our psychotherapeutic work. It shows the breadth of interest, her lateral thinking and her ability to use the tools of psychoanalytic practice, in a wide variety of challenging problems. At the same time she manages to demystify psychoanalysis, removing it

from the constraints of the ivory tower, putting difficult concepts into easily understood language for both practitioner and layman.

There is humour and sensitivity in her descriptions of clinical work with her patients, seeing them as human beings while at the same time not afraid of 'not knowing' what is happening in a session, willing to wait to find the words to express the inexpressible. The reader sees two people engaged in work together, work involving feelings and emotions leading towards a conclusion, yet withal 'held' by the analyst so that chaos does not ensue.

My curiosity was aroused by the title of the book which is also the first paper, the quotation itself taken from the poem by W.B. Yeats and used as a metaphor by Coltart to describe breakdown and healing. She takes the analogy of 'And what rough beast, its hour come round at last, slouches towards Bethlehem to be born?' and uses it intriguingly to talk of a patient whose near psychotic breakdown and subsequent wellness illustrates her analytical skills perfectly, including some unconventional ones. So too she describes herself as a newly qualified professional 'slouching' along through years of work and finally emerging in a recognisable identity.

In this paper she describes briefly, and expands in a later paper, her analysis of an older man. It is a most interesting account of breakdown and recovery, of a need in a brilliant, articulate, outwardly successful man to experience primary hatred and rage of a powerful mother. His first year of analysis produced change and improvement but Coltart describes her unease and sense of impending danger. In his second year of analysis he became virtually a silent patient and she became aware of the despair and rage he was experiencing. No interpretation seemed to shift his silence; all seemed to be beyond words. She describes her sudden explosion of anger at him as a leap for his and her freedom based on an act of faith. It felt dangerous but seemed to allow for change and for the analysis to progress.

The analogy is again used in talking of patients with psychosomatic symptoms where Coltart describes the 'rough beast' whose hour has not yet come as being 'holed up in the body', inaccessible, again apparently beyond words, a kind of psychotic encapsulation where the body symptomises the psychic pain but where there seems no way across the mind/body divide. To have familiar symptomatology described clearly and also poetically seems particularly helpful in encouraging one to see a patient in a new light.

Another paper significant for therapists assessing a new patient either for referral or for themselves is 'diagnosis and assessment for

suitability for psychoanalytic psychotherapy'. Again she puts into words all the important aspects of such an interview that one somehow knows but is not always properly conscious of, emphasising what a momentous thing one is saying in advising a patient to enter psychoanalytic psychotherapy. She stresses such criteria as intelligence, moral character (quoting Freud), and discussion about money, acknowledging that these are ideas therapists often feel diffident about. She gives a useful set of queries for psychological mindedness as criteria for suitability and says, 'psychoanalytical therapy has nothing to offer a patient who only wishes to be relieved of his suffering.' Psychic pain is the motivator for starting treatment but a patient also needs a lively interest in discovering the cause of the problems so that the therapeutic alliance can develop. Other criteria she urges therapists to keep in mind are a capacity for fantasy, imaginative use of words or metaphors, a capacity to recognise the existence of an inner reality and an unconscious and, the self-esteem coming from the acceptance of success in some area of life. As she says, 'it is an important truism that he who fails at everything will fail at analysis'. If these are severe demands, she also makes equal demands of the therapist's behaviour in the diagnostic interview; to be able to move freely within the session, not behaving 'like a caricature of an analyst' by being silent, not communicating, not asking questions, which she regards at best counterproductive and at worst actively sadistic. This is a vexed question, perhaps not talked about enough among those therapists assessing for referral; it is interesting to have such definitive views to discuss.

In a further paper on technique called 'On the tightrope: therapeutical and non-therapeutic factors in psychoanalysis' where she compares interpretation to the pole that keeps therapists balanced on the tightrope of their work, she comments: 'When, why, how and what to interpret is the balancing act of our daily lives', warning against feeling that only transference interpretations are valid, at the expense of historical meaning, of ignoring the importance of the here and now in pursuit of reconstruction of the past, in exaggerating the intensity of the therapist's influence and ignoring other object relations in the patient's life. She compares clinical skill with clinical cleverness, the former compounded of constant vigilance of countertransference, techniques of interpretation, and an understanding of the unique quality of every patient; the latter being an empty vessel, lacking the proper mode of communication and gratifying only to the practitioner. She explores jokes and humour in the analytic setting, 'mistakes' made by the therapist which are sometimes surprisingly made good, but for this

reader not enough emphasis is placed on countertransference which informs our transference interpretations.

