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Guest editorial

I am delighted to have been invited to write the Guest Editorial for this issue of the *BAP Journal* in recognition of the start of the Association's 50th year. As the current Chair I feel privileged to be able to reflect on these 50 years and to think about the immediate future for the Association and its place in the wider context.

The BAP was initially named the Association of Psychotherapists and was formed to provide mutual support for the clinical work and professional development of a small group of psychotherapy practitioners. They included members in both the Freudian and Jungian traditions. Although some had trained abroad, others had had their personal analyses and supervision with members of the British Psychoanalytic Society or the Society of Analytical Psychology, the only other British training bodies to exist at that time. They initially set up a small library, started a clinic for referrals and ran the Association from their homes. Indeed, the Association's headquarters in Mapesbury Road was obtained only 10 years ago, bringing some of these activities in house.

Gradually a training programme was established and by 1963 it had developed into the form still held today in that there are two distinct trainings, Freudian and Jungian. Although the BAP was unique at this time as the first of what has since become a large number of psychotherapy trainings, the Association still holds the additional unique position of offering these separate trainings in the same organization.

In 1982 a third training was developed for psychotherapy with children and adolescents, a training that was recognized by the Association of Child Psychotherapists in 1986. Since then further trainings have been added: a modified training for child therapists wishing to additionally become adult therapists, an MSc programme in collaboration with Birkbeck College to prepare students for a professional training, as well as postgraduate courses for members within the Association.

Alongside this the Association continues to offer a clinical service that also provides low-cost therapy for those who cannot afford a full fee, an established high-quality library and a varied scientific life. It is now developing a more research-based culture in both clinical and theoretical aspects of the work. These activities provide a forum whereby the membership as a whole

can exchange ideas, and a milieu for greater exchange between the theoretical traditions. Since 1989 the BAP has also offered short courses for those in related fields interested in analytic ideas that they might develop in their own work.

In 1989 members of the Jungian Section became members of the International Association of Analytical Psychology, which enabled them to call themselves Jungian Analysts. The Freudian Section has also changed its name to the Psychoanalytical Section to reflect the broader base within the Freudian tradition. Initially belonging to the Independent tradition, this section now includes members who describe themselves as Kleinian or Freudian.

The Association became the British Association in 1972 and established itself as a limited company with a formal constitution in 1977. During its entire history the BAP has relied on the voluntary time and goodwill of its members to keep the Association and its many activities going. We are also grateful to members from other Associations and particularly the contributions from members of the British Psychoanalytic Society and the Society of Analytical Psychology who have shared their expertise, especially in terms of training.

The BAP has had its share of difficulties over the years, as well as many areas it can reflect on with pride. Its trainings are of a high standard and its members take their learning into a variety of settings in addition to the private clinical consulting rooms. The National Health Service, social services, academic institutions and the voluntary sector all benefit from this work. Teaching, writing, speaking at conferences and so on also demonstrate the postgraduate activity of members.

When reflecting on our history it is interesting to note that early struggles about direction created splits in the organization, leading to other organizations being formed. Although painful, perhaps this has been a necessary process for the establishment of psychotherapy in general and psychoanalytic psychotherapy in particular. If the BAP were still the only psychoanalytic psychotherapy organization existing, then this narrow framework could have led to our becoming obscure. This would not have been in the tradition of our forefathers who were keen to spread their psychoanalytic understanding. I note when teaching Freud's ideas on sexuality that students are often critical, sometimes appropriately so. It is often hard for them to imagine what it was like for Freud to put forward such ideas to a world reluctant to hear them. When seen in context students will re-evaluate their criticism in a more constructive form. Today the ideas of our forebears have become commonplace, forming part of everyday language. Perhaps, like our forebears, we have needed splits in order to provide space for our thinking. Out of conflict can come creativity.

However, recent difficulties have shown how the field of psychotherapy has moved on. The emphasis has not been so much about the insularity in psychotherapy organizations but about how Associations might now organize

themselves into groups or 'families'. Furthermore, it has been about how these groups might then wish to develop in terms of accountability to the public, who have a right to know what standard of training and therefore practice we offer. Practitioners need to be able to develop their thinking, whether it is in regard to theory, technique, ethics and so on. If this is to have any widely felt implications, then it has to be with as many other likeminded practitioners as possible. So the BAP has had to think about not only how it might develop its own activity but how this fits into the wider picture of psychoanalytic psychotherapy. This naturally creates greater scope for conflict and the last few years of strife around the issue of registration have been extremely painful although necessary.

As I write this editorial three areas for consideration come to mind. The first one comes from outside of the BAP and challenges us, the second comes from our relationship with the outside world and the last comes from inside the BAP.

In his recent publication Kernberg (2000) has taken a critical view of current methods of training and lists a number of recommendations, some of which would quite radically change psychoanalytic training. He also asserts that university education should have more of an influence on this development. I do not intend to discuss his paper in depth but wish to take from it some thoughts relevant to current BAP developments.

It is my contention that the universities are already influencing the way in which we train our trainees. This is perhaps not too surprising since many members of the BAP and our training committees hold or have held university posts and bring this experience to their work in the BAP. It is often said that we infantilize students, ignoring their past experience or status. Kernberg challenges us to address the difficult dividing line between helping trainees come to terms with the fact that, however much experience they have in a related field, to make the most of their training they need to come with an open mind ready to take in new ideas. At the same time we must recognize that they will have varying degrees of expertise and their seniority in life will enable them to question the way things are done. The BAP is currently rethinking its tutorial systems, mentoring, assessment feedback and so on and although we do not necessarily agree with all conclusions reached by Kernberg, he presents us with a challenge that has much wider repercussions. For example, we are currently restructuring our Association, placing research in a prominent position: research that is not just confined to thinking about training but all aspects of clinical practice and theoretical ideas. We are developing a Continuing Professional Redevelopment Scheme which serves to ensure standards and also enables each of us to reflect on our work and identify areas for development not only for us as individuals but for the profession as a whole.

The second area is that of registration, which the British Confederation of Psychotherapists (BCP) is developing on our behalf, assisted by some of our

members. This is about our public face and the need to move from our past hope that the public in general and our patients in particular will *know* that we train to a high standard. Continuing Professional Development programmes and research are important factors when considering the levels of training, standards and terminology. What is also new is that we are making these changes in dialogue with other associations in the BCP, which provides us with our professional 'family grouping'.

The last area is the *BAP Journal* itself, now in its 41st year. The *Journal* in its new format invites contributions from those who are not members of the BAP alongside those who are. This reflects our wish for greater dialogue, which I believe can only benefit the profession as a whole.

So, in reflecting on our history and where we are today, it would seem clear that we have moved from a necessarily insular position to one of dialogue with a wider audience. Some of this change has come about because of the internal conflicts, some as a result of external influences that we hope to internalize in a creative way. If psychoanalytic and Jungian analytic psychotherapy is to survive, we have to take seriously our BAP Memorandum which begins with a statement that we are established to: 'promote, provide and increase for the benefit of the public the knowledge and skills which comprise psychotherapy as a profession in all or any of its aspects and thereby to relieve mental distress'. The art we have to acquire is how to do this while minimizing any mental distress for ourselves. I hope that the continuing development of the *BAP Journal* will enrich us in providing a lively arena for thinking and learning without conflict.

Lou Corner, Chair, BAP Council

Acknowledgement

To Elspeth Morley and Denise Taylor, past Chairs of the BAP, whose reports have provided some of the information regarding the BAP history.

Reference

Kernberg OF (2000) A concerned critique of psychoanalytic education. *International Journal of Psychoanalysis* 81: 97–120.

What does psychosis have to say about racism?

JOSCELYN RICHARDS

ABSTRACT

This article defines racism as the belief that human beings can be classified into races which are either inherently superior or inferior. As there are no objective grounds for this belief the author considers that racism is generated by an internal attitude that reflects a psychotic relationship to reality. After describing major characteristics of a psychotic mind the author introduces Sinason's concept of internal cohabitation or co-residency of two minds or selves in the one body, which is a development of Bion's concept of the coexistence of psychotic and non-psychotic personalities. The concept provides a framework for exploring the emergence in the consulting room of disturbing racist material and for developing an analytic understanding of racist issues in the transference and countertransference, particularly because it acknowledges the coexistence in both patient and therapist of racist (psychotic) and non-racist (non-psychotic) attitudes and capacities.

Key words cohabitant, internal cohabitation, psychosis, racism, Sinason.

Definition of racism

For the purpose of this article racism refers to the belief that human beings can be classified into races that are either inherently superior or inferior to others.

The concept of race

It is possible to classify the peoples of the world into different races according to physical characteristics but the attempt to find fundamental biological

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differences has always failed, although a considerable effort was made in the 19th century by the European colonial powers to make a scientific case for the superiority of the white Caucasian (see Helen Morgan's paper, 1998, for a comprehensive review of the relevant literature on racism). It is now recognized that people of different races are more alike than they are different. As Rustin says (1991: 58), 'Racial differences go no further, in their essence, than superficial variations in bodily appearance and shape – modal tallness of different groups, colour of skin, facial shape, hair etc. It is hard to find any significance in these differences except those which are quite arbitrarily assigned to them.' He also refers in the same paragraph to Van den Berghe's point 'that even visible physical features have been lacking in important cases of racism as a ground for distinction – the Nazis compelled Jews to wear the Star of David because their appearance was not recognisably different'.

However, the belief that some races are superior and others inferior endlessly recurs. As there are no objective grounds for this belief it is my view that it is delusional and generated by an internal attitude that is essentially psychotic and the basis of all racism. The processes in society whereby racism becomes 'normalized' and, as a consequence, often dominates cultures and institutions are too complex to address in this clinical paper, which focuses on exploring and understanding racism in the consulting room (for a paper that explores the links between psychosis and politics, see Gibson and Sinason, 2000).

Racism as an expression of a psychotic mind

For some time I have thought of racism as an expression of a psychotic mentality and I would like to describe what I think are the main features of a psychotic mind (or, from a Kleinian perspective, a mind functioning in the paranoid/schizoid position):

- hatred of reality, thinking and dependence; there is an assumption that dependence is dangerous and a sign of weakness and that needs can never be met;
- the conviction that all relationships are exploitative, hierarchical and based on power only and that creative intercourse (literally and metaphorically) cannot exist;
- extreme narcissistic sensitivity to real and imagined hurts;
- the belief that like-for-like retaliation is fair;
- concrete, absolutist (all-or-nothing) and rigid thinking; or, put another way, tramlined thinking where there is no room for doubt or no room for uncertainty;
- the replacement of symbolic functioning by the use of symbolic equations. Segal (1981: 49–65) has written extensively on the concept of symbolic equation, in which the psychotic mind cannot truly symbolize

but sees two things that have some aspects in common as being literally the same;
- an incapacity to acknowledge mistakes and thereby learn from experience.

The consequence of the psychotic mode of functioning in the sphere of human relationships is that human beings are perceived as belonging to unchangeable and unbridgeable categories which are organized according to hierarchical principles so that people are seen as belonging permanently to an inferior or a superior grouping – there is always someone above and someone below. People are not seen as individuals with a range of complex and changing personal needs and qualities. To be on the receiving end of a racist attitude is to feel dehumanized. To witness it in the consulting room is to feel in the presence of attitudes that feel ugly and frightening and yet need to be processed and understood rather than judged and condemned.

It is the psychotic mind that I think underpins racism. It also underpins all other 'isms' such as ageism and sexism that put people into superior and inferior categories. This sort of categorization is a transformation of the fact of differences between people, which we need to know and recognize, into a moral superiority claimed falsely to arise from these differences. The urge of this mind to put people into inferior categories, and thus deny them equality before the law (metaphorically or actually), can be so powerful that it can lead to tragic and terrifying consequences at all levels in society–nationally and internationally.

Major contributors to psychoanalytic theory have recognized the existence of a psychotic aspect in all human beings, even though the extent and influence vary. In my view, all patients and all psychotherapists have a psychotic aspect that has the potential to be racist.

Skin colour

Because the psychotic mind is very concrete in its mode of operating, noticeable physical differences, such as skin colour, are often used as a feature on which to hang racial superiority. Physical differences tend to become highlighted as if they signified a mental difference – however, as Morgan says (1998: 48), 'a black patient may come from a culture more similar to my own than a white patient'. Or, as one of my black patients said recently, she did not share her tutor's worry that, as the only black student in a seminar group, she would feel left out, because 'being black is only one aspect of my identity' – she assumed she would have other things in common with the students.

Even though skin colour is as arbitrary as any other physical feature, it is concretely responded to by the psychotic mind as if it represented real mental and moral differences that are unbridgeable and inherently superior or inferior.

When the skin colour of patients and therapists is different, the different skin colour of the therapist can come to represent the psychotic belief of the

impossibility of ever being understood. When therapists and patients have the same skin colour, other features, such as gender, class or age, get used by the psychotic mentality to represent the conviction of never being understood.

Psychotic and non-psychotic minds

Thus, in summary, it seems to me that racism is one expression of the psychotic relationship to reality which is essentially paranoid and characterized by absolutist, hierarchical and concrete modes of transforming reality and human relationships.

On the other hand, the non-psychotic mind is not racist but appreciates and does not misconstrue difference as being grounds for superiority. The non-psychotic mind, which can also be thought of as the mind capable of depressive position functioning in Kleinian terms, develops fully only in a facilitating environment. This mind, once developed, can learn from experience, can think, can symbolize and can make associations and connections, enjoys the mutuality of relationships and has the capacity and desire to make useful differentiations and to recognize and negotiate internal and external realities. Categories are recognized but are seen as a useful tool for identifying differences and making sense of information and not for classifying human beings permanently into inferior and superior groups. The sane mind in both black and white people has the potential to know that racism is deeply mistaken, unjust and inhumane.

Perhaps Shakespeare expressed poetically the sane view of racial differences when Shylock says in *The Merchant of Venice* (Act III, scene 1),

> Hath not a Jew eyes? Hath not a Jew hands, organs, dimensions, senses, affections, passions, fed with the same food, hurt with the same weapons, subject to the same diseases, healed by the same means, warmed and cooled by the same winter and summer, as a Christian is? If you prick us do we not bleed? If you tickle us, do we not laugh? If you poison us, do we not die?...

The concept of internal cohabitation

Before I present some clinical examples I would like to elaborate on the idea that all human beings can be characterized by the coexistence in the same body of a psychotic and a non-psychotic mind. Jenkins (1999: 27) has written that 'across the spectrum of diagnostic categories, patients allude in various ways to states of mind and emotion in which their autonomy is taken over to the detriment of their own goals and ambitions'. In a paper entitled 'Who is the mad voice inside?' Sinason (1993) refers to experiences in both the consulting room and everyday life where both the observer and the subject recognize that the subject has acted out of character when he does something violent or crazy, leading a friend to say, for example, that 'he wasn't in his

right mind'. Similarly, I can remember a black patient saying that it was the 'illness speaking' when a white patient expressed abusive racist beliefs during a ward group in a psychiatric hospital.

It is a matter of ongoing debate as to whether this inner experience of take-overs is due to a split in the ego as a result of early internal and/or external pressures or is due to the coexistence from birth of two different and autonomous minds that apprehend reality differently. I have enlarged in previous papers (Richards, 1993, 1999) the reasons why I began to find the more usual concepts of splitting, disavowal and internalization of perverse object relations unsatisfactory in explaining certain phenomena that I had become increasingly aware of in my analytic work with patients. I found that those concepts did not sufficiently explain why a number of patients showed genuine motivation for insight and change and then behaved as if these had never been desired and seemed to attack the therapeutic relationship. As I have written previously (1999: 28–9):

> With several patients I had the dislocating experience that the person I was with last session or even two minutes or seconds ago had gone and been replaced by another person with the same face, body and clothes but whose whole demeanour, facial expression, tone of voice and language were different. One moment there was a capacity and interest in appraising our interactions and a perception of me as a benign partner whilst the next there was resentment of the whole therapeutic enterprise, a wish to obstruct it at every turn and behaviour suggesting attitudes of suspicion, antagonism, superiority or indifference towards me as the therapist.... The switch would often occur after helpful developments had taken place – as if change desired by the patient was also perceived as threatening.... Patients themselves often expressed awareness of alternating experiences they could not control ... [for example, a male patient] was late for a session and said, 'I don't know what happened – I got up at the right time and the next thing I knew it was past the time to leave – someone must have altered the clock.'

In order to see if I could understand these phenomena better I began to take an interest in Sinason's concept of internal cohabitation or co-residency of two selves or egos in the one body from birth and began to work with him and other colleagues in developing and exploring the clinical application of this concept. The concept involves a dual-track analysis of two coexisting selves in which neither mind is considered to be subsidiary to nor split off from the other, although one mind is able to think and the other is not. The concept is a development of Bion's concepts of the psychotic and non-psychotic personalities, which he considered coexisted in every human being (Bion, 1957). According to the concept of internal cohabitation, a person who can think about their problems always has an internal 'other' cohabiting with them who has a psychotic way of relating to reality. The concept is also similar to Rosenfeld's concept of 'the narcissistic omnipotent self' who adopts bully tactics when that self feels threatened by the libidinal self's relationship with the therapist (Rosenfeld, 1987: 86–8).

Clinical examples

I want to present clinical examples in which the concept of internal cohabitation provides a framework for exploring, during the course of a therapy, the psychotic underpinning of the perception of the therapist as racist, racist attitudes in the patient and the patient's distress at being taken over by them. Most of the time I use clinical material in which I differentiate the patient's mind from that of the other cohabitant of the body by denoting the patient as *you* and the internal cohabitant as *the other person, the other one, the internal adviser* or *someone else who lives in your head with you*. However, because I was seeing one of the patients at a time when I was still learning how to apply the concept, I will present some material where initially I did not make any distinction and called both 'you'. Although I think of the *other one* as the psychotic personality, I do not use that term with patients as it can be heard as denigratory labelling.

I will start with two vignettes and then present two longer cases.

1. A black therapist whom I was supervising in the National Health Service was seeing a white female patient, Ms A, in once-weekly psychotherapy. Ms A was in her late 20s.

In one session Ms A said, denoting a positive transference, that she had bought a packet of jelly babies during the week and had noticed that she was particularly selecting the black ones to eat and said with an affectionate laugh, 'it was like I was trying to put you inside me and keep you there'.

She started the next session by saying that she had passed another patient of his on the stairs – and had then added, 'your black patient'. She was then silent and looked sad. After a while the therapist commented that she had seemed certain it was his patient and this had seemed to make her sad and he wondered what she was thinking. Ms A said she had been envying this other patient because she was black and added, 'I thought you must prefer her because she is black like you'.

Much of the rest of the session was spent in exploring this assumption and identifying it as belonging to the other mind and that one's belief that the different skin colour of patient and therapist meant that there was a divide between them that was unbridgeable. The session also looked at how this belief negated and cut across the patient's actual experience of having a therapist who she felt did understand her and was helping her for the first time in her life to understand the reasons for difficulties in relationships.

2. A woman in her 40s was mugged by a black man, causing severe physical injury to her right arm. She was referred to me at a GP surgery where I have a clinic because she could not recover emotionally from the assault. She felt particularly upset because she had become phobic of all black men. She both feared and hated them, which upset her because she had a black colleague with whom she used to get on well. Before the mugging she had not thought of herself as racist and although she initially felt her reactions were understandable, she thought that after 18 months her reactions were

irrational. She was clear that a reaction she did not agree with was dominating her and that there was an internal pressure to respond only to skin colour. This was the beginning of exploring the concrete, tram-lined and paranoid thinking of the other mind.

3. Ms H: I want to present some aspects of my work with an Asian woman, Ms H, who had grown up in the West Indies and was in her 30s when referred. In the assessment it was noted that she was very governed by a belief in her 'rights and liberties' and by a grievance as to how she had been treated in all her relationships. She had been the only child in a large family to be sent at an early age to be looked after alternately by both sets of grandparents. There was an enormous sense of deprivation.