A paper I read twice is 'The Superego, Anxiety and Guilt', an introductory public lecture given at the Institute of Psycho-Analysis, where she traces the theories of development of the superego: she points out that Freud's original view of the overcoming of the Oedipus complex being the instigator of this new agency of the ego, when the son identifies with the father and internalises him, is the precursor of an object relations theory. Klein pulls back the chronology to an object related baby internalising primitive superego part objects and Freud develops his structural view of the personality, of id, ego and superego. The differences between superego and conscience are explored, the latter being conscious or at least capable of being made conscious, the former being partly unconscious and closely linked with the id energies.

The clinical example of anxiety and guilt in an hysterical patient is clear and illuminating and very moving, the aim of the analytic treatment being to give choices to the patient in the management of her inner world, paying close attention to the anxiety producing the symptoms, the prohibitions from the superego, acknowledgement of her sexuality and the positive value of her defence mechanisms.

So too the description of a man with obsessional neurosis, often apparently intractable, so often producing a feeling of intense irritation in the therapist, who must observe the interminable rumination, the indecisiveness, the rituals. I found helpful her thesis that this patient-provoked irritation is one of the most effective and important ways an obsessional patient can express his underlying aggression, at the same time as dissociating from the conscious wish. Helpful too the reiteration that the patient's need to suffer his illness, painful though it is, is based on unconscious guilt.

One can continue to illustrate the enormously useful concepts of this book, comparing the profoundly moral precepts with the pragmatic, down to earth ideas, the humour with the fundamental seriousness, the masterful literary analogies with the clinical vignettes. Dr Coltart uses her own personal philosopies of life to sustain and enrich her clinical work, and believes that 'the quality of sustained, unflagging attention' is our most important therapeutic tool. The book is confirmation for experienced psychotherapists, affirmation for more newly qualified practitioners.

HELEN ALFILLÉ

Extending Horizons: Psychoanalytic Psychotherapy with Children, Adolescents and Families.

Edited by Rolene Szur and Sheila Miller. Karnac Books. 1991. pp. 474 Pb £24.95

'Clinical work, theory and research in creative interaction' writes Rolene Szur in her introduction to this impressive collection of articles by Child Psychotherapists and analysts, which will interest other practitioners. As the range and degree of disturbance of the young people being referred for child psychotherapy widens, the professional response has been to develop new thinking and evolve increasingly flexible approaches. *Extending Horizons* provides a compendium of these current developments. This long and wide ranging book also has a polemical intent: child psychotherapy, like other professions in the public sector, is increasingly having to justify itself, to prove that its treatment methods are effective and relevent. All the royalties from *Extending Horizons* go to the Child Psychotherapy Trust, dedicated to promoting the training of child psychotherapists to work in the Health Service. Throughout the book the underlying message is that theory can be underpinned by research, and that child psychotherapists are evolving techniques which go towards the systematic, long term evaluation of their work. The hope is that the provision for the treatment of disturbed children will eventually be increased.

Perhaps the first impression of *Extending Horizons* is that in structure and scope it is extremely comprehensive. Care was taken that it should embrace a wide theoretical spectrum. The majority of the contributors trained at the Tavistock Clinic but the Anna Freud Centre and the Institute of Psychoanalysis are well represented. There is an interesting contribution by a prominent Jungian and a brief note about the work of Margaret Lowenfeld. Despite this wide diversity of theoretical orientation there is no confusion. The collection is integrated and held together by the excellent editorial comments by Rolene Szur which precede each chapter, placing each contribution in a clinical context and providing cross references where appropriate. Many chapters start with an overview of the particular concepts that have illuminated an aspect of work for the author.

In the early sections themes are considered under the age group of the patient, and the type of treatment offered. Part one, 'Patients, Families, and Treatment Approaches' focusses on the range of interventions that are considered when a child or young person is referred,

starting with what is the bedrock of our clinical experience, an account of intensive long term treatment. Alan Shuttleworth explores the technical as well as the theoretical issues involved in treating a six year old boy and recaptures the experience of treatment for patient and for therapist. The scope then widens to include other treatment methods, the indirect treatment of a young child through his mother, shorter term work for troubled adolescents, and explorations with families.

Infant mental health work, with its preventative potential, is one of the fastest growing areas in the Paediatric field, and one in which it is recognised that the child psychotherapist has a particular contribution to make. Among the contributors to Part two, 'The Psychotherapy of Infancy', Isca Salzberger Wittenberg describes brief therapeutic work with the parents of infants in different situations, including severe maternal post-natal depression, and unresolved mourning for the loss of a previous child. Longer term joint intensive work with mother and child is described by Helene Dubinsky and an appropriate inclusion to this section familiar to many readers, is part of, *Through the Night: Helping parents and sleepless infants* (Dilys Dawes. 1989).