In the sessions she frequently told me, in a way that usually made me feel harangued, about the terrible, unjust, sneering and insulting way people in the street treated her – to the point that she would feel provoked to shout at them and sometimes hit them. Sometimes they hit her back, which always shocked her. She was very upset and indignant about these experiences. I got the impression that these people were usually white, although one day she told me with even greater indignation that two black girls had looked down on her. She would know people had 'snobbed' her because of a look, a cough, the sucking of their teeth or a gesture – for example, touching their nose or waving their hand (I thought 'snobbed' was an effective condensation of snobbery and being snubbed). These movements or noises immediately signalled to her that people thought she was 'a second-class black creature' without any rights. She would shout and assert in sessions how wrong this was – 'how very, very wrong and very serious' and accuse people of depriving her of her rights. She often used the pronoun 'you' while accusing someone of a criminal act against her – for example, 'you shouldn't treat people that way – it's very serious'. Thus it sounded as if she was using the term 'you' in the same way that the term 'one' is used as a generic statement – 'one shouldn't treat people that way' – and also as if she was telling me off for seriously mistreating her because of my racist views. I also noticed that at the end of a session, after shouting, she would often say 'thank you' in quite a different tone of voice as if genuinely thanking me for listening.

However, for a while I could not make use of the observation that there was a change in tone of voice from accusation to gratitude as I was taken up with the gradual realization that I was one of these white people, in fact, perhaps *the one*, who was perceived to be depriving her of her rights and 'snobbing' her. It took a while for me to realize that this was probably so and I think the main reason was because the image of these racists was so extreme that I could not recognize myself – 'she couldn't possibly be talking about me' was my thought. This is not good analytic thinking, I know, but that is how it was.

When I realized that I was very probably the person perceived to be 'snobbing' her, I said '*you* think I'm snobbing you' and linked this belief with

the gap between the sessions which had made her feel that I had completely forgotten her because she was not white like me. She responded by looking astonished and said in a calm, kindly, matter-of-fact tone, 'I don't mean you – you're not like that', and added, 'I'm not talking about you – I know you do your best for me and want to help me'.

We had a few sessions like this where I was sure I was accurately recognizing that in the negative transference I was a figure who thought herself to be racially superior to the patient and thought the patient deserved only second-class treatment. Nevertheless, the patient never agreed with my transference interpretations. Instead, she always made it clear that she did not see me that way. However, some seconds later there would seem to be a confirmation of my interpretation in that there would be further announcements in an aggrieved voice about very terrible behaviour being meted out. I kept trying to understand this duality. In my conceptual thinking, I had only recently begun to see whether the concept of internal cohabitation could help make more sense of these two very different perceptions of and reactions to me and the two very different ways of talking to me. I began to conceptualize that there was a patient who did not experience me as racist while there was someone else who lived in her head with her who was convinced that I was racist and saw her as an inferior 'black creature' who deserved no rights and that she was, understandably, outraged about this. I began to contemplate the possibility that when I said '*you* think I'm snobbing you', the patient (the sane one) naturally assumed I was referring to her and not to someone else in her head and was thus surprised that I would think this of her because she was quite clear that I was not racist – I might be a bit slow and stupid (!) but was not racist. Thus, I began to speak to the patient about someone else who lived in her head with her and was separate from her.

Working this way was particularly helpful during a session when the patient reported going on a skiing holiday and having unexpectedly to share a room with a black Afro-Caribbean girl. She experienced this girl as 'intrusive' and assumed that the organizers had put them together because they thought they were the same. She reported feeling insulted by this assumption and had asked for a room on her own. There was a lot of aggrieved talk about it being wrong to impose on people – 'who are you to impose'. After some period of reflection I said to her,

> I think you are telling me about the other one who lives in your head with you who felt certain that she had been seen as the same as the black girl and had felt insulted by this. I think you are confident that I am pleased to see you again after your holiday but I think the other one has a different view from you and assumes that I feel insulted to be in the same room as her because I'm white and this belief understandably makes her feel that this is an unfair imposition of very wrong views and she feels she has to protest.

The hostility disappeared from the patient's eyes and voice and she laughed and said 'I did really want to be friends with her – she seemed quite a nice girl

really and I didn't want to be awful to her but ...' (and the tone changed back again) and there was a reassertion of the view that people take away her rights and impose unfair injustices on her.

Thus, the patient understood me and indicated that she was not racist and did not see me as racist, but the other self quickly intervened and reiterated her usual views. We were then able to explore how quickly left out the other one felt when Ms H and I could communicate and how this led to a reassertion of that one's belief in having been relegated to an inferior position and the unfairness of this.

Much of the psychotherapeutic work from then on focused on examining the occasions when the patient's perception of me as a benign figure who was concerned to understand and help her changed to someone whose only interest was to make her realize, signalled through the operation of certain gestures or sounds, that I was a superior white person who thought that, as a black person, she was beneath me. The exploration was never easy because the cohabitant always suspected that I was trying to change her so that she would not protest but put up with racial injustice.

Nevertheless, the recognition that she was not the same as this internal other mind helped Ms H to engage in the therapeutic process instead of remaining in an aggrieved position throughout a session. Thus, we could work out, for example, that some very disturbed behaviour in a hostel during a break – shouting and fighting the other residents – occurred because the other person in her head felt so deprived and abandoned by my going away. She was so sure I had dropped her because she was black and worth nothing that a girl, sucking her teeth, was immediately perceived to be cruelly commenting on her deprived status from birth. When I interpreted this she was able to talk appropriately about her early sad experiences with her mother, who seemed to prefer her younger sister.

On another occasion she started a session by saying,

> I get disturbed by people sneezing and coughing. There is a part that thinks people are sneering at me and that this has to do with inferiority and superiority but it's unfair of me to shout at someone for coughing when they really had a cough and were not sneering at me – they must be amazed.

She then added, 'I don't like shouting – I feel guilty and ashamed'. Although she called the internal cohabitant a part of her, she was actually recognizing that there was an internal other that was different from herself and took her over when convinced that someone had been sneering at her.

Of course, I could not know to what extent the patient's reporting of racist insults outside of the consulting room represented an accurate perception or a misunderstanding. Both could have been true. Even though it was emotionally and intellectually difficult, it seemed to me that the best help I could give the patient was to help her differentiate her views from those of the other internal person in the consulting room, which also involved monitoring and

containing the intrusion of any racist views from the psychotic other in my head.

4. Ms L: I now want to present some of my work with another patient who came to England from Eastern Europe when she was 24. She said she had come to England to study and, because she felt lonely and disoriented away from home, had married a Scotsman rather precipitately whom she subsequently divorced when he turned out to be an alcoholic. Ms L became very depressed after this and found it hard to continue her studies and was referred for psychotherapy. She was then 27. She felt very cut off from her family, partly because the upheavals in that part of the world made communication difficult and partly because she could not bear her parents to know what a 'total failure' she was. There was a recurring belief that she had no future, was doomed to fail at everything she attempted and that no one could be trusted. She said she had only felt like this since coming to England.

She was clearly a very troubled young woman and elicited my concern. In the assessment sessions there was evidence of racist ideas which, at first, I did not want to register as they made me feel uncomfortable. I could hear that she was in the grip of a belief that, as a foreigner, she was near the bottom of a hierarchy and that black and Asian people living in this country were also seen as foreigners who were even further below in the hierarchy. She mentioned that she was working with Indians in a supermarket and said: 'I'm not racist ... it's just that I don't belong there, I should be studying.' Later she said that her GP was an Indian and couldn't understand her. She also referred disparagingly to refugees being like 'peasants' and there were references to black and Asian people working in the local council whom she said 'don't speak well and they wear Indian clothes'. She said she would prefer to work with 'British people'. She became tearful and said 'there are many barriers here, it makes me want to give up. I feel so stupid, so down, I haven't got a brain any more. There is no place for me in this country. I know British people don't like foreigners.'

I was aware of strong internal reactions which included internal advice that I should correct and criticize her racist ideas or explain that I was not British but Australian! When I had processed these reactions I said that it seemed as though she did not think of herself as a racist but kept finding there were racist ideas in her head that she feared I might share and, thus, that I would think of her as a foreigner and say she had no place in this country and would not offer to help her as I would only want to give help to a British person, even though she was very troubled and needed help. I suggested that this belief frightened her and made her want to claim that she was very different from the black and Asian people who also lived here. She looked surprised and then cried and said 'I do think you wouldn't want to help me'. A bit later she thought perhaps her Indian GP had been helpful.

She was so dominated by paranoid and nihilistic thoughts that after the second assessment I referred her for an emergency appointment to a psychiatrist and gave her another appointment to see me. She accepted the referral to

a psychiatrist and did not keep her appointment with me. A few months later, however, she was referred back to me with the suggestion that she was less depressed and needed psychotherapy now and not medication.

She apologized for not keeping her previous appointment with me. She said the psychiatrist did not think she had any problems and seemed to be laughing at her (I knew he was white and English). We explored why she had not come and she thought at first it was because she had fallen in love and everything would be all right. But then she thought it was because I would not want to see her as she had become 'a very nasty person – I say such nasty things'. She also felt she had let her parents down – 'they expected me to grow up, get a job, get married and have children'. She had been pretending things were OK, but now she had let them know she had been depressed she felt they were judging her – 'I can't go back to my country because I'm a failure'. She also said: 'It's impossible to come here and be a first-class person.' I commented that it seemed that she felt she could tell me about her worries and fears of having failed because she thought I would be interested to understand and help her but then she got advice in her head that informed her that I was either laughing at her or judging her and that she had to be a first-class person to be accepted by me. She responded by speaking about an older sister who understands her and would never reject her. But then there was an announcement that she did not need help from anyone – 'I don't need anyone. I can be successful all on my own.' I said I thought that, having felt she could get understanding and acceptance from me, as with her sister, she was now being advised internally that she did not need me.

At the end of this meeting we agreed to meet twice a week. By this time L was living with a young man, N, a Muslim from an Arab country who had come over to study some years earlier but had drifted into working in a hotel. They had fallen in love with each other. Although she felt very happy about this, she knew that all was not well internally and was pleased to have an offer of psychotherapy, although there was a belief that it was doomed to fail, like everything else. Also, there was a hint that she was feeling pressured to defend her choice of N against some inner disapproval projected on to me because she said, somewhat imploringly, that he was not a practising Muslim, was westernized and not very dark skinned.

Soon after commencing therapy she became pregnant and was determined to keep the baby. Not long after this she and N decided to get married quickly on the advice of a solicitor so that the Home Office might reconsider their decision to deport him as his visa had run out. It took 18 months of agonized waiting before the Home Office made a decision that he could stay. While she was pregnant N was very supportive – buying baby clothes, preparing the flat and so on. After the birth he did not involve himself directly in looking after the baby but returned to studying while working in the evenings.

Once they got married the other person who had previously been criticizing L relentlessly then turned on N. L experienced the other person's views as an inner voice that was unstoppable. According to the other person, N could

do nothing right, although the impression I got from L was that he tried very hard to look after her and make plans for their future and she would say tearfully how awful it must be for him to listen to the nasty things she said. For example, while pregnant she got a job in a clothes shop as an assistant and when he would suggest that he came by to take her home she would say no because she did not want the others in the shop to see to whom she was married. She reported that he was hurt and would say 'you should be proud of me'. When he got into difficulties at work she supported and admired him for standing up for his principles while the other person declared that he was useless as a breadwinner.

For a long time she could not bring herself to tell her parents about her situation. She was convinced that they would think she had gone mad to have married a Muslim. Obviously there were some external realities to this situation as people in her country were at war with Muslims. It was her mother she was particularly worried about as she would be critical and non-understanding. She thought her father and siblings would accept her, although when she listened to the other person in her head she believed she had let them down too. She particularly worried about her baby having a brown skin because over there it would not be acceptable, unlike in London.

A view of a very hierarchical world unfolded which we began to map out as belonging to the other one who was the internal cohabitant of her body. In this world white British people were on top and black and Asian people at the bottom. In this hierarchical world I was seen as white British and in full agreement with these views, which I found disturbing and would have to think out carefully how to respond analytically so that I was not pushed internally by the ill adviser in my head to deny, criticize or collude with such a belief. Also, there was a view that really L belonged with the white British – that is, with me (and I would often experience an intense internal pressure either to criticize this belief or collude with it) – but the belief in hierarchical dominance also made this impossible – 'you can't be first class in this country'. There was a terror at being seen to be at the bottom of the hierarchy – 'a total outcast' – and this belief seemed to fuel an insistence that really she was superior to people from black and Asian ethnic groups. We came to identify these views as the other person's. By this time we were calling the other one in her head 'the other person' or 'the internal adviser' and came to observe that it was under pressure from this other mind that L said things she later felt were nasty. L sometimes referred to the other mind as the 'negative person'. Recurringly, L would be internally advised that I did not accept her as an equal human being, disapproved of her for marrying N and that I only put up with her on sufferance. Whenever she was late there would be a desperate apology and panic that I would be angry and tell her to go home.

Eventually L did tell her parents – by telephone – that she was married and that she had a baby boy, F. Only some weeks later could she manage to tell

them that N was a Muslim from an Arab country. Father had seemed accepting but she was not sure about her mother.

About six months after F's birth L's mother arrived and stayed for a month. I was given a description of how the mother could not stop complaining about the size of the flat and the poor provision made by N for his wife and child. She would not talk to him and made openly critical comments in front of him, although in her own language. She thought he was dirty and beneath her daughter – she criticized L for marrying him. L found she could not defend him or her choice of him. She began to join her mother in criticizing N and believing that she 'should have married a blond man from home who earned a lot of money or, at least, was an Englishman or a Scandinavian' – then she could be proud of her husband instead of ashamed. However, there would be a switch in the sessions from an expression of contempt for N to tearful sympathy for him as to how awful it must be when she and her mother looked down on him. She would then describe her mother as 'self-centred and insensitive'. Then, under the influence of the internal other person, a diatribe against N would re-emerge and L would feel guilty for having these views. I said that I thought she, the patient, felt hurt and crushed at having her choice of husband criticized, not only by her mother, but by the internal adviser who fully agreed with mother's racist views and also informed her that I, too, believed she had married beneath her and was now permanently inferior because of this.

These issues were explored many times – both during mother's stay and after she left. Sometimes this resulted in L expressing tears of sympathy for N and herself as she recognized some of the real pressures they were under – small flat, young baby, marrying prematurely, coming from different cultural backgrounds, low income, no family support and dependence on the Home Office to make a decision about their future. At other times it led to a recognition that as soon as L felt more sympathetically linked up with N at home or in the therapy session and/or experienced herself as linked up with me in being able to explore and understand these issues the other person would jump in and make denigratory comments about N and announce that she and F did not need him, that he was useless as a father and she was going far away to a new country. Often L thought these were her views and would later feel guilty and puzzled. We gradually worked out that the other person reasserted herself at these points because she felt painfully excluded from the relationship both with N and with me, that is, from L's key partnerships, and wanted to leave permanently. L became clearer that the other person was the one who made racist comments about N and others and did so when she believed she was hatefully excluded from L's relationships and seen as a worthless, total failure at the bottom of the hierarchy. We worked out that this one expected always to be condemned and judged as nasty, cruel and insensitive rather than have her mind and motives understood.

Concluding comments

Racist issues require the same approach as other issues in analytic work – namely, working in the transference and countertransference, being aware of contexts past and present and recognizing the defining characteristics of psychotic views expressed by the patient or therapist. However, because the emergence of racist material in the consulting room can be highly disturbing for both patient and therapist, the latter can give way to an internal pressure to give up being analytical and then many opportunities for deeper understanding are lost.

In this article I have described some of the ways in which I found the concept of internal cohabitation useful for exploring racist issues in the transference and countertransference that have occurred with some of my patients. It provided a framework for identifying and exploring the racist views of the psychotic personality internally cohabiting with the patient and the belief that I, as therapist, held racist views towards the patient. Such an exploration enabled patients to differentiate the psychotic views of their internal cohabitant in and outside the consulting room and thus to recognize when they were not in agreement with them. This sometimes enabled a patient to recognize the madness and cruelty of the psychotically based racist thoughts held by the internal cohabitant, and also to have some understanding of how truly frightening it is for that self, with its paranoid and all-or-nothing mentality, to live in a world that is perceived to be permanently hierarchical – because if you are not on top you are on the bottom. Through the process of differentiating themselves from the ill other mind, patients were enabled to gain some understanding that the trigger for the expression of racist views, or the belief that I was racist, was often a perception by the internal cohabitant of being painfully excluded from those relationships of the patient's where a working partnership had been established.

The concept of internal cohabitation also helped me to recognize that there was a cohabitant or psychotic self who lived with me internally who, if not permanently monitored, could undermine my analytic work with patients. Without this concept I might have, under the unrecognized influence of this other person in my head, either avoided racist issues altogether, assumed I was free of internal racism, been judgmental and critical of racist attitudes in my patients, colluded with the invitation to express a racist view or lost my way completely and given up analysing.

In conclusion, I have found the concept of internal cohabitation particularly useful because it provides a framework for acknowledging the coexistence in both patient and psychotherapist of racist and non-racist attitudes and capacities.

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Some reflections on the supervisory container in work with perversion

MARGARET HAMMOND

ABSTRACT

In this clinical article, I explore the experience of supervision in my early work with a patient who exhibited perverse splitting mechanisms. I describe how the supervisory relationship provided a container within which I could access the feelings that were being split off in the transference. I explore how I was helped to integrate these affects in myself through supervision, and was gradually able to experience them with my patient, enabling her to begin the difficult work of integration.

Key words container, perversion, space, supervision, vacuum, dismantled.

RIDDLE: Q. When is a space not a space?
A. When it's a vacuum.

I decided to write this article when, as a qualified Jungian analyst of just three years' standing, I was coming to the end of a period of regular supervision. This ending was not totally of my choosing, and I found myself experiencing strong feelings of resistance and loss. I was interested that the feelings were all to do with one patient in particular. This observation has led to me to think further about the specific function of supervision in relation to my work with this patient, whom I shall call S. In this article, I shall draw on ideas from Freudian, Kleinian and Jungian theorists.

There is much in the analytic literature about supervision for training purposes, but I have found little written about supervision of specific cases. H.F. Searles, in his seminal article of 1955, 'The Informational Value of the Supervisor's Emotional Experience', introduced the idea of the Reflection Process, which is how he described the process by which unconscious feelings are transmitted from the patient to the therapist and then to the supervisor in this parallel relationship, where they can be made conscious and so transformed

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into thought. In this article, he included examples from his own experience of supervision to illustrate his theme. Janet Mattinson extended this idea in 1975 when she published *The Reflection Process in Casework Supervision*, and Hugh Gee referred to the process in 1996, in an article in the Journal of Analytical Psychology. Hugh Gee substitutes the word 'resonance' for 'reflection', to emphasize that emotions experienced by the supervisor are in response to the process both of the therapy and of the supervision, rather than in parallel to those processes. So, in ending my supervision, I was bringing to a close a relationship that had not only resonated with my therapeutic relationship with S but had provided a container for that relationship, and for myself within it. I had a strong sense of having had a safe space, and, in realizing that, as we began to contemplate the ending, I had a clearer awareness of the vacuum within my patient, from which supervision had helped me to extricate myself, and begin to understand it more fully. I had needed a space in which to explore a vacuum.

Definitions

Before I introduce S I want to consider some definitions of perversion. Much has been written on this subject and many definitions proffered. My patient presented with the wish to sort out her sexuality, whether or not she was lesbian, as she actively pursued sexual relations with both sexes. However, the term perversion, in this context, has nothing to do with homosexuality, but more to do with her quality of relating. I have selected three definitions. Robert Stoller (1985: 3–43) says: 'Perversion is the erotic form of hatred.' For him, a sense of sin is essential to perversion, for it involves the desire to hurt, harm or humiliate the sex object, the self or, in fact, both. The hostility in perversion takes form in a fantasy of revenge hidden in the actions that make up the perversion, and seeks to convert childhood trauma to adult triumph. Barry Proner (1988) puts a similar idea into more Jungian language, saying that perversion represents an unconscious determination not to combine opposites, and to work against any good internal connections. For him, the unconscious intention is to damage, and that can include damage to the self and the individuation process. Perversion is a feature of the shadow. However, with my patient, the activities and feelings that make up the perverse behaviour sometimes appear as a wish for a good connection, although doomed to failure, because of her compulsion to control the other. Joyce McDougall (1995: 183–214),while acknowledging a defiant element in perversity and addictive behaviour – a defiance against internal parental imagos – emphasizes that this constellation can be seen as an attempt at self-cure. The patient has devised a way to avoid unbearable psychic suffering, and has, through careful control of others, constructed an environment designed to try to repair narcissistic damage, and also to deflect the forces of infantile rage from being turned back against the self or against internal parent representations. In my work with S I was readily in touch with Joyce McDougall's formulation,

especially as, with me, S was consciously striving to construct a repairing environment (from which she thought the perversity could be kept out) to protect us both from the forces of infantile rage. It was only when I myself was contained in supervision that I could get in touch, in any more than an intellectual way, with the unconscious hostility and the wish to damage, and so gain access to the perverse system.