The need to plan appropriate treatment resources in a time of profound social change is addressed in Part Three, which includes a section on a walk-in service for adolescents. 'Work with Ethnic Minorities', attempts to tackle one of the important issues of the day for those who work in the public sector, in a workshop which explores the effects of ethnic difference on the therapeutic relationship. Much of Part Four; 'Special Areas of Work' will be familiar to readers of the Journal of Child Psychotherapy and other publications in the field as it includes updated and expanded material already published. This section deals with the extension of psychotherapy to children who have suffered additional, external trauma, including sexual abuse, or family breakdown. Francis Dale describes the treatment of two children suffering from congenital physical handicap with the attendant psychological consequences. Valerie Sinason writes on Psychoanalytical Psychotherapy with the severely, profoundly, and multiply handicapped. Frances Tustin, in *What Autism is and what Autism is not*, builds on what she wrote in *Autistic Barriers in Normal Patients* (1986) distancing her views from the concept of normal primary autism and distinguishing between childhood autism and childhood schizophrenia. She describes the autistic children who could benefit from psychotherapeutic treatment and pinpoints those elements in the treatment which give rise to change.

Two fascinating contributions on infancy, are divided by the sec-

tional structure of the book. Both tackle, from different perspectives, the question of the way in which a mother's attentive response to her baby promotes his development. The final section, 'Theory and Research' starts with 'The Splitting Image: A Research Perspective', by Mary Boston. The 'split' concerned is between the 'objective' researcher, and the 'subjective clinician', and the divide between the recognition of the cognitive and the affective aspects of human development. Mary Boston describes some recent findings in infant development research using new techniques which challenge the traditional theories held by academic psychologists of an undifferentiated state in the early weeks of infancy. Detailed observations using video and filmed records are found to correspond very closely with the 'subjective' observation studies designed by Esther Bick which now form part of adult and child analytic and psychotherapeutic trainings.

Many readers will find some part of *Extending Horizons* of special interest to them. For me, long puzzled why an adult patient should show the infantile startle response on the couch at the end of the session, it was 'Some reflections on body ego development through psychotherapeutic work with an infant'. Genevieve Haag explores the link between the psychological and the physical aspects of infant development illustrating the theme with an account of therapeutic work with a little boy who was seriously inhibited both in motility and in responsiveness. Her thesis, linked in a fascinating way with Grotstein's background object (James Grotstein 1981) is that dorsal contact continues to provide emotional anchorage in post natal life and that early object relations are mediated through this, and through interpenetrating eye contact.

It is impossible to do justice to the variety of interesting contributions to *Extending Horizons* in a few paragraphs and many have not been mentioned. No review would be complete without reference to weaker areas and I was disappointed that a more energetic attempt was not made to tackle one of the most difficult questions facing those child psychotherapists who work in Child Guidance Clinics or in Departments of Child Psychiatry, that of the relationship between individual and family therapy.

ANASTASIA WIDDICOMBE

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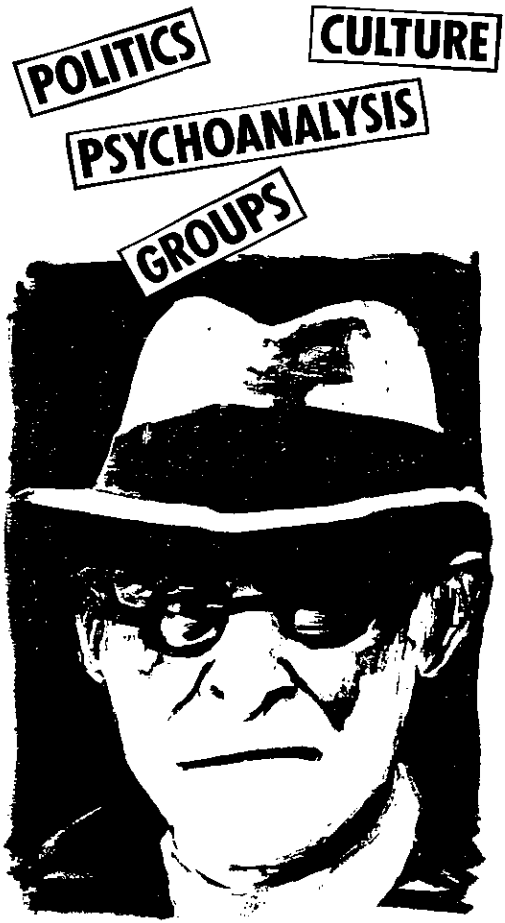

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