History of S

Reconstructing from my experience of S in the analysis, I suspect that she was extremely close to her mother for the first 18 months of her life, and that the first betrayal was the arrival of her sister. Family legend says she tried to hit her with her potty! So much of her adult behaviour has been designed to reproduce an infantile fusion, as if that state had been abruptly and unbearably terminated. There was an obvious rupture, when her parents went through an acrimonious divorce while she was still small. They both remarried and the family split up. She had to live with her mother, although by that time her strong attachment was to her father. It seems that in the face of this disruption, she was left struggling to cope without support with overwhelming jealousy, striving in her mind to find ways to control the people around her, to rescue herself from an arid no-man's land in which she feared she would perish. Early on, she explained to me that, in her world, no one loved anyone. She didn't know how she would recognize such a feeling. As a child she imagined herself an alien, being tested to discover the limits of her endurance, and sat all alone at school, wishing fervently that her father would die, to release her from the pain of not being with him.

In the early therapy, when she came twice a week I learnt of her many sexual relationships, with men and women. With men, she was very critical, but at the same time terrified of their power. With women, she engaged in highly sensual relationships with women she despised. This gave her control because, in her mind, they were lucky to have her. She could then regress to an infant state, actually suckling from their breasts, confident that they would not abandon her. However, this behaviour also controlled her, because her partner became the container for a despised infantile part of her from which she could not separate. Once set in motion, the system quickly disintegrated because it was too claustrophobic, and the partners were despised anyway. There were constant partings accompanied by tremendous rage, or sensual reunions until someone broke away and paired with another.

I was aware of a maelstrom in action in the world of my patient, but in the room with me she was struggling to build a nest, which she literally did by snuggling into the rug. I felt very engaged by her. I was moved by her tears, I felt bereft if she didn't come, and wrote copious notes, struggling to contain and understand something very elusive. I was in some state of unconscious identification with my patient, which left me struggling to get control, as she

did, and to use my mind, through the notes, to master something uncomfortable. I thought at the time that she had formed a good attachment and had regressed rather quickly to an infantile level. I now think it was more like a state of 'illusory oneness', as outlined by Masud Khan (1989: 20–30). He describes a technique of intimacy, a make-believe situation in which two individuals renounce separate identities and boundaries to produce a heightened sense of intimacy. This corresponds to the technique described by S in her sexual encounters with women, and perhaps it was present too in the analytic frame. Khan says that the unconscious requirement is that the other person shouldn't have any needs themselves, but be entirely devoted to the narcissistic requirements of the subject, a situation readily re-enacted early in therapy.

Our illusory oneness received its first blow when I charged S for a holiday she took within the analytic term. She was so disturbed that she nearly withdrew from therapy. On that holiday she had a dream:

> I am in a huge house where murders are being committed. My parents are there, and we are searching for the murderer in the dark. There are lots of boxes. I have a little torch, and I am with a woman. Then, it's morning, and I am relieved to have survived the night. There is a Punch figure on the bed, who I know is connected with the murder. Then, the woman turns out to be the murderer, and lays about her with a meat cleaver. I wake terrified.

I felt we were searching for a murderer in the dark, an internal murderer, who violently attacked my patient, but there was also a trickster about, in Mr Punch. There seemed to be terror felt by part of her, that if I wasn't in a state of identification with her, I might turn out to be murderous.

The supervisory triangle

She began to come three times a week 18 months into her therapy, and at that point I began regular supervision, a time lapse which, as it happened, corresponded to the period between her birth and that of her sister. I was bringing a third person, a man, into the therapy at the precise time that I think she turned away from her mother to her father.

I want to digress at this point to consider two ideas about triangles, one Jungian and one Kleinian. I will start with the Jungian idea of Coniunctio. Jung described how the human psyche has an archetypal inbuilt propensity for relating, which he called the coniunctio. This concept embraces many relationships, including male and female, parent and child, self and ego, light and shadow. Coniunctio requires two separate subjects who come together and produce a third, the triangle. This third may be an actual baby, but it may also be a growing child, a strengthened ego, an advance towards individuation. It is a model for growth of the psyche. In the internal world of my patient, the process of coniunctio has been so damaged that she has had to contrive it herself. In her mind, the parental coniunctio is broken, with no creative holding

for her baby self. The link between male and female is highly confused, an infantile part of herself has been petrified, in both senses of the word, and her ego has been weakened by many vertical splits. By taking my patient to supervision, I was establishing a possibility for an undamaged coniunctio, in a supervisory relationship that would resonate with the analytic one, so the dislocations could be felt and explored.

Ronald Britton describes something similar from a Kleinian stance. He writes (1989: 87), 'The primal family triangle provides the child with two links connecting him separately with each parent, and confronts him with the link between them which excludes him'. Britton starts with the assumption that the parental coniunctio is in place, and has produced the child. He describes how the child will have fantasies of love and hate connected with this relationship and his exclusion from it, and goes on: 'If the link between the parents perceived in love and hate can be tolerated in the child's mind, it provides him with a prototype for a relationship of a third kind, in which he is not a participant' (1989: 87). Britton is describing a process whereby the growing child develops a capacity for thinking based on a situation of containment, in which love and hate can be managed. The child learns to tolerate exclusion without feeling total disconnection. There is a flexible container where powerful feelings can be moderated. My patient grew up in an atmosphere of severed links, where hate regularly overcame love, and where the only possibility for relationship was to surrender the self to the other. There was no safe space for thinking, and the linking that thought can create. In hindsight, I think it was my unconscious identification in this area that made supervision so valuable. By establishing a supervisory triangle, I was opening our dyad to objective thought provided by a third person, with the possibility for cooperation between these symbolic parents, and by so doing was establishing a link between thinking and experience, and producing a three-dimensional psychic space in which to try to understand my patient's difficulties.

Supervision and sexuality

The importance of this other space is illustrated by our work with sexuality. My supervisor was male, which provided a male–female dynamic in the analysis of this highly sexual woman. It was very helpful not only to hear a male viewpoint but also to experience a masculine element, when the gay female sexuality became excessively charged emotionally. I struggled to understand the sexual elements of the transference. S was adamant that there weren't any, and there mustn't be any, because that would spoil everything. She talked to me about her sexual activities, but with extreme embarrassment. It really was as if there were two separate S's, one promiscuous and free speaking, and the other coy and inhibited. I was reluctant to question her much on her sexual life, because it felt so intrusive. However, this was difficult, because it was also so central to what she was telling me. I analysed the discomfort and we talked

about the reasons, but nothing changed. S still spoke of the part of her that she couldn't bear to let me see. We puzzled about this in supervision, and I was often aware of an excited atmosphere pervading our discussions. Because of the nature of the material I was bringing, my supervisor suggested that I read The Story of O, a story of sadomasochism and a perverse attempt to realize the self by obliterating it. This book I found both erotic and disturbing, but it seemed that, in reading it, I had gone beyond the fantasies that S was struggling to tell me. Something changed in me, and the very next session she was able to be more explicit. She was also able to tell me of her fear, which was apparently reinforced by all her girlfriends, that I was getting aroused by her material. This was both a fear, and a hope: a fear because it would make me like so many other woman in her life, and a hope because it would give her the longed-for control. Actually, I was not in touch with any excitement in the session. It seemed that the only place I could get in touch with that feeling was in supervision. In the session I was reacting to part of the transference, rather than experiencing and interpreting it. The capacity of my supervisor to allow the excitement seems to have engendered a feeling of safety in me.

Supervision and the bill

The first big drama of the therapy erupted between S and me three months into the supervision. To assist her in coming three times a week, S had enlisted her father to help with the payment. I was uncomfortable with this, and did not believe that she could not pay, because she had a well-paid job. I understood that this came from a regressive wish to be Daddy's little girl, and also from her strong feeling that he had damaged her, so he owed her money for therapy. I had analysed these motivations, but to no avail. Also, I now think, affected by the state of illusory oneness, I really wanted S to come to three-times-a-week analysis, and had been reluctant to challenge this in case she should change her mind. However, I was very discomfited when she arrived in September, at the start of the three-times-a-week therapy, saying that her father had agreed to pay for all of it, and that he would make the cheque out to me directly. I felt trapped, angry and incompetent.

I questioned this arrangement with S but she was unwilling to think about it. She was delighted that, at last, her beloved Daddy was showing his love for her by paying the money. I think there was an idea that he would approve of me if she did, and that, in her mind, this was some way of bringing the parents together. She seemed oblivious to the drawbacks. The first month the cheque arrived on time, the second month father lost the bill, and the third month the money did not arrive. I felt extremely angry. I challenged S, who was, by now, uncomfortable about the effect this was having on our relationship. We discussed her taking over payment of the bill or, at least, that any arrangement she had with her father could be between them, with the cheque made out to her. The result was that I received a letter from father, saying that S had

reported this discussion and asking my advice.

Although the tone of the letter was constructive and concerned, I was faced with a dilemma. It would feel collusive not to tell S of this letter, but I felt angry with her for engineering the situation and angry with myself for not challenging it earlier. I did decide to tell her of the letter, and to let her know what I said in my reply to father. She was beside herself with rage. She was furious with her father for treating her like a child by writing to me above her head, but also aware that she had implicitly encouraged this. She was furious with me for having received the letter, as if I was cooperating in the infantilization, and because I insisted on talking about money when she did not want to. On the one hand, it seemed that she unconsciously sought to control me through her father, who was to express all her negative feelings towards me and analysis. On the other hand, by assuming that he was refusing to pay, she experienced him as rejecting her, and she wanted to retaliate by cutting herself off from him. In her mind, she was back between the fighting parents, having thought she had controlled me and seduced father. I had a vivid experience of life between mother and father in that third place, when I spent an uncomfortable weekend, convinced that I had committed a huge error by answering the letter. I felt isolated and exposed, as did she. In hindsight, I think S could not tolerate the fact that she had no control over the actual getting together of father and myself, as a symbolic mother, by the exchange of letters. It felt intolerable to her to be an outsider. For my part, it felt essential that I had my own 'partner', my own third, where my part in this collusion could be reflected on and my own catastrophic anxieties could be digested and transformed into thoughts.

Supervision and attacks in the dark

After this episode, instead of the rage becoming more integrated, the feeling was again cut off and housed elsewhere. S launched herself into a new lesbian relationship, again with a woman she found most unattractive. This relationship she described as being in never-land. She talked of feeling enclosed, in a dark place, which was desperately safe, but which would lead to her extinction. She could only get out by causing great damage, to herself or her friend. It was as if she really did hide herself away from the storm in a womb or claustrum. However, inside that place, she expressed her aggression by behaving like a capricious demanding sexy baby, which her partner welcomed as part of the performance. She was indulged, acting out the infantilization that had been apparently so abhorrent coming from father. Now all her hostility to therapy was expressed through the words of her girlfriend, who said it was too much, too long, and I was the wrong person. I imagine the three of us were in the system where one parent was always criticized through the words of the other. Although I knew, intellectually, that this was my patient's way of attacking me, I just did not feel attacked. In a chapter called 'Perversions of

the Transference' in *Sexual States of Mind*, Donald Meltzer (1973: 138) talks about the split object that can produce 'a vulnerability to the seduction of mutual idealisation in the maternal counter-transference'. It was as if there was one kind of never-land with me, an intellectual idealization, where I could dimly see an attack going on but could not relate to it emotionally. The other never-land was a highly emotional one with the partner, where doubtless my patient encouraged the criticism of me, thereby finding a container for her own dissociated feelings. I was kept in a place that was, in my patient's terms, inside enough to keep me attached to her, and outside enough for me to act as a container for the hated outsider feelings. I was stuck. I did interpret the hostility, but words were ineffective until I could feel it. This eventually happened in supervision.

My supervisor had been regularly talking about ambivalence and hostility in my patient, which had flared in the matter of the bill but was now cut off. This went on until, a little before the summer break, I suddenly got in touch with the attack, not from my patient, but, it felt, from my supervisor. I felt that my patient's efforts were being misunderstood, that my understanding was being undermined, and I became defensive and hostile. Then, finally, light dawned. It was as if the feelings about me that S was trying to contain in her relationship with her girlfriend could be felt by me only in my parallel relationship with my supervisor. There, away from her defensive system, I could, in Britton's terms, 'manage to listen to another point of view, while hanging on to my own'(p.87), thus tolerating the love and the hate that she was splitting up. In Jungian terms, I had been able to let the opposites come together in me and gained an insight that, in turn, initiated a process in my patient. Gradually S is learning to own her own attacks and beginning to tolerate some ambivalence.

Supervision and projective identification

With the support provided for me in supervision, I was beginning to let go of my mental holding of this patient and open myself to her affects. I would, in fact, let the analysis become the container. With S this was very difficult. I think she had no expectation of being related to or held, except by what she produced through her own control. Therefore, in a way, she held herself together with her own kind of thinking, and pulled in partners, who sometimes felt like collaborators, to contain the feelings or parts of herself through projective identification that she couldn't manage. In this atmosphere, it seemed vital that I should speak from real feelings, but it was particularly hard to capture what those feelings were. It was as if I, too, needed a partner who could contain and identify those split-off aspects that had crept into me unnoticed and who could help me get in touch with myself in relation to her, by returning my projections to me. Meanwhile, S filled the sessions with a huge cast of characters, all of whom played some part in her drama. I felt

marginalized, but to interpret the transference seemed narcissistic, as if I had a compulsion to push myself in too. This confused and crowded feeling was especially strong after a weekend break.

At this time she started a new job involving more travelling. This disrupted the analytic sessions, and although I was prepared to be flexible, I also acknowledged the importance of a stable container. I found myself agreeing to change, and then feeling guilty about it, in relation to what my supervisor might think. I realized that I was behaving like S, who would project into me a disapproving superego figure when telling me of the latest sexual encounter. It seemed I had set up my supervisor as a stern, disapproving father, so I could play the kind, flexible mother. My supervisor suggested that I was wanting to keep in tune with S, in order to avoid her despair. By behaving as if I had no limits to what I could offer, a kind of triumph against parental boundaries, I was avoiding facing the despair associated with the loss of the Oedipal illusion. This insight has enabled me, and gradually S, to take in the enormity of this despair and its all-pervasive quality. It also started me thinking about the need to integrate father and mother, with qualities of both justice and mercy.

I have also learned to think of my feeling of guilt as a possible indication of a perversion going on under the surface. In our discussions about rescheduling, S was able to tell me what goes on in her mind. On one occasion, she had been particularly anxious, really hoping that I could find another time. She asked, and we arranged one. However, as soon as I offered something, she accepted it, and it was as if it vanished. She changed the subject instantly, and began to strongly criticize a male friend, calling him a 'lonely git'. I had a picture of a much-wanted gift being hoarded away, almost out of mind. We talked about this next session, and I learned that she told herself that I liked the change – it was to a 7.30am appointment – but she would have to get up too early. She also described how I had seemed too ready to offer her something, and then she wanted to ask for more, to see how far she could push me, to see how weak I was, and what I would do to keep her. Perhaps I was now the 'lonely git'. I felt duped, but I also understood more how the perversion was operating in the transference. I needed a stern, disapproving father aspect in myself to cope with this, and it was as if my patient knew it.

Supervision and faulty splitting

This last example illustrates the confusion between good and bad that I experienced when working with this patient. I introduced ideas of sin and the intention to damage in the definitions at the beginning of this article. Here I was really seeing how my wish to safeguard her three-times-a-week analysis, in the face of some difficulty from outside circumstances, was both valued by her as precious, because she did talk about this, but also attacked as weak. I had to consider that I was being pressured to act out a part of her self rather than analyse it. John Steiner (1993: 113) explores what he calls faulty splitting. He

describes a situation in infancy where psychological splitting for the protection of the infant ego does not occur along a natural line of cleavage, but is more like a piece of salami sliced by a knife. Good and bad parts are on both sides, glued by the perversion. Jung speaks of the Archetype of the Mother, with positive and negative poles. In my work with S both aspects were present, in a symbiotic way. She had a capacity to transform good into bad in her mind, by interpreting my responsiveness to her as solely the result of her control, thus turning the nurturing mother into a weak or self-seeking one. The good and bad aspects remained undifferentiated. Her infancy and childhood were so confusing that it seems there was no one who was consistent enough to help her mediate these opposites, or even recognize the difference between them. Again, this was work I needed to do for both of us in supervision.

Fate of the object and supervision

I began to wonder what was happening to 'me' inside my patient, observing that whenever something happened between us that carried enormous affect, it seemed almost instantly cut off. Donald Meltzer (1973: 106) talks of dismantled objects, in relation to the structure of the internal relationship within which perverse sexual activity takes place. I think these structures are also relevant to the way that the analyst is used by the patient. For Meltzer, objects of sexual excitement are dismantled objects as distinct from part objects. The point is, they can be immediately reconstituted when desired. Ordinary splitting incurs damage to the object, and repair work must be done before it can be reassembled. I have seen something like this in operation regularly, with the splitting up then reconnecting, which is such a feature of S's complicated relationships. 'The original dismantling', says Meltzer (1973: 106), 'may have been to protect the object, to assemble it later'. This may have been S's way of protecting her father from her rage. However, the dismantled object degrades into mere sensuality, because it no longer represents the sum of its parts. It becomes a matter of sensation rather than emotion, and, as such, the experience isn't available for introjection, and so no internal change occurs.

In the work with S I have felt regularly dismantled. Before a holiday break, I have had a sense of being dismantled before I departed. She has often come to a last session totally disconnected, hardly in touch with her reason for coming. She has come back after a break, again, unable to remember why I was important to her. I think I am being protected from rage, but it is also the cut-off rage that is in operation. There is no mother, good or bad, because she might produce overwhelming affects. Then, when back in contact with me, I have a sense of her reconstructing me, desperate for me to say something to touch her, or to engage her mind, as if, from that, she can reassemble what stands for me in her, and maybe reassure herself that she has survived in me.

In supervision, I think I wanted someone who could hold on to me in the face of this dismantling, and be sensitive to my affects, when so much of my energy was going on apparently holding on to her and our relationship. In reaction to this dismantling, I experienced a strong loyalty to my supervisor. When I needed to prepare some work to present to a clinical seminar, I was determined that it should not be my work with S. Somehow, it felt that there was so much promiscuity around, that I must keep this relationship between me and my supervisor, and not risk further dismantling. It was as if we were doing some psychological work within a fixed boundary, with the advantages and drawbacks that that incurs, but it was vital work on behalf of my patient, and important that I kept something whole and continuous.

Supervision, change and resistance

I think the work is moving on. My experience in supervision has enabled me to extend the container that I am able to offer my patient, whose experience in analysis is very different from my own. Her relationship with her father has greatly improved. Recently, there have been glimpses of a wish to get closer to her mother, although this brings huge anxiety and pain, with this fear that she will just be 'hurling herself at a brick wall'. I think her relationship with me, with my hopefully 'good enough' internal world, and a 'good enough 'relationship to an external supervisor, is making this possible. However, a pattern is becoming very obvious. As soon as she has what might seem a 'good' experience from someone in her life – her father, occasionally her mother, a friend (usually male) or from me – she has a violent reaction to it, and shoots off into one of her sexual ways of acting out. After a recent constructive telephone call to her mother, she then got in touch with extreme emotional pain from the past, invoked by memories of her mother's rejections. For the next week, she was obsessed by the wish to follow up a relationship with a woman with whom she had a one-night stand. After a session when she had felt particularly held and understood by me, and was able to spend an evening alone in her house, and feel good, she then reacted by contacting many ex-sexual partners, to see if she still had any hold over them. I was thinking how the good experience must be dismantled, in Meltzer's terms, when I came across the work of the Jungian analyst Donald Kalsched and his Self Care System, described in The Inner World of Trauma (1996: 11–40).

Self-care

I began to understand how making links between self and other, and symbolically connecting with good parents, were experienced by a part of S as dangerous, because if she were to trust these links she might expose herself to disappointment and despair. This made sense of the confusions, because so many things to S were good and bad. It helped me understand her dissociations,

and this innocent part of herself that she had to fight to protect through her manipulations. I began to see the perversion as her way of avoiding retraumatization. S would sometimes describe being 'taken over' by a part of herself that would then obsess her, driving her to pull in her 'containers' for sexual activity, when she felt lost, empty and abandoned. She referred to this part as 'the baddie'. I began to see this as the activity of the self, in its capacity as organizer of the psyche, to ensure survival, by excluding all external influences, except when they could be rigorously controlled. Kalsched describes this inner figure as:

> A truly daimonic figure, who would cut her off from her embodied feeling self, in the world, in order to keep her in her persecutory mind, where he would have total control over her unrealised personal spirit. Such is the perverse goal of the self care system, when early trauma has simply broken the heart too many times.

The many dreams of murder and violence seem to substantiate this view. Two years into her therapy, S dreamt: 'I am with a crowd of Arab refugees, struggling along. Men are cutting their heads off at random with great swords. I am terrified.' Perhaps S and I are indeed struggling with a violent inner figure, and the dissociations, the addictions and the despair are not only the outcome of her life experiences, and how she dealt with them, but are also tied up with a primitive archetypal aspect. This would be a dark side of the self, which can't be metabolized and was never grounded or contained in infancy. She talks often of her dark side and, I think, until recently, has tried to protect me from it. The raison d'être of this archetypal aspect is to prevent a good dependent relationship, in which sufficient separateness and space could be tolerated. To achieve this would involve tolerating the pain of separation and loss, which, at present, feels unbearable. This is also linked to my having to tolerate the loss of supervision at this time, and the good relationship that helped me cope with disappointment. I think S voiced something of this before the last break, when I said 'Perhaps you want to take with you a picture of a me who could keep you alive inside me'. She said 'Oh yes!' Then she said, 'but then, I would hope, and that feels very dangerous'. I have understood her perversion as a defence against hope, and how for S that can so readily lead to feelings of despair and disappointment.

The supervision has now ended. The experiences I have described have enabled me to make many connections with my patient, and the three of us have been able to understand a great deal. However, I think we have now encountered the real perversion, this dark side of the self, that has such a powerful hold, setting out to harm, with the illusion of protection, that keeps good at bay, for fear it might lead to betrayal. My task is now to keep in mind my internalized supervision, as a 'self and other' care system, in the face of her system, to manage and understand the disappointments and betrayals that she brings to the transference, and to interpret them in the hope that she may gradually be enabled to cope with such feelings herself.

Conclusions

I have tried to describe how the supervisory relationship, resonating with the analytic relationship, was an essential part of my early work with this patient. It was the nature of the perversion to split the psyche, in order to elicit desired reactions and control the object. This mechanism perverted the transference, so the dissociated affects were available to me only intellectually, not emotionally. These necessary affects surfaced in supervision, where I was then able to experience them and begin to integrate them into the work with my patient. I have illustrated, too, how I was able to bring my unconscious identification with S to supervision, and my projections, which paralleled hers, and how, through the work of owning my own lost parts, I was enabled to do some work on behalf of both of us, which is gradually appearing in the analysis. The fact that my supervisor was male was an important part of the process, connecting up, as it did, male and female, and symbolizing relating parents. I think this reconstituted the Oedipal Triangle, and helped me in my struggle to hold her and my internal parents together, when she unconsciously wished to split or triumph over them. In the psychic space thereby provided, it was possible to actually experience S as well as to think about her, and so deepen our understanding.

My patient has a terrifying emptiness at the centre of her psyche, where she experiences a feeling of total isolation. She struggles to fill this space with part relationships that she can manipulate, to avoid fear and despair. At the same time, she maintains the vacuum by splitting and dismantling good objects – in Meltzer's terms, because to retain them means the loss of triumphant omnipotence, and in Kalsched's terms, because they represent the risk of retraumatization. In supervision, I was held in the mind of my supervisor as was my relationship with my patient. I think this double containment enabled me to contact emotionally the emptiness in S. I had a secure, contained space for thinking, in which it was possible to differentiate between a space and a vacuum, and for some transformation to begin.

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The face of the therapist in psychotherapy practice

FRANCES HOUSE

ABSTRACT

The importance of the face of the mother has been the subject of psychological research into infant–mother interactions as well as infant observations. A responsive face has been shown to contribute to a healthy sense of self and well-being in the infant, whereas an unresponsive face can cause distress and withdrawal. This paper considers this phenomenon from two perspectives: the concept of the Archetypal Mother in Jungian analytical psychology, and the Object Relations school of thought. A preliminary study is then made of the relevance of the therapist's face in the therapeutic encounter. Six respondents were interviewed about their experience, as patients, of the therapist's face and the possible links with their earlier experience of the mother's face. Results of this study suggest that for the majority the face of the therapist was of considerable significance, especially for those whose mothers had been depressed or who presented an unresponsive face during their childhood. These respondents expressed a strong need to have face-to-face contact with the therapist for at least the first year of therapy.

Key words containing holding, mother archetype, mother's face, shame, transference, transformative looking.

Listen to the night
scooping and hollowing out ...
You stars
doesn't the lover's

Frances House was among the first intake to graduate from the MSc programme in the Psychodynamics of Human Development run by the BAP in collaboration with Birkbeck College. This article is an edited version of her dissertation, which was awarded a distinction by the Birkbeck/BAP examination board in November 1999. The full text is available from the author or from the BAP. She is currently a counsellor at the University of Portsmouth and also has a private counselling practice.

delight in his
loved one's countenance
come from you?
Doesn't his secret insight
into her pure face
come from the pure constellations?

(R.M.Rilke, Third 'Duino Elegy')

Introduction

This poem of Rilke's suggests that our fascination with the face of the beloved has an archetypal quality to it, evidence of some generic memory deep in us all. Could it be the face of the archetypal Mother, 'her face of love, once for an endless moment turned on me', as Robert Graves wrote? Perhaps there is here: 'An aura of long-forgotten, and now half-remembered, imagery, the face of the beloved representing elements from pre-verbal memory, when the face of the mother filled the child's world with radiance and adoration' (Wright, 1991: 17).

When writing about archetypal images, such as the face of the Mother, it is sometimes possible to express what we want to say only by using poetic imagery. Jung himself said, when talking about his theory of archetypes, 'nobody but a poet could begin to understand' (quoted by Serrano, 1966: 60).

> Perhaps a baby at the breast does not look at the breast. Looking at the face is more likely to be a feature. What does the baby see there? To get the answer we must draw on our experience with psychoanalytic patients who reach back to very early phenomena and yet who can verbalize, without insulting the delicacy of what is preverbal, unverbalized, and unverbalizable except perhaps in poetry. (Winnicott 1971: 112)

This paper has been inspired by my weekly observation of Charlie, from birth to18 months, for whom his mother's face seemed to be the most beautiful object in his universe:

> His mother then laid Charlie down on his back on a mat on the floor and sat beside him, with her face close to his. He immediately started to gaze at her face. Then began the most lovely 'conversation' between mother and baby. Jane (his mother) rolled her tongue 'rrrrr' inviting Charlie to copy her, which he endeavoured to do, moving his tongue around his mouth, sticking it out, smiling repeatedly at his mother, murmuring 'aaah' in a deep voice and pursing his lips. Jane copied his sounds and his facial expressions and they both seemed completely in tune with each other. This 'love conversation' continued for about ten minutes with Charlie never taking his eyes away from Jane's face. It was as if he was transfixed with delight, as indeed also was his mother. (from my observation of Charlie, aged 8 weeks 5 days)

Casement says 'the child's capacity to light up the mother's face ... is the fundamental basis of self-image and self-esteem' (1990: 93). In studying the recent psychological research into infant development I found this theme repeated:

that it is particularly the responsive face of the mother that contributes to the development of a sense of self in the infant. It seems to confirm what Winnicott (1971) observed some years previously. An infant with an unresponsive mother, 'whose face is frozen by a depressed mood, is forced to perceive, to read her mood at the cost of his own feelings being recognised', writes Phillips in his book on Winnicott (1988: 130). When the baby looks at her, he will see only how *she* feels. Being seen by the mother is being recognized for who one is. The infant cannot risk looking, if looking draws a blank, if he cannot get back something of himself from what he looks at. Thus, Winnicott proposes that what happens in psychotherapy is: 'A long-term giving back to the patient what the patient brings. It is a complex derivative of the face that reflects what is there to be seen' (Winnicott, 1971: 117).

Freud writes that the beginning of analytic treatment consists largely of allowing the transference to develop. Through the transference the therapist can become the recipient of the patient's 'internal objects' that he finds unbearable and therefore unable to contain within himself. The good internal objects can also be projected on to the therapist in the form of idealization, to protect them from contamination by the bad objects inside himself. It is as if the therapist 'holds' or contains all these projected objects on behalf of the patient, making sense of them, until such time as the patient is able to reintegrate them into his own psyche in a bearable form, through the medium of interpretation. The analysis of this transference forms the main body of the therapeutic work. Much of this process takes place at an unconscious level. Put more simply, at the conscious level: 'Every patient approaches an analyst ... with the hope that the analyst will be able to respond to him in a way which was more satisfactory than the parents' (Symington, 1986: 111).

A preliminary study

> I believe there is a gap [in psychoanalytical theory], though not a total one, where the face should be and that taking this gap seriously could bring about a re-balancing of theory that could give the neglected face a greater degree of pre-eminence. Who knows, it might change therapy too? (Wright, 1991: 3)

In thinking about this 'gap' I was interested in exploring the significance of the face and in finding out whether there were any connections between the patient's experience of the therapist's face and his earlier experience of his mother's face. I was also interested in discovering what happens to the patient when lying on the couch, compared with sitting face to face. I wanted particularly to interview people about their experience as patients because there is very little in the literature from their point of view, rather than from that of the therapist, which must be rather different.

For this study I chose to interview six people on the following basis: they were all qualified counsellors or therapists who, I therefore knew, had received therapy; they included both men and women who had had a variety of

therapeutic experience both sitting face to face and on the couch; and they were either currently in therapy or had recently finished, so the experience was still fresh in their minds. For ethical reasons I ensured they all had had therapy with therapists unknown to me. I realized that this would not be a representative sample, but I hoped to show that this could be a worthwhile avenue for research.

The interviews lasted about an hour and were recorded, with the respondent's permission. They were not told in advance what particular connections I was interested in looking at. They were simply told that I was doing a study of the significance of the face of the therapist. The questions fell into two sections. First, I asked about their experience of the therapist's face – for example: What, if any, was the significance of their face? How important was it for you to be looked at by your therapist? How important was it for you to look at your therapist? Did you lie on the couch or sit face to face? If you lay down, at what point in the therapy did this happen and how did you then feel? The second section was a simple question about the respondent's memories of their mother's face as a child. The final question was: Do you think there is any connection between your relationship with the face of your therapist and your mother's face? Lack of space does not permit a full analysis of the findings here, but the main points that emerged will be referred to in the discussion below.

Theoretical background

Jungian archetypal theory

Jung maintained that all the essential psychic characteristics that distinguish us as human beings are with us from birth, as innate predispositions. He called these modes of functioning archetypes, and they come from within the 'collective unconscious' which he believed was common to all human beings, as distinct from the 'personal unconscious'. There are two aspects of the archetype: the biological one, which describes a pattern of behaving but also, as Jung says: 'The picture changes at once when looked at from the inside, that is, from within the realm of the subjective psyche. Here the archetype presents itself as numinous, that is, it appears as an experience of fundamental importance' (Jung, CW 18 para 1228).

Numinous can be defined as 'suffused with a feeling of divinity'. For, as Stevens writes when referring to the 'primal relationship' between mother and child: 'The moment the mother-child dyad is formed, Eros is constellated; and it is out of love, or what Jungians call 'the Eros of relationship', that ego-consciousness, selfhood and personal identity grow' (Stevens, 1982: 13).

Thus, for Jung, we are all born with the Great Mother archetype embedded in our psychic structure, although at an unconscious level. It is experienced as images and, like all archetypes, has a positive and a negative aspect: the Good Mother and the Terrible Mother. Both aspects need to be mediated by the

personal mother, as otherwise they remain in the unconscious as frightening entities. This dual aspect of the mother archetype corresponds to the observation that all children are deeply ambivalent in their feelings and behaviour towards their mothers: she who caresses also slaps; she who gives also withholds; she who grants life may also take it away.

In archetypal theory, the Mother is the prime archetype from which all other archetypes come. Her face is the 'Face of the Other', and creates the pattern for all subsequent relationships with the Other. Her role is as a mediator, a humanizer of the Other for her infant.

'Clearly it is important for the stability of the attachment bond and the health of the child that the mother should succeed overall in constellating the Good Mother, rather than the Terrible Mother' (Stevens, 1982: 91). However it is possible for some mothers to be 'too good', as Winnicott (1965) emphasizes, as opposed to being 'good enough'. Such mothers can hinder the growth of independence in the child by being too attentive, by meeting the needs of the child too quickly before the child is able to make the 'spontaneous gesture' that, in his mind, produces the mother's response. For such a child, there are two alternatives: either being in a state of permanent regression and merged with the mother, or else totally rejecting the mother, even a seemingly good mother.

Where Jung differs from the 'object relations' school of psychoanalysis is that, for him, it is not only the behaviour and personality of the actual mother that is important, but the way the archetypal experiences are actualized by her in the child. Thus the critical factor is not the actual mother, but the mother complex, which is 'a product of the interaction of the mother with specific phylogenetic components of the child's maturing psyche' (Stevens, 1982: 91). Jung saw these complexes as the building blocks of the human personality, and their integration into the conscious awareness of the individual as of supreme importance in the development of the person.

Nevertheless, throughout all schools of psychotherapy there seems to be a general consensus of opinion, backed up by research, that the actual face of the mother plays a crucial role in determining the healthy growth of the child. As Wurmser writes:

> Love resides in the face – in its beauty, in the music of the voice, in the warmth of the eye. Love is proved by the face, and so is unloveability proved by seeing and hearing, by being seen and heard. A child can be loved without being given the nipple, but love cannot exist without face or music. (Wurmser, 1981, quoted by Mollon 1993: 48)

Research into facial interaction between infants and mothers

Recent neurological research has shown that lively face-to-face contact between mother and baby plays a crucial part in the healthy brain development of the child: 'The mother's emotionally expressive face is the most

potent source of visuoaffective information, and in face-to-face interactions it serves as a visual imprinting stimulus for the infant's developing nervous system' (Schore, 1994 :91).

Murray (1991) has studied the effects of postnatal maternal depression on infant development and found that children of depressed mothers were more insecurely attached to their mothers, more likely to have mild behavioural problems, and showed poorer outcome on Object Concept tasks at 18 months. She also studied how infants respond to the disruption of normal maternal communication by means of experimental 'perturbations'. In one such experiment, the mother was instructed to cease responding to the infant and adopt a 'still' or 'blank' face, while continuing to look at her infant. Here the infant first tried to engage more effectively with the mother, frowning at her and thrashing his arms in an agitated fashion. When this failed to elicit a response, the infant seemed to reduce his distress by withdrawing from engagement with the mother, becoming self-absorbed, and gazing at his hands or looking blankly into space. This evidence, together with that from other similar experiments, supports the view that by at least 6 weeks, the infant seeks interpersonal engagement with his mother, and if she does not provide the appropriate response, the infant will avoid engagement with her and will fall back instead on experiences that are generated and controlled solely by himself.

Tronick et al. (1978), who have worked extensively with the 'still-face' experiment, suggest that it is the infant's sense of impotence when trying to elicit the mother's active involvement that most contributes to a form of depression developing in the infant. This is reflected by Broucek (1982), who suggests that when this cycle of expectancy is broken and the expected response is not forthcoming from the mother, the baby begins to show signs of distress, as if the mother has become, temporarily, a stranger to her infant. What this then produces is a sense of shame in the infant, as a result of the mother's failure to recognize and respond to him.

Babies also derive pleasure from making things happen. 'This sense of efficacy and the pleasure associated with it, is in my opinion, the foundation of self feeling,' writes Broucek (1979: 312).Where this sense of efficacy is damaged and the infant experiences repeated failure to influence his environment, most especially his mother, and his expectations are unfulfilled, the infant becomes traumatized. Thus the sense of being recognized, together with a sense that he can make things happen, particularly in relation to his mother, seem to be two essential aspects of the infant's healthy development.

Experience of the face of the therapist

I next turned to the writing on the face of the therapist in psychotherapy practice. There is little information, as Wright suggests. I have attempted to draw together some of the findings. Searles recognized the importance of his

face as therapist in his work with severely ill schizophrenic patients. He found that in session after session they would sit and stare at his face:

> With all the absorbed wonderment and responsive play of facial expressions of a child immersed in watching a fascinating motion picture. The therapist and in particular, his face, comes to serve as a kind of mirror image to the patient. ... In the evolution of the patient's transference to the mother-therapist, the patient becomes able to detect, and make increasingly part of himself, the whole realm of emotion which was too inaccessibly hidden behind the inscrutable face of the actual mother of his infancy, and which consequently has heretofor been walled off, within himself, so that his own emotionality has been as inaccessible to him as was the realm of feeling in his mother. (Searles, 1965: 648)

Thus the therapist here does not simply interpret but, by expressing his own emotions in his face, enables the patient to access within himself his own previously cut-off emotional states. Just as the child learns about his own feelings through the eyes of the responsive mother, so the patient can similarly learn from the face of the therapist, who 'reflects back emotionally with his face, and gives the patient an experience that makes good the earlier deficit' (Wright, 1991: 6).

The therapeutic effects of this face-to-face experience reflect Jung's recommendation that the therapist sits face to face with his patient, which I refer to below. For a patient whose mother had such an 'inscrutable face' as Searles describes (and many such people come into therapy), such face-to-face experience might well be beneficial. Kohut (1971) writes about the 'Mirror Transference', which is a response by the patient to the basic and vital human need for 'empathic resonance'. He talks of the 'gleam in the mother's eye', which, for some people, was sorely lacking. It is as if the infant's basic need to be mirrored by this gleam in the mother's eye is reactivated and transferred on to the analyst.

The central feature of the mirror transference is the need to exert control over others, by forcing them to be mirrors. When this controlling effect can be recognized and accepted by the therapist, it becomes clear that one of its functions is to allow the patient to feel effective. When a patient thus unconsciously controls the therapist, he is shown to have power. This sense of power reflects Broucek's (1979) observations on the importance of efficacy. For the therapist, it can often be uncomfortable to feel so controlled by the patient, but provided he can tolerate it and not retaliate, a healthy transference/countertransference process can take place. The therapist cannot replace the mothering that the patient lacked in childhood, but he can provide, by his tolerance, a holding environment, to enable the patient to internalize a similarly tolerant attitude to his own needs and hurts. He thus allows, as Jung says, 'the unconscious to co-operate instead of being driven into opposition' (C.W.16 para 366).

The experience of lying on the couch

Jung and Freud had very differing attitudes to the issue of where the patient should be in relation to the therapist. For Freud, the patient lay on the couch, unable to see the analyst, in order that external stimuli should be reduced to a minimum, so that ideally he could then transfer on to the analyst any thoughts or feelings that emerged. Jung, on the other hand, strongly advocated the face-to-face position, insisting that the therapist relate to the human reality of the patient, thus allowing the patient in turn to observe his reactions and to develop what Buber (1937) called the 'I-Thou relationship'. Fordham (1978) nevertheless felt that Jung was too literal in his understanding of the importance of face-to-face communication, and advocated the use of the couch, a position adopted by many other post-Jungians. Samuels (1985) explains that, in his practice, the patient lies on the couch and he places his chair beside the head of the couch, not behind it. In this way, the patient can look at him or look away, and he too, as the therapist, has the same freedom.

Jacoby discusses the advantages and disadvantages of the couch versus the chair. He suggests that the risk of resistance remaining unnoticed is greater when patient and therapist are face to face, and also that it is more difficult for the patient to express his fantasies and thoughts about the therapist while sitting opposite him. On the other hand, the fact that both partners can read each other's faces and communicate with their eyes is important, as it can include a whole range of non-verbal communication. Jacoby here highlights the importance of non-verbal signals as a crucial medium of understanding between patient and therapist:

> In my experience many nuances in eye contact may play a role; some patients cannot bear to look at me, while others, by staring at me, keep controlling suspiciously the least of my reactions. These phenomena may tell the therapist an entire story about childhood fears and their manifestation in the present transference situation. (Jacoby, 1985: 193)

Lichtenberg writing in his 'Forty-five years of psychoanalytic experiences on, behind and without the couch', he has mixed feelings about the use of the couch. He says: 'the couch can hold one up supportively, [in the Winnicottian sense] and also hold one down, ensnarled in doubt, humiliation, guilt and anger' (1995: 282). He continues, following Stern (1985), that we greet and form attachments to others through eye contact. Infants scan their mother's face for her affective expressions that serve as signals of acceptance, safety and caring. It is part of our normal human way of communicating.

> Analysts who choose to deprive themselves of the opportunity to view their patients' facial affective expression, relying only on verbal exchanges, either do not appreciate the significance of affects or are willing to work with one arm tied behind their back. (Lichtenberg, 1995: 284)

He cites the example of a patient whose mother had a tendency to avert eye contact and to practise affect-avoiding, non-communicative chattering. He found it therapeutic for her to sit face to face, and by following her verbal content together with her gestures, her facial expression and her attributing him with 'tuning her out', just as her mother had done, they could together recognize the disturbed attachment patterns they were recreating.

In concluding this section I quote Hobson, who expresses this experience as a therapist very simply: 'Perhaps it was the fine details that mattered most; how I grunted, when I spoke and when I kept my mouth shut, and maybe, most important of all, the gestures, looks, smiles, and facial contortions' (Hobson, 1985: 220).

Discussion of results of the study

In this section I will discuss the overall findings of the study and explore their meanings in the light of the existing psychotherapy literature. To avoid confusion with the mother, when the gender is unknown, I have referred to the infant, the patient and the therapist as 'he'.

The main findings

The face of the therapist seemed to have most significance for those respondents who described their mother as having an unresponsive face. This meant a face that was blank, depressed or invisible, or with her eyes often closed and also one that looked angry or critical. This significance was also true for those who experienced their mother as unreal, as if she didn't exist, or who felt that she never really saw them at all. These respondents all felt a strong need to *look at* the therapist's face, on arrival and departure, as well as during the session. Looking at the face gave the patient important feedback about who she or he was, their sense of identity, their sense of self. Being looked at by the therapist was also important for some people as a way of feeling held and contained, although for others it was felt as an intrusion. Shame was an important issue for all the women respondents, and being looked at by the therapist, although uncomfortable, was needed by some respondents to work through the feelings of shame. A progressive ability to 'let go' of the face of the therapist and lie on the couch after some time was reported by the majority.

At the end of each interview I was interested in finding out whether the respondent himself made a connection between the face of the therapist and that of the mother. Two respondents had volunteered early on in the interview that they saw a strong connection between their need to look at, and be looked at by, their therapist, and their earlier lack of positive face-to-face interaction with their mother. Two others, in response to my final question, agreed that there was a link here. Of the remaining two, one said that because

of what he described as an over-involvement with his mother's face, he preferred not to be looked at by his therapist, and the sixth felt that because he knew he was 'the apple of his mother's eye', he did not need to see or be seen by his therapist, except briefly on arrival and departure.

Looking at the face of the therapist on arrival and departure

This was reported as an anxious time for nearly all respondents, when they needed to scan the face of the therapist for reassurance that all was well and that the relationship was still intact, both before and after the session. For example: 'When I arrive at the door I would look at his face to see how he was. I know now he greets me with a smile and I feel, "Good, he's the same person", because I think I had the anxiety that somehow he'd be different from when I saw him last.'

Another respondent described this as a significant but also negative experience: 'I only see his face when I arrive and leave and it's hugely significant, the expression I see on his face, which is usually deadpan, indifferent, as though he doesn't want me there at all.'

One way of interpreting this anxiety is in the light of Bowlby's work on attachment and separation. This shows the importance of times of joining and separating and the fear of loss that this can evoke, and for those who as children suffered from an insecure attachment to their mothers, this anxiety can be carried over into adult life. However, understanding this issue also in terms of the boundaries of the therapeutic space, as well as in the light of archetypal projections, will be referred to below.

Looking at the therapist's face during the session

The theme of needing to monitor the therapist's face for any reaction ran through five responses. What they could read there either encouraged or deterred the patient from expressing their feelings. For example, one respondent said how he watched his therapist's face: 'it gives me a lot of information about whether I can open up. Sometimes I was quite shocked by her reactions. It stopped me going further as she looked so taken aback'. Perhaps this need to read the therapist's face can be understood by reference to Meltzer, who writes of the 'aesthetic conflict' that every infant suffers from. He sees it as:

> The conflict between the aesthetic impact of the outside of the 'beautiful' mother, available to the senses, and the enigmatic inside which must be construed by creative imagination. Everything in art, literature, every analysis, testifies to its perseverance through life. (Meltzer, 1988: 22)

The difficulty in reading this face, over which 'emotions pass like the shadows of clouds over the landscape', as Meltzer poetically describes it, can be

replayed in the therapy by those patients for whom the mother remained as enigmatic outside as she was inside. As one respondent said, her mother had 'an idealized beautiful face', but she never felt that she knew anything about her.

The experience of being looked at by the therapist

'Transformative looking'

One respondent said:

> After about six weeks of sitting face to face, my therapist said '*You* need to look at me, and have *me* look at you, and not lie on the couch for at least six months.' This felt a great relief because it meant he had really understood what was going on inside me and how it had been with a mother who was not looking or had her eyes closed.

For Winnicott (1971), the 'good enough mother', when looking at her baby, is able to mirror what she sees there, so that what the baby sees in her face is a reflection of himself. Thus the baby sees himself in terms of the *difference* he makes to his mother's face, a difference specifically related to her response to him. This responsive looking contributes to the infant's development of a good sense of himself. Where there has been a lack of this mirroring response, because the mother has been preoccupied with her own troubles, the role of the therapist is, as Wright (1991: 6) puts it: 'to reflect back emotionally with his face and give the patient an experience that makes good the earlier deficit'. Another respondent, who felt her mother 'was not real', spoke of her need for a real relationship with a real person, and described how her therapist responded to this need by becoming more responsive in his facial expressions so she could eventually feel 'there was a real person there'.

'Containing holding'

> Therapy involves not only a 'transformative looking', which creates new symbols, but also a 'containing holding' , which is a prior condition of this being possible. (Wright, 1991: 300)

Several respondents referred to the need to feel metaphorically 'held' by the face of the therapist through face-to-face contact and his benign gaze. One respondent described how sometimes while expressing some painful emotions she noticed that her therapist had stopped looking at her, and she felt 'dropped'. Winnicott refers to this experience: 'A child with a seriously depressed mother could feel infinitely dropped'. It may be that for this patient, this was a reliving of that earlier experience. Bion (1962) describes the role of the mother as a container for all the unbearable aspects of the child's inner world. Perhaps the sense of feeling contained develops if the patient can actually see that the therapist, unlike the depressed mother, is able to bear what to him feels so unbearable.

The experience of shame

> Shame is originally grounded in the experience of being looked at by the Other, and in the realisation that the Other can see things about oneself that are not available to one's vision. (Wright, 1991: 30)

The issue of shame was volunteered by all four women in the study, not prompted by me. It therefore seemed of particular importance and was expressed with considerable feeling, for example: 'I did feel a lot of shame sometimes, as though my therapist was looking into, or through, me.'

This next response seemed particularly relevant to the issue of being looked at:

> I sometimes felt great shame at being looked at. I've worked on this a lot. I think that if I hadn't been sitting face to face, the issue of shame wouldn't have been addressed in nearly such depth. Lying down sometimes felt like a cop out. I think I wouldn't have been able to really experience and work through such a painful emotion on the couch. It was the fact that he was looking at me that was important.

This reflects Broucek's observation about the use of the couch:

> On the one hand, by minimizing the patient's shame, the couch facilitates free association and better enables the patient to follow the basic rule of psychoanalysis, which is that the patient report whatever comes into his mind, regardless of whether he considers it irrelevant, repugnant, or embarrassing (i.e. shame-inducing). On the other hand, the use of the couch mitigates or bypasses the affect of shame. The problem created by the use of the couch is that in *bypassing shame one also bypasses the analysis of shame*. I believe that Freud's sensitivity to shame, which resulted in the physical arrangement of the patient on the couch and analyst safely out of view, led him to collude with the patient in the avoidance of shame analysis. (Broucek, 1991: 86; emphasis in original)

This provides an interesting alternative way of thinking about the use of the couch and how it might contribute to the avoidance of the analysis of shame.

Broucek (1982) also describes how, when the mother presents an unresponsive face, the baby shows signs of distress, and he suggests that shame is evoked when the mother fails to recognize or respond to the infant. In addition, as Sidoli (1988) says, a child needs to have reflected back to him a sense of his own intrinsic goodness. When this is lacking, and he experiences instead criticism and disapproval, his self-image can be seriously damaged, and a sense of inner 'badness', of which he feels intensely ashamed, can result. For these four respondents, all of whom had depressed, blank-faced or unresponsive mothers, or who were very concerned about their mother's disapproval, a sense of shame was probably present very early in their lives. Inevitably, as Wharton (1990) concludes, this sense of inner badness has to be kept hidden. It seems that it is only with the understanding and 'approving eye' of the therapist that these feelings can begin to be brought into the light. However, at the same time Lichtenberg observes: 'Patienthood by its very nature triggers

shame. Having one's illnesses diagnosed, one's faults exposed, one's hidden idiosyncrasies dissected, and one's unconscious plumbed, arouses humiliation, embarrassment, and mortification.' (Lichtenberg, 1995: 291)

Thus, being a patient in itself provokes shame and humiliation, and therefore the same early intense feelings of shame get reactivated. A child needs to have fostered in him a sense of his own potency, an 'illusion of omnipotence' as Winnicott calls it. A person who suffered humiliation or ridicule because of his actual lack of potency as a child may well feel intense shame again in the face of further impotent feelings induced by being a patient. As Winnicott emphasizes, the mother has to let the child down gradually, to help him cope with the disillusionment that he is not, after all, all powerful and at the centre of his parents' universe. Sidoli writes: 'He is struggling to manage his impotence and omnipotence alternately. For a toddler to integrate hopelessness and helplessness proper to a realistic sense of self-esteem, a great deal of containment and support is needed from the parents.' (Sidoli, 1988: 128)

The therapist, too, has to let the patient down gently, in addition to providing this containment and support, if his self-esteem is not to be damaged a second time.

Archetypal projections

Jungians assert that the individual has within himself archetypal images of both mother and father. The mother archetype has two aspects, the Good Mother and the Terrible Mother. Both these contrasting images can also be projected by the patient on to the therapist and it is the task of the therapeutic process itself to enable these archetypes to be reintegrated in a more human form into the psyche of the patient. From the evidence of the responses, such archetypal images were often present. There were descriptions of the actual mother as the Terrible Mother: 'persecutory', 'unpredictable', 'changeable', 'capable of turning into a witch-like figure at a moment's notice'. Several patients expressed the fear that the benign Good Mother/therapist too might be transformed in this way when there was a hint of a 'grim' or 'disapproving' look. One patient in particular felt as if her therapist, at the start of her therapy, totally embodied this Terrible Mother, 'not caring if I lived or died, while I lay abandoned and rejected on the couch'.

For those patients who had projected the Terrible Mother archetype on to the face of their own mother, arriving at the door of the therapist's consulting room was an anxious moment. They may well have been fearful that the therapist too had been transformed into this Bad Mother in their absence. As several respondents reported, they needed to look carefully at the therapist's face to check that he was pleased to see them, and that he was indeed the same person they had left behind at the last session.

Move to the couch

The gradual work of dissolving the archetypal projections, on to both the actual mother and the therapist, in order, as Jung puts it, 'to restore their contents to the individual who has involuntarily lost them by projecting them outside himself' (C.W. 9, para 160), was part of the developmental process reported by several respondents. Their ability to then 'let go' of the face of the therapist and to lie on the couch could be interpreted as a result of the dissolution of the power of these archetypal projections.

Looked at in terms of object relations theory, one could say that the negative internalized aspects of the mother's face were being transformed as a result of the positive containing holding of the attentive therapist's face. Once this had started to happen, and the patient was able to begin to let go of the face as one of the primary means of communicating, a space was created in which symbolizing can take the place of looking: the 'word', in the form of interpretation, becomes increasingly important.

Maternal and paternal modes

What this move seems to represent is a progression from a maternal mode of therapy, in which holding and responsiveness are the prime features, as advocated by Winnicott, to a paternal mode, as advocated by Freud, in which interpretation acts as a separating experience, creating a space in which to think, to be more objective. This reflects the move from an initial dyadic mother–baby relationship, which some patients need to recreate in order to correct the earlier distortions of the maternal mirror, to a triadic relationship, which then includes the father, whose role it is to enable the child to separate from the mother, to turn away from her face, and to face outwards to the world. The paternal mode provides the patient with another view, from outside the mother–baby dyad, which 'disallows that which is longed for, and therefore creates a space for thought and symbolising and knowing what is lacked' (Wright, 1991: 298). It is not, however, that the 'loving mother' abandons the baby to the 'stern father', rather that the two modes are embodied in the one person of the therapist.

The boundary

Similarly, Chasseguet-Smirgel makes a distinction between 'the maternal capacity to facilitate regression and wait, allowing gestation, and the paternal function of interpretation and boundary setting' (1986: 41). She describes how the ending of the session is a way of providing paternal reassurance that the patient is able to return to the 'everyday world of consciousness'. It is precisely because of the clearly defined boundary, enclosing the therapeutic space, that regression is made possible.

Recognition of this paternal function of boundary setting can contribute to a broader understanding of the concern of the respondents about the face of the therapist at the end of the session. It can represent the change from a maternal mode to a paternal one, which involves a level of anxiety that is more than simply the fear of separation. However, Modell, in writing about different levels of reality, provides an alternative way of understanding this:

> For many patients the entry into the consulting room or the space between the door and the couch becomes an intermediate area that belongs to neither ordinary life nor to the psychoanalytic setting, It is here that the difficult transition between an ordinary and an extraordinary relation takes place. (Modell, 1990: 31)

Conclusion

My findings support the view that the face of the therapist is of particular significance to those patients who suffered from an unresponsive or depressed mother. The one respondent who reported his mother as being neither depressed or unresponsive did not have a strong need to look at or be looked by his therapist. The provision by the therapist of both a metaphorical 'containing holding' as well as a more literal 'transformative looking' can help the patient develop an increased sense of his own self. What also emerged strongly was the critical importance of choice between chair and couch for each patient at each stage in therapy.

I am aware that this is only a preliminary study looking at highly subjective phenomena which do not lend themselves easily to psychological research methods. None the less, I feel that it is important that we explore ways of assessing and researching the experience of the patient, in order to enlarge our understanding of the psychotherapeutic process itself.

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Editorial

It is with great pleasure that we introduce a new Clinical Commentaries Section. Although this initiative is not particular to this Journal, we believe that the *BAP Journal*, with its three different sections – Psychoanalytic, Jungian and Child and Adolescent – provides a unique opportunity for lively dialogue.

We hope that readers will be stimulated by this discussion of detailed clinical material and, at a later date, theoretical concepts. It seems fitting and useful that the *BAP Journal* should develop as a forum in which differences are explored and debated, opposed or confirmed, in order to enhance our clinical practice. As analytic thinking is increasingly challenged by the proliferation of other therapies, it becomes ever more important that differences in the profession can be openly and vigorously debated. For our first clinical commentary we are publishing an account of a session with a couple that we feel begins to illustrate the breadth of skills of BAP members. We are delighted to feature our first three responses from colleagues who span the different sections of the BAP and hope this discussion will prove the beginning of an open and exciting dialogue about clinical work.

The Clinical Commentaries Editor

Clinical material: Anne and John

The couple came in with their usual smiles and hello's. The therapist began the session by announcing the dates of the coming break (having decided to start with this, after failing to get the information last week: once the session starts it has such momentum).

Anne said 'right', and got out her diary, with some fumbling, John asking her, 'have you got that?' Anne said 'are you going away for a nice holiday with your family?' Before the therapist managed to take up the implications of this at this point, John was off:

> You know next week is half-term, and I was going to send Anne and the children off to my family in Wales? I thought I'd be coming to the session. But now I've managed to claim some time off, and I'm going with them for five days, so we won't be here next week. It's funny in view of our discussion here last week about my work pressures.

The therapist said that John was quick to tell her that they had organized to have a nice time too, and that this should be understood as his way of quickly dispelling the feelings stirred up by their picture of the therapist's going off to have a nice time with someone. John thought this was absurd.

The therapist then tried another tack, wondering whether John might be implying a link between the work that had been done last week, and his standing up for his needs at work by claiming time off. John said this was not what he'd meant, nor what he could consider. His reference to last week was just about the coincidence, and his getting time off was a matter of timetable delays at work providing the opportunity. Anne then said that things at John's work were even worse than they had been and, on top of everything else, his boss was moving to another department – things were so fluid and insecure.

The therapist offered the thought that this resonated with what it may have felt like to hear the surprise announcement about a break. Both vehemently denied this. They felt it was quite natural for her to take a holiday, etc, etc. The therapist said to Anne that she was being very 'adult' about it, but there might be other feelings too.

Anne said rather tartly to the therapist, 'Well I'm trying hard to be adult.' (This was a reference to a previous discussion about her getting stuck in the

relationship as 'little', while John was often stuck as 'big'.) Anne said, 'After all, it's not like you are going for a year's sabbatical', and the therapist said, well, it might feel as though Anne didn't know what the therapist would do next, like the boss at work, and in fact three weeks may well feel like a very long time, especially since John could take only a few days. 'No, no, no.'

John then said, 'I'm not sure why we're persisting with this, when what we really wanted to talk about today was sex, about why Anne cannot respond to all my efforts.' He spoke of the efforts he'd made to woo Anne lately, and how angry and frustrated he felt about her blocking everything. The therapist said she thought this topic might link with how powerfully each of them seemed to be blocking a certain kind of intercourse with the therapist here in the session. This was not responded to directly. Instead John continued to complain about Anne's 'constant blocking' of him in the sexual arena.

Anne spoke about a power struggle between them at home, and how she felt she'd lost her way, like when you lose your bunch of keys and turn the house over to find them, and then they turn up where you first looked. Right now she felt that she'd lost the keys and couldn't respond to what John wanted.

She was smiling in a rather tight, nervous way throughout this. She then said she'd been given a bottle of champagne and chocolates on Valentine's morning. John said they'd talked through the day and he felt Anne had promised intimacy. She'd made a special supper, and then when bedtime came she'd gone off and spent an hour checking her emails. Anne said John had emailed her the next day very angry and disappointed, a horrible message, saying if she couldn't deliver he would be driven to have an affair, as she had, and so on. She felt desperate, didn't know whether to pretend ('No,' said John), or whether he was going to abandon her, or what.

John was very angry, going on about how much he'd given and how she gave nothing, and he couldn't stand it, and she never did things just because they would please him, although he did things often just because they'd please her. Anne talked of how she couldn't find the feelings, and at one heated point, 'maybe I just don't fancy you.'

John said furiously, 'well, if that's the case, what is the point of all this, why am I bothering?'

There was rather a terrible pause here, and then the therapist suggested that what they couldn't see at the moment was how much they were in this together, how much what was going on was something between them, something they both contributed to. The therapist said the pattern could be seen here in the session, perhaps this could be explored in time, (this in response to their continual rejection of transference comments), but that right now their feelings were felt about each other. The argument was not about sex in a simple sense, it was also about power, and linked back to Anne's earlier statement about the power struggle. They both responded to this by quietening down, and Anne responded verbally too, agreeing.

The therapist went on to spell out the link to their relationship with her, offering the thought that there was a power struggle here too, which meant that much of what the therapist said could not be allowed to be of any use to them; they had to shut it out. Anne responded directly to this, agreeing again.

John got going again, however, forceful and angry towards Anne, and the therapist asked whether he could see what he was asking for from her was compliance. 'Compliance would be nice,' he said, 'just some of the time.' There was another crescendo of anger and, on Anne's part, apparent despair.

The therapist, feeling something forceful needed doing, said that the way into all this really could be to study what happened here: there was the opportunity for one kind of intercourse here, and it could be seen just how difficult it was. She suggested that it had to do with just how hard it would be for each of them in their different ways to allow themselves to need anything from her, to feel dependent. Something was known about what a dangerous state dependence had been for each of them, what painful experiences they had had in the past with people they depended on. Anne filled up with tears, and began to sob with increasing pain. She was clearly really touched by this.

After a moment the therapist suggested that it was also a real difficulty for John. No, he said, he was only too happy to have help, if this could be solved, and he would be only too happy for Anne to make him feel good. The therapist said it seemed like he was talking about wishing he could be made to feel bigger, but that was not quite what she meant by dependence.

Anne came in to support what the therapist was saying, pointing out that John couldn't hear the therapist, couldn't be 'little'. He said, 'I've been little at home this week' (he perhaps meant 'needy', but it didn't come out looking like need). 'No,' said Anne, ' you've been bigger than ever.'

Finally, somewhere around here, John had a moment of head in hands, looking miserable, and as if he too was near to tears.

Anne went on about her sense of not being safe to depend on anyone.

The therapist said something about how perhaps they both felt this, and enacted it, although in such different ways. John tried to control what went on, to keep himself as 'the big one', and when Anne played 'little' to this, accepting John's assumption that he must supervise and prescribe everything (from children's teeth-cleaning through to defining the necessary pre-conditions for sex), she felt increasingly inadequate and resentful. On the other hand, Anne seemed to raise John's hopes of getting what he wanted from her and then to treat those hopes quite cruelly. Each of these ways might convey clues as to how they felt treated as children. And, at the same time, both continued to yearn to be able to really take something from someone else, be given something. 'Yes,' said Anne. And the therapist pointed out that, even when it was offered, here or by each other, it was so hard to take. 'Yes.'

Then Anne said to John, 'I did stroke you last night.' He confirmed this, and added that she turned over and gave him a hug. 'But do you remember what you said?' he added, turning rageful again. 'Yes, I said "it's a long time

since I did this",' said Anne. 'Yes,' said John furiously, partly to the therapist. It was a bit hard to grasp why he was angry again but, on clarifying, it seemed to be that it made him furious that she knew it had been a long time, and that it had been a long time, and so how could he be expected to be pleased by it?

The therapist said something about John's feeling like he was a starving man being given a crumb, which he agreed with, and he went on to be very contemptuous and dismissive of crumbs. Anne said she felt hopeless, there was nothing she could do, if these attempts to make a start were so scorned. The therapist said they had just seen an example of what had been talked about before, that because they each felt so unsafe about being loved, they could not allow the other in to provide an experience that might begin to make a difference. John was still ranting, so the therapist repeated this another way, namely by asking if he saw how he was crushing Anne, and depriving himself of something he could have, because of his rage about what he hadn't had. There seemed to be some agreement with this.

It was time to finish, and John reminded the therapist they wouldn't be there next week, saying they would be away having a nice time. Anne looked painfully doubtful of this, and both smiled wryly.

Clinical commentary: Anne and John

STANLEY RUSZCZYNSKI

Such a process recording of a session as this, written with this degree of openness and detail, provides rich material through which we might learn about what is taking place in this session at this point in the therapy. It is not necessary to think that an objective description is presented of what actually took place (although accuracy is sought and might well be achieved to a high degree). What is more useful is to consider that the therapist is bringing a story of the experience of being with the patient(s) during the course of the clinical work. Both in what is presented and in the manner of the presentation, the therapist is inevitably and appropriately affected by the transference and countertransference relationships as they predominate in the therapeutic process at that time. As Bion has taught us, it is likely that the clinician has been successfully drawn into playing a key part in the drama of the patient's internal world. In the presentation of the session, therefore, the therapist presents the material not only from the perspective of a well-informed messenger but also from the position of an intricately involved participant saturated with aspects of the patients' projected states of mind and object relations.

This approach to the clinical material does not, as I have already said, imply that the therapist cannot give an accurate and objective picture of what took place. (Making use of the countertransference, for example, requires the processing that is only possible from the observing third position.) Nor does this approach imply that technical mistakes are not made. What it does imply is that monitoring and understanding the therapist's part in the session is central to understanding the patient(s)' object relations as played out in the therapeutic encounter.

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In this commentary I will briefly spell out some of the associations I had to this transcript. By definition, this is a less dynamic response to the material than if it were discussed in a supervisory/consultation situation, where it would be possible to develop and elaborate some of the identified themes.

From the very beginning of the material presented we are thrown into what we soon learn to be the dynamics of the marital interaction. The therapist makes a decision before the couple arrives to start the session by announcing her forthcoming holiday break. She does this 'after failing to get the information in last week' because 'once the session starts it has such momentum'. She goes on to tell us that before she is then able to respond to Anne's question about her going off 'for a nice holiday with your family', John starts to talk about the couple's plans for half-term. (This suggests that she was again occupied by feeling that she was prevented from saying what she wanted to say but not monitoring this as a dynamic to be understood in the therapeutic process.) Then, when she has an opportunity to suggest that John's telling her about the couple's holiday plans was a way of dispelling the feelings stirred up by her announcement, John proclaims this as being 'absurd'. The therapist immediately 'tries another tack' and changes the content of her interpretation. (This seems to suggest that the therapist did not process John's response to her interpretation but instead offered a new slant on her interpretation.) When John yet again fends off her comments, she offers yet another interpretation relating again to her holiday announcement and the couple's surprise at it, only to be met again with both of the couple 'vehemently' denying it.

With the benefit of having read the transcript of the whole session, I became aware on rereading these opening exchanges that they contained three overlapping themes that I thought went on being repeated throughout the session and give diagnostic clues to the nature of the couple's internal object relations.

First, the therapist seems to be caught up in a degree of 'busyness' and activity which, it seems, has her acting on and reacting to the patients and then reacting again to their reaction to her. Although it is not uncommon in clinical work with couples that the therapist may have to be more active than with an individual patient, the 'busyness' of the therapist in this session is noteworthy and needs to be understood. Her decision to start the session with an announcement is done in the face of failing to do so the previous week, as if she now feels in opposition to something. At points in the session it is as if the therapist feels pushed by the couple and then finds herself pushing them. At other points she is rebuffed and responds by pressing the couple again. It is interesting to note that early in the session the therapist suggests to John that he was 'quick to tell her' about his arranging something for the family and that this might be 'his way of quickly dispelling the feelings stirred up'. This dispelling of feelings through quick action (including verbal activity) might be thought of as being a central feature of the session overall.

Second, the therapist seems to get caught up in the content of the exchanges rather than primarily focusing on the dynamic processes that occur between the couple and/or between the couple and her. We read that at one point she 'repeated' something she has said in 'another way'. It is not clear whether there was consideration given to why she had not made herself clear in the first place nor why she was not heard or understood the first time she had spoken.

Third, exactly as the therapist says to the couple at one point, there is a continuous sense throughout the session that compliance from the other is what is required and that it is actively sought. This is certainly the situation between the couple, although John's demands are often more overt than Anne's. It is also what the therapist seems to have become identified with. In addition, we read that the defences against compliance are either thoughtless rebuttal or more aggressive withdrawal. Who demands compliance and who is required to be compliant moves around among the participants, between the couple and between them and the therapist.

An interesting illustration of this emerges at one point when the therapist says that she feels that 'something forceful needed doing' (rather than something being understood). She offers an interpretation that Anne is 'clearly really touched by'. The therapist then turns to John with a similar interpretation, which he refutes. At this point Anne 'came in to support what the therapist was saying'. I was left unsure whether Anne had understood something and wanted to help John in doing likewise, or whether she had simply agreed with the therapist in a compliant way and was now joining her in an effort to get John to also comply. My suspicion that it is the latter that is aroused when we subsequently read that Anne has a 'sense of not being safe to depend on anyone'. Compliance does not require dependence, whereas feeling understood and gaining understanding would be likely to arouse feelings of dependence and gratitude. Twice in the session, although clearly aware that transference interpretations are constantly being rebuffed, the therapist tells the couple that understanding processes in the room would be helpful to the clinical work. She adds on one occasion that this can be done 'in time' (meaning later in the therapy). This was another illustration, I thought, of the therapist, although correct in what she says, getting caught up in requiring something of the patients.

What is noteworthy about these overlapping themes, I think, is that they all relate to a state of mind and object relating that is not primarily about an intercourse between cooperating but separate people. Rather, the themes are more about an effort to colonize and control the other through bullying and coercion. Action seems preferable to thinking and compliance is sought rather than understanding. If the therapist has been recruited into this state then we can hypothesize that these are the dynamics that operate between the couple, and are therefore illustrative of the couple's states of mind and object relating.

In this transcript of her experience of the session the therapist has vividly recreated these psychic states and object relations of her patient-couple as well as showing her own inevitable identification and involvement with them.

The therapist's interpretation about there being a power struggle between the couple seems accurate and probably central to an understanding of their interaction. Who has power in the couple's relationship? There is an interesting sequence when John complains that he is constantly rebuffed sexually by Anne. Anne says that she feels that she has lost her keys and cannot respond to what John wants. We also read that on Valentine's night Anne goes off to check her own emails rather than joining John (a separate male) in bed as he felt he had been led to expect. Neither of the partners seems to have the key to open up to the other nor to get into a contact with the other. There might also in this material be a reference to a struggle over who has the penis in the relationship, but a penis that is feared. Both of the partners seem to fend off the possible approach from the other, probably because of the fear that the entry would be intrusive and would be colonization rather than relating. This is more what Anne fears, I think. But there is also an anxiety that contact might be disappointing. For example, when Anne does make tentative moves towards John, he pushes her off, saying that it is not enough.

The question about who has power also emerges between the therapist and the couple. Early in the session John and Anne come together to refute something the therapist says. The question here becomes one of who now has the powerful penis/keys/interpretations – the couple or the therapist? Another version of this appears, I think, when later in the session Anne aligns herself with the therapist, supporting her in what she is trying to say to John. By identification she joins the therapist and hopes to cloak herself with her perceived knowledge and power.

It is as though making a more robust approach across the gender divide has come to be seen as aggressive. Throughout the session, John is seen to be demanding of Anne whereas she seems to rebuff him. This is paralleled with the therapist more often addressing John, who often rebuffs her. The person making the approach is feared, although, of course, it is pertinent to wonder what both the partners project into that more potent role.

One final comment. An interesting question that is raised by the therapist in the session is in relation to the couple's difficulties in accepting transference interpretations. If the partners are relating in a more paranoid-schizoid way (action rather than thought; compliance rather than understanding) then both of them will have a preponderance of splitting and more projective defences, evacuating those parts of themselves considered to be unacceptable. The therapist necessarily becomes the repository for these projected states and the material of the session shows how any attempt, through making transference interpretations, to help the couple or either one of them to re-own some of these projected parts is frequently met with great resistance. The purpose of

the defence at present is to be rid of these aspects of the self. Interpretations that invite the patient(s) to take back these projections might therefore, at this point in the treatment, feel persecutory and, as a consequence, are fought off. Such a defensive structure might influence the therapist in the use she makes of her understanding of the dynamics of the couple and analytic process. At present, her understanding might best be used to inform what Steiner has referred to as 'analyst-centred interpretations' rather than 'patient-centred interpretations' (Steiner, 1993: 131–46). This requires the therapist to carefully track and tolerate her emotional response and countertransference, rather than use a more actively interpretative approach.

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Clinical commentary: Anne and John

ELIZABETH A. SMITH

When working with partners in marital therapy, I am constantly struck by the psychological parallels with the early mother–child relationship, and consequently how marriage relationships are influenced by the early experience. In infancy the child experiences the basic elements of intimate human relationships – learning in the family to interact in a larger intimate circle. In marriage, the child, now older, re-enters a familiar system, but in a different role. This second partnership, exposed in therapy, often reveals a couple who are no longer children but are not yet mature adults – this ambivalence is seen in the unfulfilled infantile needs at one level, and in the failure to develop adult behaviour at another. Perhaps no other interpersonal relationship comes so close to replicating the early mother–child intimacy – or offers such satisfaction of the need to be looked after, and for care and protection. The early period of adult couple relationships, the holding, caressing, looking into one another's eyes, the pre-verbal sounds and development of a personal language, are similar to early intimacy between a baby and its parents. Each partner has the opportunity in turns to be helpless, comforting or strong for the other. Because the partner is trusted, it is possible to express and behave regressively without risking embarrassment or anxiety. This reciprocal giving and taking brings satisfaction, self-esteem and forms the dyadic relationship.

In the opening paragraphs of the 'Anne and John' account I was struck forcibly by the powerlessness of the therapist, who seemed to be prevented by the 'momentum' of the previous session from informing her patients of the forthcoming holiday break. John is clearly shocked when he hears the news, and reflects his feelings at receiving the therapist's information by an authoritarian and controlling comment to Anne. In contrast, she escapes her feelings with a polite remark. The therapist seems powerless. It becomes apparent that

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they too had made arrangements for half-term – Anne to visit her parents and John was planning to see the therapist on his own. Anne voices her anxiety about how fragile and insecure life is for them; with the therapist going on holiday, bosses at work leaving, and so on. Anne's feelings are picked up by the therapist, but neither seems able to respond.

I thought the concept of regressive and progressive roles was very important in the early part of the session – a neurotic defence in both Anne and John. This was regression as a reversion to childish behaviour and progression as an attempt to conceal weakness behind an adult facade. John seems to become more irritated by all the attention Anne is getting from the therapist, and changes the subject to talk about his sexual frustration. The therapist makes an interpretation about the marital power struggle, which I felt was avoided or not understood by John but was taken up by Anne. Anne struggles with the idea of her lost keys as a symbol of the power struggle and responds to the therapist's interpretation of the difficulty of verbal intercourse in the session. She has lost the way and cannot open the marital sexual lock because she has lost her key. She searches her memory of the beginning of the marriage hoping to find it, but it is still lost. She has lost the keys to the marriage, and cannot unlock the way to John, but she is still looking. Meanwhile, John's efforts with gifts of champagne and chocolates are not successful. Are they seen as crude attempts to try to buy her favour, which merely emphasize that he does not understand her ambivalence?

Why do couples destroy one another's sexuality? How do they accomplish it? Among the destructive emotions, two are most striking – the rebellious hostility and rage towards the partner, and the fear of rejection or abandonment. Sometimes the two are related. We know that the anger and fear of loss characterizing marital relationships are not necessarily the product of a 'here and now' reality, but are the recreation of early family relationships and remain unresolved in the marriage.

An understanding of the Oedipal collusion is basic to the marital relationship. The Oedipus complex shapes a marriage positively in a repetition of the parental marriage, and negatively in an attempt to reverse the parental marriage. In joint therapy it seems important to identify which memories and experiences from the Oedipus stage influence the marriage. Unresolved Oedipal conflicts evoke jealousy and possessiveness as sibling rivalry and wishes for exclusive attention are forces in childhood. Parental transferences towards the partner result in abandonment fears and excessive dependence and demands. Often a partner who has not resolved his or her early infantile attachment to his or her parent begins to rebel like an adolescent against the authority and control of the spouse.

In conjoint therapy, the power of the system to model a different experience can help to contain or resolve the Oedipal difficulties. Where the patient couple are working with one therapist (in this case female) this forms a threesome or triangle, and there is always a danger that if two people do

something together, the third experiences being left out. The man can feel that the women are joining against him, or the wife can feel that the therapist is a rival for her husband. In a foursome these problems are much less apparent. Where the therapists are male and female, this creates a very powerful model, and containing experience. It also gives opportunities for the patient couple to work in two pairs, with a man and with a woman, and it is not inevitable that one will experience being left out. In this case, Anne and John might have benefited from a conjoint therapy model, and the therapist might also have found it beneficial.

The therapist acknowledges that Anne and John's early experiences of hostility, anxiety and great unhappiness can result when a marital relationship is governed too heavily by neurotic and unresolved transferences belonging to childhood, especially to the extent that they are beyond the couple's awareness.

Anne seems more aware than John. They both use emails to avoid confrontation – she to read before bed, avoiding sexuality, and he to threaten her with an extra-marital affair. However, he is adult enough to react decisively against Anne's suggestion of a pretence of positive feeling toward him. Then she wonders whether she is capable of feeling at all. The therapist manages to secure some ground at this point, by acknowledging that their sexuality is complicated, but is linked to an earlier exploration of a mutual struggle for power introduced by Anne in the session.

The therapist introduces the idea of John needing compliance from Anne, in response to John's anger towards Anne. It immediately made me wonder whether the therapist had picked up a countertransference from Anne. Was Anne being compliant to the therapist? Was she not able to disagree? Feeling in need of a sense of security that therapist will not abandon her? She allows John to voice her disagreement and anger towards the therapist, relying on him to do this. The development from two-person to three-person relationships in the therapeutic alliance is not easily achieved because it involves blows to self-esteem and loss, when one is not as special or unique as had been thought. In this account can be seen the successes and supports of the interaction that influence the therapeutic system one way and then the other.

A considerable movement in the therapy comes when the therapist identifies in a meaningful way to both, but especially to Anne, their past history and how they have been unable to trust without feeling and fearing catastrophe. It clearly makes an impact on Anne; even John joins in but understands it only in the area of Anne changing towards him. He does not understand mutual dependence. Anne feels that she has an ally in the therapist and John admits to feeling 'little'. The therapist wonders if she herself is feeling low and depressed but does not explore this. John shows in his manner his feeling of abandonment and despair. Anne identifies with him.

The therapist describes the pattern of their relationship as controller and compliant – raising each other's hopes and then sadistically rejecting each other. At the same time both wish to be able to experience dependency and trust.

It seems that the therapist momentarily holds the couple – they acknowledge a moment of intimacy, and Anne comments that it is a long time since they felt so close. John reacts with wild anger – he asks why, knowing this, she still refuses him. The therapist responds with the understanding that having a little makes John feel even hungrier. John agrees but obviously feels that a crust is less than having nothing at all, as it reminds him of earlier emptiness.

At this point, John's anger gets some acknowledgement. But help is painful. He gets in a final retaliation when he forecasts the pleasure of their holiday, while the therapist is away. He seems to be a man in fear of being dominated. He feels afraid and defensive in relation to others, including the therapist, his wife and his employer. He deals with this by continually taking the offensive.

There is little real communication between John and Anne; little meaningful relevant interchange; the struggle for power is manifested on a sexual level and neither partner finds a way to reach the other in the longer term. They each seem afraid to make the first move in case the other will interpret this friendly advance as weakness or dependency and exploit it to make further demands, particularly John to Anne. This results in repression and fear of conceding towards each other – they fear giving themselves or being manipulated. John and Anne hunger for intimate love and tender care but are barely able to express their feelings or needs in a way that the other can respond to. Anne seems to have a greater capacity for self-understanding; however, this couple have a strong psychological fit. Both have great difficulty in maintaining autonomy. The struggles with one another both threaten and strengthen their need of each other to define their defensive roles. Reconciliation at this point implies passivity and possibly inferiority.

> Continuous fighting simultaneously separates and unifies allowing both partners to joyful experiences of intimate symbiosis and at the same time the equally joyful experience of personal boundaries and individual expression. The marital power struggle often appears to be a substitute for a love ritual. (Balint, 1959)

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Clinical commentary: Anne and John

ELPHIS CHRISTOPHER

We are invited to examine and comment on one session. We do not know how long the therapist has been seeing this couple. There is no history and no personal narratives. It is as if we are in the position of Bion's 'ideal' session with no memory and no desire.

How are we to view it? We could put ourselves in the therapist's shoes or we could act as supervisors. Perhaps both positions coexist.

The session begins with the difficulty of announcing a forthcoming break. Is this the first break or one of several? We do not know. It seems difficult to introduce the topic. The couple enter with their usual smiles and 'hello's'. This sounds rather like the personae (to use Jung's terminology) with which they face the world, at variance with the tumult that occurs in the session. The therapist comments on the momentum once a session starts as though there is so much to say in such a short time. This feels like a repetitive situation with great pressure on the therapist.

The decision to start the session with talking about the break sounds crucial. There is always a delicate balance between letting patients start the session – setting the agenda – and the therapist doing so. However, this is leftover business from the previous session. One wonders whether at an unconscious level the couple were picking up that there would be a forthcoming break and wanted to deny it. Certainly, in the session itself there is enormous resistance to accepting the idea of a break and its relevance and importance to them. Denial seems to be their way of coping with what they find difficult or unpleasant, making it very hard for the therapist, who valiantly and persistently keeps at it. The anxiety level is high in everyone.

Anne is the 'nice one' in the couple, with John as the 'nasty one'. Anne asks a seemingly innocent but loaded question about the therapist going away with her family. It presupposes that the therapist has a family, together with Anne's longing to be part of it. John cannot bear to know about it, pushing on

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with his holiday arrangements, although hidden in his comments is the hope that he would have had the therapist all to himself, excluding Anne. The threesome, triad, would become a twosome, dyad, avoiding the Oedipal triangle, and having mother alone. The therapist does not take this up. Does she hear it? The therapist almost accuses John of being quick to tell her that they had organized to have a nice time too, but is the therapist too quick with this comment, ignoring John's hope for a twosome? His retaliatory remark seems to force the therapist to comment on the previous work done on making links, standing up for his needs. Again this seems to force John into a retaliatory response.

Anne supplies the information about John's work being more difficult – fluid and insecure.

The therapist then makes the link between this information and the surprise about the break. The struggle to hear/accept this ensues. It is denied. They both try to be adult and grown up. The therapist does seem to deny their wish to appear generous. It is hard for the therapist holding on to two positions and the splitting that goes on.

John complains about Anne 'blocking him' in the sexual arena. Perhaps he feels blocked by the therapist in allowing him to have 'intercourse' with her on her own without Anne.

There follows a powerful exchange of angry, negative feelings. Both feel impotent and cannot get close to one another or the therapist. She picks this up very well. There is a power struggle in the session with the therapist. She does not make a transference interpretation here, which feels right, but enables them to reflect on the power struggle between them in the session. She then makes the link to the power struggle in the session with her so that what she says cannot be allowed to be of use to them. It has to be shut out. This feels appropriate.

This is followed by agreement from Anne but anger from John. There is a seesaw of anger from John and despair from Anne.

The therapist has to contain both the anger and the despair. She does this well, bringing in the difficulty each of them have with allowing themselves to need anything from her (she might have referred back to John's evident hope to have her all to himself , and to Anne going on holiday with her), and links this with their problems in the past – how they depended on people and the pain this brought them.

Facing John with his neediness feels very threatening for him. He has to automatically deny it.

There follows a fruitful exchange that touches each of them deeply, about how hard it is to depend on anyone and how each shows this in different ways – namely, John being 'big' (in control) and Anne being 'little'.

It seems as though there has been a shift in their relationship that had been built on unconscious collusion of John 'big' and Anne 'little'. Anne, it seems, decided not to be 'little', being tired of feeling inadequate and therefore becoming resentful. Is this what made her reject John and go off and have an affair, thereby directly exposing John's insecurity and vulnerability? He then reacts by becoming more demanding, especially sexually.

There is then the issue of feeling unsafe about being loved. Neither can allow the other in to provide an experience that might make a difference. John continues ranting. John deprives himself of something he could have because of his rage about what he has not had.

In summary, the work with this couple is very difficult, especially for a single therapist. Both are narcissistically damaged and neither seems to have an internal world of a cooperative couple.

The relationship or marriage seems to have been founded on an unconscious collusion. John seems to be the stronger person, the container, containing Anne who seems to have colluded with the situation. Perhaps there is a shared unconscious fear of weakness and vulnerability, each one hoping the other will deal with it. While Anne projects her strength on to John and allows herself to be little, John can seem to be the stronger one. Both deny their real needs.

Something has changed. We are not sure what, but we know Anne had an affair, and although this did not end their relationship, it threatened it. Perhaps Anne unconsciously used it as a catalyst for change. Jung (1931) first used the idea of container/contained in his chapter on 'Marriage as a Psychological Relationship'. Although the container may tire of doing the containing and look outside the marriage, the contained may 'grow up' and resent being infantilized. We are not sure what brought the couple to therapy. Perhaps it was the sexual problem – namely, Anne's refusal of sex. John says as much. Although a collusive relationship can gratify emotional needs up to a point, there is little room for growth and change.

Both Anne and John have acute dependency needs, and there is a rivalry for whose need is greater. Each would like the therapist for themselves, which makes them resistant to her interpretations and makes it difficult for them to use what she can give them. The therapist is well aware of this.

A single therapist has a doubly difficult task. She has to contain the splitting going on and not be tempted to take sides. She must also allow a coniunctio – a good working internal couple to develop within herself – rather than allow a 'warring of the opposites'.

The split within each partner may try to force a split in the therapist, preventing her from having a fruitful dialogue. John particularly and overtly invites retaliatory responses that the therapist works hard to avoid. Anne does this more insidiously and covertly. It would be all too easy to take Anne's side against John because she seems to be the nice, amenable and sad one.

The therapist valiantly resists this, and by doing so does her best to bring the focus back to what they can have from her and from each other. She also works hard to enable them to understand what they do to prevent it.

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Crazy Jane: Lost sanity and catastrophic betrayal in Richard Dadd's painting

MARILYN MATHEW

One day, rather long ago, when I was a teenager whose one ambition was to go to art school, I remember wandering into the Tate Gallery. There I stumbled on an exhibition of paintings by an artist I'd never heard of called Richard Dadd. Tucked away among the landscapes, portraits and the bizarre, fantastically detailed and grotesque scenes of fairy folk was a small 10 × 14 inch watercolour entitled 'Sketch of an idea for Crazy Jane'. The painting immediately caught my attention and I stared for ages, captivated and entranced. Some people are fixated by the *Mona Lisa*'s smile, but for me it's the hauntingly enigmatic eyes of *Crazy Jane*.

In this review I will revisit the painting that first caught my imagination. I begin by introducing some biographical details about Richard Dadd and follow this with my own personal response to the painting, developing it as if it were a dream image. Finally, I will amplify aspects of the painting for wider consideration.

Crazy Jane is, at first glance, a portrait of a wild woman. Painted in washed-out duck-egg blues, primrose yellows and dirty pinks with touches of darker greys and greens, it depicts a disturbing aspect of the psyche. Perhaps it is no surprise to discover that Richard Dadd had an intimate relationship with madness. He spent 42 years in criminal lunatic asylums and was one of four siblings out of seven who died insane.

Born in Chatham in 1817 into a respectable and apparently happy family, his artistic talent flourished, and from the age of 13 Dadd began to draw seriously. He entered the Royal Academy School in 1837, and was described by a colleague as 'one of the noblest natures and brightest minds that ever existed'. He was an attractive, well-liked and gifted artist who seemed to be embarking on a brilliant career. But in 1842 he set out on an arduous journey – a sketching tour of Asia Minor and Egypt – that was to change his life.

Whether it was triggered by sunstroke, or the exhaustion of travelling, or the immersion in ancient and exotic cultures, it seems that during these travels Dadd first began to feel unhinged. The storm clouds of psychosis were

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gathering rapidly, and by the time he arrived in Egypt, raw archetypal powers had erupted. Dadd became convinced that he was being pursued by demonic spirits and, by the time he returned home, he was 'utterly foreign to his former character'. He had become gloomy, suspicious, quiet and unpredictable. People began to worry when they discovered 300 eggs in his studio and a floor covered with eggshells, alongside drawings of his friends with their throats cut. His father's refusal to accept his son's dangerous insanity cost him his life; Dadd stabbed him to death and he thereafter spent the rest of his life incarcerated.

The Bethlem Hospital in Southwark (now the Imperial War Museum) was where Richard Dadd painted *Crazy Jane* in 1855. This image illustrates 'The Ballard of Poor Crazy Jane', which tells of a 'wandering wretched creature' whose heart has been broken and mind forever fractured by a deserting lover:

> Now forlorn and broken hearted
> And with frenzied thoughts beset,
> On that spot where last we parted,
> On that spot where first we met
> Still I sing my lovelorn ditty
> Still I slowly pace the plain,
> While each passer by in pity
> Cries God help thee Crazy Jane. (from Allderidge, 1974)

The song and verse of the ballad resonate in the elliptical movements of the picture's composition, suggesting a swirling dance. Long-haired, wild and wind-blown Jane, clearly a male model, who has the sharp eyes of a jay and collects snippets of exquisite paraphernalia with which to make herself beautiful. 'She' stretches diagonally across the paper, carrying above 'her' head a branch decorated with knots of blue ribbon, bunches of feathers, twists of columbine and dried leaves. In the other raised hand are clasped a few strands of broken-eared wheat that look as though they have been wrenched impetuously from a field. Woven into her hair are more threads of columbine, ribbon and a peacock's tail feather. Her skirt is patched and its deep grey band grounds the figure at the base of the picture, linking tonally with the green trees on the distant horizon. Jane stands as if caught in mid-twirl, as though at any moment she might flick her twiggy wand and flounce off. In the background among the trees stand the ruins of a castle, its turret encircled by black carrion crows. These harbingers of death flock and swoop ominously about our heroine, like demonic thoughts against the expanse of innocent pale grey clouds.

Jane is the heart-broken crazed heroine, but perhaps there is more to her than meets the eye if we choose to look deeper. To look at a painting can be an invitation to dive into its world. As Joy Schaverien writes:

> The work of art can act as a conductor for deep psychic forces and channel a profound level of communication between viewer and the picture. Great art is intensely personal and yet it transcends the merely personal. It is the recognition of the human condition which is embodied in the work, which induces such affect. The spectator stands in some 'possessive relation' to the state which is depicted. The recognition that the artist has known this state also is an affirmation to the viewer. The picture which communicates thus, goes far beyond words in illuminating the essence of the human condition. In this recognition the viewer is, in a sense, merged with the picture. (Schaverien, 1991)

Looking at the painting of *Crazy Jane* I am drawn irresistibly to the eyes. These windows of the soul stare unblinking into the observer and seem to encapsulate a moment when linear and eternal time intersect. The quality of the eyes seems to pull one back through their archetypal image to a numinous experience of being clasped in Jane's clear unwavering gaze. The gaze is unquestionably mad, but they contain a direct and soulful wisdom, which is loaded with meaning and depth. It reminds me of the look of a newborn child whose gaze invites one to enter into the realm from which it has recently emerged and has not yet quite forgotten. Perhaps in this gaze we might have an idea of the underlying significance of this painting. Like the *Mona Lisa*, I am not sure exactly what it is that is so enigmatic, but it speaks to a depth. A painting, like a myth, can have a powerful impact, as Jung appreciated: 'Because of its numinosity, the myth has a direct effect on the unconscious, no matter whether it is understood or not' (Jung, 1959).

Suppose we treat this painting as an image that might offer both clues to the past and hints of future movement, as well as a statement of the present and the painter's internal world?

With 'her' fixating enigmatic gaze, it would be tempting to imagine an anima/animus figure – a person's 'other dream half' or 'soul image', a guide linking consciousness to the underworld. Jane's ambiguous sex might denote transsexuality, but also suggests the Trickster, a mischievous mercurial shape-changing figure who Jung termed: 'a faithful reflection of an absolutely undifferentiated human consciousness, corresponding to a psyche that has hardly left the animal level' (Jung, 1959).

The archetypal image of the Trickster, otherwise known as the spirit Mercurius, is a collective shadow figure that might seem at first to be simply a fool. Jung mentions, in his chapter 'On the Psychology of the Trickster-Figure', that the intriguing complex image of this archetype often contains hidden secrets that are not simply of a shadow nature. Close behind the Trickster stands the Anima, who is endowed with considerable powers of fascination and possession, but he also links the Trickster with the potential of a saviour figure. A Trickster figure appearing in a dream might well indicate that there are destructive unconscious states of mind about, but it might also denote the possibility of transformation.

Thinking about Jane's trappings is particularly interesting to me as they can add to an understanding of the painting's symbolic meaning. The old ditty about wedding garb comes to mind: 'something old, something new, something borrowed, something blue'. Is Jane still wearing the trappings of a marriage that never took place? The blue ribbons wound around her wrists, arms and twig are knotted with beads and buttons (means of tying and fastening as well as decoration), feathers (evoking flight and Icarus) and dried sycamore leaves (is it too far-fetched to think of sick-amour?). Long strands of dried wheat (fertility and seeds of basic nourishment) are crumpled and woven through the knuckles of her right hand, encircling her head and hips. Small white daisies (flowers of innocence) and wisps of a blue columbine (flowers that overwhelm and strangle) decorate her tresses and snake around the branch she holds.

Dadd paints Jane's eyes with a strand of hair falling between them, separating left from right. The almond-shaped eyes resemble a pair of butterfly's wings, echoed by the all-seeing third eye of the iridescent peacock's feather that swoops out to the left. The beautiful Psyche became a butterfly, and was immortalized in mythology as the symbol of the soul. In Dadd's picture the 'butterfly' of Jane's eyes is split in two by the strand of hair. Perhaps his vision of his self is fractured.

The crumbling tower in the background, perhaps a symbol of dashed sense of self, is reminiscent of the image of the Tower of the Tarot or of Gormenghast, Mervyn Peak's extraordinary and complex castle. According to the Tarot, the Tower represents a complete and sudden disruption of a basic

foundation – havoc, breakdown, loss of stability – and even reversed means being imprisoned in an unhappy situation.

The black company of crows circling the ruined building swoop like dark shadows behind Jane; their leader turns its head as if communicating with the rest of the flock. I understood these birds to be the ominous harbingers of death, the shady spirits of the departed, or a connection with the demonic aspects of the collective unconscious. However, an artist/patient recently brought a self-portrait to a session. The portrait contained a large black crow hovering above his head and, when I asked about the significance of the black bird, he explained that for him it was a very positive image that symbolized inspiration. His artistic creativity comes from encountering the depths of his psychic world, but what surprised me somewhat was that the black bird's rather ominous nature could be viewed as such a helpful image.

The question remains as to how much *Crazy Jane* is a self-portrait or a portrait of a fellow patient. Was the model confused by his sexual identity or a transvestite? Was he dressed by Dadd to pose for this picture or was she/he an image from his imagination?

I think paintings always bear the print of the artist who creates them, and to some extent are always biographical. In painting *Crazy Jane*, Dadd depicts a catastrophic betrayal. Perhaps, more than any other of his numerous paintings, this one lets us know how it feels to have one's sanity lost forever, leaving only the possibility of painting as a raison d'être and a hope of communicating a state of mind for which there are no words.

Acknowledgement

I would like to thank Patricia Allderidge, curator of the Museum of the Mind at the Bethlem Royal Hospital, for permission to reproduce the image of *Crazy Jane*. The Museum, in Monks Orchard Road, Beckenham, Kent, is open by appointment and is definitely worth a visit. It houses a small collection of amazing paintings, drawings and sculptures by a number of artists who have suffered a mental disorder. Dadd's *Crazy Jane* is one of several of his paintings exhibited alongside other works of art which comment on mental illness.
The Museum of the Mind, The Bethlem Royal Hospital, Monks Orchard Road, Beckenham, Kent BR3 3BX. Tel. 020 8777 6611.

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Books Reviewed

Mad Men and Medusas: Reclaiming Hysteria and the Effects of Sibling Relations on the Human Condition

By Juliet Mitchell,
London: Allen Lane, 2000. pp 380, hbk £20

In her latest work Juliet Mitchell undertakes a radical re-evaluation of the concept of hysteria. At the core of this book is the idea that hysteria has feigned death and is hiding within both psychoanalysis and psychiatry.

Juliet Mitchell's influential (1974) *Psychoanalysis and Feminism* used psychoanalysis to challenge feminist orthodoxy. Twenty-six years later, with *Mad Men and Medusas* Mitchell uses her formidable scholarship in the fields of feminist studies, literature and psychoanalysis to challenge psychoanalytic orthodoxy. This challenge has arisen not out of iconoclastic motives but out of clinical experiences that have forced her to reappraise some of the accepted ideas of psychoanalysis.

Mitchell asks: 'Where has hysteria gone?' 'If it is no longer present, did it ever exist?' 'If it exists what is it?' 'Where is hysteria hiding?' 'What of male hysteria?' 'What might hysteria tell us about the human condition?'

The author proposes that hysteria seemed to vanish because of the successful attacks made on the concept from many directions. The postmodernist aversion to generalizations renounces any broad categorization such as hysteria. (Mitchell says that the wishful nature of this postmodernist argument is in itself hysterical.) Feminism attacked the idea of hysteria, seeing it as a term superimposed by patriarchy and male psychiatry on victimized females. Cognitive psychology has eroded the idea of the power of the Freudian repressed unconscious on which the theory of hysteria depends. Modern psychiatry, with its lack of the concept of the unconscious, has rendered the term hysteria 'obsolete'. From within psychoanalysis, the rise of object-relations theory, with its emphasis on the dyadic relations between mother and infant, has obscured some of the discoveries and insights of the earlier classical view. At the same time, Mitchell argues that postwar British psychoanalytical

developments have tended to remove sexuality from the picture, which made it more likely that hysteria would disappear.

Mitchell's answer to the question 'does hysteria exist?' is clearly 'yes'. It is to be found 'alive and unwell' (p. 41), hiding within the fragmentary diagnoses such as Gulf War syndrome, borderline states, multiple personality disorder, anorexia, schizoid states and the host of other phenomena that have displaced the diagnosis of hysteria.

It is when Mitchell asks 'what is hysteria?' that she breaks new ground. Her answer goes something like this: Hysteria expresses a longing for maternal care that is felt to have been lost because of a catastrophe. This disaster is the traumatic realization that one has been displaced by the birth of a sibling or the sudden awareness that such an event is possible. The result is the primal scene fantasy 'which occasions a retrospective imaginary perception of the "unimaginable" event' (p. 24) of parental intercourse. The subject is catapulted back into a primal state of catastrophic anxiety in which the ego is overwhelmed and one's existence is felt to be at stake (Freud's model of primary 'birth anxiety'). This is a defensive denial of displacement and a defensive regression to the state before this awareness, into a position of unassuageable longing for exclusive maternal love. This is a state that precedes differentiation of mind and body. The denial of the reality of sibling-displacement works only partially. The unconscious retains the awareness in the form of a repressed primal scene fantasy. This contains the image of non-existence, of not being present at one's own conception. A compensatory parthenogenetic fantasy develops in which the subject is able, with no outside intervention, to conceive and give birth to himself. One is now triumphantly present at one's own birth.

Mitchell is proposing that the primal scene fantasy is a *consequence* of overwhelming anxiety and is not primary. Mitchell is proposing 'an inversion of the accepted psychoanalytic ordering' (p. 22), so that, rather than seeing the Oedipus complex leading to sibling awareness, she sees instead the awareness of siblings (or their possibility) as causing 'the relationship to the parents to become fully Oedipal' (p. 23). It is this particular constellation of sibling awareness as a trauma – which breaches the ego's ability to cope – regression, the primal scene and the parthenogenetic fantasies that Mitchell proposes as the basis of hysterical presentation. The hysteric is always vulnerable to any situation that may be felt, unconsciously, to repeat the catastrophe of displacement trauma. A slight may be experienced as a trauma. The trauma of displacement is sexualized by the patient to make the breach on the ego more bearable.

Many previous authors have observed that the hysteric's aim is to know what the analyst wants and then to provide it. This wanting is the result of the subject's marked propensity to identify with whoever is seen as able to provide what is missing. The identification is regressive and is a substitute for an inability to cope with the loss of one's place and the love of the object. The

patient insists on remaining in a state of pre-awareness of sibling displacement. The patient is not able to symbolize or represent his or her distress; he or she can only *present* it. This *presentation* of various bodily or other symptoms encapsulate the endless, unsatisfiable need of the patient to undo the sibling displacement, to be reinstated and exclusively wanted.

Mitchell discusses the frequently encountered tendency of the hysteric to identify with the dead. (She highlights Freud's hysterical identification with his dead friend Tilgner's cardiac symptoms.) One of the aims of this identification is to triumphantly 'become' the dead person in order to survive (again and again) the threat of deadly displacement by the sibling rival.

Mitchell uses the term 'laterality' to distinguish these ideas about the importance of sibling awareness in hysteria, from the usual emphasis on generational factors. Her intention is not to discard the central importance of Oedipal factors but to widen out the concept. In support of her argument Mitchell uses evidence from her own clinical work and from detailed re-evaluations of some of the classic case histories of psychoanalysis. Among the cases she reviews are Eisler's 'Tram Man', Rosenfeld's 'Mildred' and Balint's 'Sarah'. Mitchell believes these cases can be re-read in terms of hysteria. From this point of view, Rosenfeld's much-acclaimed pioneering treatment of a psychotic is seen as the treatment of a severe case of hysteria.

With Freud's 'Dora', Mitchell proposes that a re-reading of the case reveals the clear presence of not just the patient's mother but also the importance of Dora's relationship with her brother Otto. Mitchell says Freud's account shows that Dora was identified with her brother, was wild and masculine and took on his illnesses in order to get the attention she saw him winning. Dora craved this attention and was jealous. She then experienced a psychic blow due, thinks Mitchell, to the doctor's intervention which designated her bed-wetting and her nervous asthma as weak and therefore unmasculine. At this point Dora gave up her identification with her brother and became girlish. She realized that she could no longer maintain the illusion that she *was* her brother and collapsed back into a denial of her displacement by him. It was from this point on that her hysteria fully developed.

Mitchell believes that Freud's inauguration of the Oedipus complex contained 'a massive repression of the significance of all the love and hate of sibling relationships' (p. 77). This repression has continued ever since within the insistence on generational relationships to the exclusion of lateral ones. The reasons for this are to be found in Freud's own personality, his family background with its complex ties of intermarriage, and his relationship with his siblings, particularly his dead brother Julius. Freud diagnosed himself not as a case of neurosis but as one of hysteria. Freud's hysterical symptoms were manifest during his relationship with Fliess-as-sibling. Mitchell suggests that the texts show that Freud strongly identified with his patient 'E' (of the Fliess correspondence) and with his symptoms, which Freud shared. Later, when Freud treated Dora, he had overcome his hysteria. He unconsciously wished to

distance himself from it. In so doing, he ignored, in his account of Dora, some of its significant sibling features. Likewise, says Mitchell, Freud repressed obvious material to do with sibling relationships in his commentary on *Hamlet*. Freud may have dropped his interest in male hysteria because it was rather too close to home, so that he rediagnosed both himself and his male hysterical patients as neurotic.

It is a central point of Mitchell's argument that hysteria was initially regarded by Freud as not gendered. The first cases of hysteria that Freud discusses are *males*. She quotes Freud's own words stating his conviction about the existence of male hysteria. Hysteria, though, soon became designated by the largely male medical world as a female disorder because of the stigma of weakness it carried. Men may have 'war neurosis' and 'Gulf War syndrome' with their florid hysterical symptoms, but men may not have hysteria with its connotations of unmanliness.

Mitchell's study of hysteria is wide-ranging. She looks, for example, at the phenomenon of possession and its relations to hysteria. In a chapter that I found one of the most interesting she looks at memory and the way it is bypassed by hysteria. She examines the way that memory is conceptualized by psychoanalysis and argues, convincingly, that this is one of the key features that distinguishes psychoanalysis from all other theories of the mind.

The existence of what Mitchell calls the 'parthenogenetic complex' is taken for granted. In this complex the hysteric refuses the normal disillusionment that he or she cannot, alone, produce a baby. Although plausible, little evidence for it is given. It seemed to me that at times Mitchell might be overstretching her evidence, particularly in some aspects of her re-reading of the Dora case. Mitchell's linking hysteria with intimations of mortality convinces me, but I find her assertion of its link with the death instinct over-speculative. I find her argument about the link between lateral relationships and hysteria most convincing when she discusses Freud's personality, the classic case histories of other analysts, her own clinical work and the lives of writers such as Anne Sexton.

Ultimately, Mitchell regards hysteria as an inevitable aspect of the human condition. She believes that the primary trauma of our birth as a potential state into which we may regress, our prolonged vulnerability following birth and our awareness of our own death as the ultimate displacement, mean that hysteria is an inevitable aspect of our human condition. Hysteria is, then, a defence against thinking and knowing: thinking the unthinkable and knowing the intolerable. Seen from Mitchell's point of view, hysteria is ever present, highly adaptable and underlies a spectrum of conditions that may be given many other names, ranging from mild neurosis to psychosis.

I find the overall force of Mitchell's explanation of hysteria compelling. This book has thrown light on some of my own, previously obscure, clinical experiences. I will wait to see whether the passage of time bears out this initial impact. Meanwhile, I think the book is a *tour de force* of experience, wisdom

and scholarship. It is something to be reckoned with. I would be very surprised if this challenge to aspects of classical and object-relations theory does not provoke a debate within psychoanalysis. I think this debate will do nothing but enrich our work.

SIMON ARCHER

The Feeling of What Happens. Body, Emotion and the Making of Consciousness

By Antonio Damasio
London: William Heinemann, 1999, pp. 385, hbk £20

Antonio Damasio, born and educated in Portugal, is head of the department of neurology at the University of Iowa College of Medicine. In his previous book, *Descartes' Error*, he showed that mind cannot exist or operate without body, and argued persuasively that emotions are essential to our survival. In this second book, he once again illuminates the area where neuroscience asks the same questions as philosophy about the nature of the self and the nature of consciousness.

Writing for the layman as well as the scientist, his prose is lucid and elegant, his examples vivid and his definitions clear and consistent. Damasio presents hypotheses rather than certainties. *The Feeling of What Happens* is grounded in his clinical case studies and neurological researches; it is also lit up throughout with an understanding of the contemporary philosophical debates about the nature of consciousness. Damasio in this book redefines the term 'mind'. Whereas other neuro-scientists, such as Susan Greenfield, talk of *the* mind, Damasio, in a provocative footnote, refers to 'mind' not as a *thing*, but as a *process*, a continuous flow of mental patterns that encompass both conscious and non-conscious operations. *The Feeling of What Happens* is therefore a book about consciousness.

Damasio sets out the main theme of his book and his thesis in his first chapter. Consciousness and emotion are not separable: they must necessarily be linked to the body. The matter of self is a critical issue in the elucidation of consciousness. He proposes that the problems of consciousness are a combination of two related problems. First, how does the brain inside the human organism engender the mental patterns we call the images of an object; in other words, how do we get a 'movie-in-the-brain'? Second, how does the brain engender a sense of self in the act of knowing?

Damasio argues persuasively that consciousness is not a monolith; that core consciousness needs to be distinguished from extended consciousness. What Damasio calls core consciousness is the simple biological phenomenon, mediated by neuro-anatomical structures (summarized on pp. 193–4), that provides the organism with a sense of self about one moment, now, and about one

place, here. 'The scope of core consciousness is the here and now' (p. 16). What Damasio calls extended consciousness is a complex phenomenon evolving over a lifetime, which provides the organism with an elaborate sense of self and places the person in individual historical time. Extended consciousness includes memory and allows us to develop language, creativity and conscience. Clinical cases, especially the description of his work with David, who has only short-term memory, support his view that core and extended consciousness must be differentiated. David's story is both vivid and moving. The evidence from his clinical work has convinced Damasio that core consciousness is possible without extended consciousness. If, however, core consciousness is defective, there will be no extended consciousness.

If consciousness can be differentiated, so can self. The two kinds of consciousness correspond to two kinds of self – that is, the core self, 'ceaselessly recreated for every object with which the brain interacts', and the autobiographical self, which corresponds to a non-transient collection of unique facts and ways of being that characterize a person. Underlying both is what Damasio calls the 'proto-self, the deep roots of self, the collection of brain devices which continuously and unconsciously maintain the body state, of which we are not conscious. The proto-self is 'the coherent collection of neural patterns which map, moment by moment, the state of the physical structure of the organism in its many dimensions'. These patterns or structures are intimately involved in regulating the steady internal state of the living organism (p. 154). 'Homeostasis is a key to the biology of consciousness' (p. 40).

For Damasio the problem of consciousness can been seen in terms of two players – the organism and the object – and in terms of the relationships of those players. The organism is the entire unit of our living being, our body and the brain, which holds within it a sort of model of the whole thing (p. 22). The object is anything that causes a change in the organism. With consciousness we are able to make a relationship between the two – the organism can relate to whatever it is that has caused it to change. Core consciousness is the process of achieving a neural and mental pattern that brings together in about the same instant the patterns for the object, the patterns for the organism and the patterns for the relationship between them (p. 154).

What is the relevance of emotion? For Damasio emotion is crucial. In a historical aside he comments that for most of the 20th century neither philosophers nor scientists studied emotion seriously. For his part, Damasio believes that consciousness begins as a feeling and that consciousness is a feeling of knowing. He argues that the brain structures most closely related to consciousness process body signals from the internal milieu and from the environment, and all operate with the non-verbal vocabulary of feelings: 'It is thus plausible that the neural patterns which arise from activity in those structures are the basis for the sort of mental images we call feelings' (p. 313).

Damasio starts by making clear his definitions of feeling and emotion. In his vocabulary, emotions are outwardly directed and publicly observable

whereas feelings are inwardly directed and private. Emotions pervade our being. Emotions are complicated collections of chemical and neural responses, all of which have some kind of regulatory role to play in the life of the body and some of which are publicly observable. Emotions are part of the bioregulatory devices that we need to survive; they produce a specific reaction to a situation and they regulate the internal state of the organism so that it can be prepared for that specific reaction. At their most basic, emotions are part of homeostatic regulation. Emotions have varied bodily responses: some are obvious, as in changes in the skin and muscles, and others are not so apparent, as in the secretion of hormones and peptides and the release of neurotransmitters. Damasio's researches have convinced him that the absence of emotion is a reliable correlate of defective core consciousness.

Damasio reserves the term 'feeling' for the private mental experience of an emotion, when an emotion becomes an image. Consequent to the state of emotion and the state of feeling, there exists the state of feeling made known – that is, known to the organism having both the emotion and the feeling. We are only conscious, we can only *know*, when we can map the relationship of the object and the organism. Damasio's hypothesis is that core consciousness occurs when the brain's representation devices generate an image, a non-verbal account of how the organism is affected by the processing of an object. 'With the licence of metaphor, one might say that the swift, second-order non-verbal account narrates a story: that of the organism caught in the act of representing its own changing state as it goes about representing something else. But the astonishing fact is that the knowable entity of the catcher has just been created in the narrative of the catching process' (p. 170).

Only a neuro-scientist can judge how convincing are Damasio's deductions about the workings of the brain; only a philosopher can determine whether Damasio has tackled the hard problem of consciousness, subjectivity. For a lay psychotherapist Damasio's book provokes serious reflection about both the theoretical and clinical bases of our practice. He makes clear that the psychoanalytic unconscious is 'only part of the vast amount of processes and contents that remain non-conscious'. His list (p. 228) of the 'non-known' includes not only 'all the fully formed images to which we do not attend', 'all the neural patterns which never become images' and so on, but ends with 'all the hidden wisdom and know-how that nature embodied in innate homeostatic dispositions'. 'Disposition' has an echo of 'archetype'. For the clinician, the concept of a proto-self and a core self coexisting at the same time as the autobiographical self justifies the notion of continuous dream life and frees one from referring to such processes as primitive, as if they were developmentally early.

The Feeling of What Happens is not an easy read for those with no knowledge of neuro-science, despite Damasio's patient exposition of the neurological issues by means of clinical examples that may seem repetitive to more knowledgeable readers. Nevertheless, for the psychotherapist the book is important because Damasio has provided the tools for grounding psychotherapeutic

theories and practice in contemporary neuro-scientific research. Its significance for the analytic community is already being recognized.

GINA ALEXANDER

The Revealing Image: Analytical Art Psychotherapy in Theory and Practice

By Joy Shaverien
London, Jessica Kingsley, 1999, pp. 236, pbk £16.95 (first published by Routledge, 1991)

Since its first publication in 1991, Joy Shaverien's thoughtful and inspiring book *The Revealing Image* has become a seminal text. It links the two worlds of analytical psychotherapy and art therapy in the practice of analytical art psychotherapy, which establishes the art object in a central position as the locus of transformation.

Drawing on the work of Jung, especially *Psychology of the Transference*, Cassirer's *Philosophy of Symbolic Forms*, the psychoanalytic theories of Freud and Winnicott, and the archetypal theories of Hillman, the book delves into both the life *in* the picture through its embodied image and the life *of* the picture through transference, mediation and interpretation.

Familiar psychoanalytic concepts such as transference and countertransference, boundary and frame, are clearly described and applied to the process of working with art in therapy, as are the ways in which the picture may influence the transference to the therapist and the ways the transference may influence the pictures.

The process of making art is well known to have an inherently healing potential, but it is the way that images, or a series of images, can mediate and transform within the frame of a safe therapeutic relationship that is the focus of the book. The earlier chapters deal with the theories behind analytical art psychotherapy and two later chapters describe clinical examples.

Of particular interest theoretically is Chapter 2, which describes the way that a picture may embody a *Scapegoat Transference* and how its disposal may play a significant part in the resolution of the transference. Creating a scapegoat is a ritual means of atoning for sins. Traditionally, two goats were chosen, one to be sacrificed as an offering and the other to be banished into the wilderness burdened with sin. This form of splitting of good and bad, picturing the bad and its subsequent disposal, can be used in a way that is unique to analytical art psychotherapy as the picture can be got rid of, kept safe or given as a gift. The attack can be safely made on the picture rather than the therapist who survives as witness.

Joy Schaverien describes how the picture in analytic art psychotherapy

becomes an embodiment of the process of soulmaking operating in the individual and between the pair. She challenges the long-held view in art therapy that the making of pictures is more important than the final image, claiming that both are important, and she develops this to identify four stages in the life of the picture before disposal: identification, familiarization, acknowledgement and assimilation. She describes how the evolution of an image or a series of pictures can have a formative effect on consciousness; by 'uncloaking' an unconscious image and working it through using drawn or painted images, an art object can mediate and transform both inner and outer worlds.

The boundary in analytical art psychotherapy extends to include a studio and a gallery where patients/artists have the opportunity of reviewing their artwork with a therapist/viewer. In reading about this, I became acutely aware how I hold on to the threads of my patients' dream series, sometimes recalling their histories. How enormously interesting and useful it would be to be able to get dreams out of a cupboard and lay them all out for review in the way that is possible with paint and paper! Analytical art psychotherapy allows the pictures to speak for themselves and act directly on the unconscious of both patient and therapist. As discussed in Chapter 7, an art image can become a numinous *talisman*, embodied and empowered with magical transcendent properties.

The most powerful and riveting part of this book in contained in Chapter 8. Here Schaverien portrays in depth the work with a patient called Harry. His pictures, illustrated in black and white and in colour, are fascinating in themselves, but looking at the series through an analytical lens reveals archetypal processes at work. Jung paid particular attention to the spontaneous images that arise from the unconscious, discovering the 15th century woodcuts of the *Rosarium* to have unique relevance to the transference – and this is where Harry's pictures come to life in the book. Schaverien comments on the progression of healing in Harry's artwork, which mirrors the archetypal images of the *Rosarium*. We can follow the alchemist's metaphysical endeavour of creating gold from base metal through the sequence of *nigredo*, *albedo* and *rubedo* in the modern media of paint, felt-tip pen and charcoal.

This book is essential reading for anyone who is interested in the healing powers of art, the archetypal nature of images, and ways of tracking the transference. Analytical psychotherapists may find themselves inspired to rush out to the art shop and stock up on paints, or at the very least look with added enthusiasm on any artwork that finds its way into the consulting room. Jung positively encouraged his patients to paint and draw, as he did himself, and I frequently find myself working with people who use art as a means of self-expression, discovery and healing. Sometimes pictures can say more than words, which this book so eloquently illustrates.

MARILYN MATHEW

Hysteria

By Christopher Bollas
London, Routledge, 2000, pp. 192, pbk £16.99

In this book Christopher Bollas explores hysteria in the light of his supervisory experience. He was struck by how often his students opted for a diagnosis of borderline personality disorder when the patient under review clearly suffered from a hysterical disorder. Bollas uses different perspectives to explore the essential traits of the clinical phenomenon of hysteria. He achieves this by giving equal weight to the self's stages of psychic development, its object relations, its biological development (what Bollas refers to as the self's bio-logic) and the self's formation in a cultural framework. Bollas' intellectual capacity for overview and his ability to synthesize different perspectives often strike the reader as unique in the field of psychoanalysis, confirming his position as an eminent proponent of the Independent school of psychoanalysis. Although Bollas' work rests fundamentally on Freud's theories, he acknowledges the influence of British object-relations theory (the schools of Klein and Winnicott) and of the work of Lacan in particular. The complexity of thought manifested in this book makes it difficult, if not close to impossible, to review in a way that does justice to its scope, its scholarly ambition and its creative originality. I will therefore try only to highlight those ideas that I found particularly interesting and clinically useful.

Bollas begins by taking the reader through the diagnostic maze surrounding different character disorders – that is, perversion, borderline, narcissistic and schizoid. He considers the hysteric in many ways as the most complex character of all. With the exception of what he refers to as the 'malignant hysteric', he considers the hysteric's relation to the primary object as different from those of the other character disorders. The experience of a mother who lacks an unconscious sense of maternal desire for the child's sexual body, especially the genitals, characterizes the hysteric and is a theme that Bollas returns to throughout the book. In other respects the child often experiences maternal interest, passion, investment and care. Bollas describes the mother as being in conflict over the child that she knows she has failed. In response to this, the child seeks out who he or she is in regard to the mother. In so doing the infant suspends the self's expression so it can fulfil the desires of the mother, the primary object. Bollas would consider the mother herself to be a hysteric. She may be a whole object, but in respect of her sexuality she is insecure and communicates this to her infant. In object-relations terms the hysteric views sexuality as a form of separation from maternal love and this opposition between love and sexuality becomes, according to Bollas, a core feature of hysteria. Although Bollas argues that sexuality in itself is traumatic to all

children, as far as the hysterical patient is concerned, the personality is organized as an opposition to the knowledge of mother as a sexual object.

Bollas firmly puts the popular view of hysteria as a female disorder in its place. Indeed he thinks there are as many male as female hysterics and gives male impotence as an example of a common conversion symptom. As if to underline this view he includes ample case material relating to male patients. In a chapter entitled 'Functions of the Father', Bollas gives an interesting clinical vignette, which captures the essence of a hysterical father who refuses to fulfil his fatherly function, and instead joins with the children in acting out anti-authoritarian positions. In this chapter he also explores how the hysteric, more than any of the other 'characters of psychoanalysis', is deeply ambivalent about growing up: 'Being a charming girl or boy, a beguiling man or woman, seems compromise enough' (p.82). He coins the term Barbie children to conjure up the image of unusually good children who suspend their true selves in order to realize what they imagine to be parental desire. However, as he illustrates so vividly in the book, the tragedy is that the hysteric endeavours to be the ideal boy or girl throughout a lifetime, keeping an innocent child as the core self. He also describes how the hysteric is aware of losing out, is envious of others' maturation and how the sadness over what is lost becomes part of the hysterical melancholy.

In a later chapter Bollas describes the anorectic as someone who most radically expresses the hysteric's ability to reverse the maturational process, where progressive weight loss becomes a corporeal manifestation of a psychic reduction. The anorectic claims that he or she is simply caught up in a cultural system promoting the ideal slim self. Bollas concludes that the plethora of support programmes and facilities for anorectic patients, although they do save lives, can do so by colluding with the hysterical process, 'implicitly accepting the reduction of a complex adult into a simplified being' (p.105).

Bollas' idea of absence, and particularly the eroticization of absence, is especially interesting. He sees the hysteric as creating forms of presence in order to play off absence. For example, sudden abstention from communication is often very arresting, so the hysteric absents himself to create a lack in the other. Bollas links this manifestation with the hysteric's feeling that the mother's absence is caused by a withdrawal from the child's sexuality, hence the absence becomes eroticized. Bollas asks the question why, if the hysteric is in conflict with sexuality, does he or she so often appear sexual? The answer, Bollas argues, lies in what he describes as the hysteric's somewhat peculiar auto-sexuality. I quote:

> They imagine themselves the mother's secret object of desire and then, through self-stimulation, erotise the object, which is either narrated back to the mother or performed in her presence. As the mother's sexuality is also auto-erotically based, her narrations and performances express love of the internal object at the expense of the other. (p.62)

Although hysterics do of course engage in intercourse, they often use sexual encounters, to quote Bollas' image, as 'banking' events, collecting and saving up material for their auto-erotic life.

In a later chapter, 'Self as Theatre', Bollas explores the manifestations of the hysteric's behaviour in relation to a clinical vignette. He discusses how the hysteric changes the narrative order from simply telling an event to showing it. He wonders what is the nature of the anxiety surrounding this transition. He suggests that it might be related to the transition from the symbolic to the imaginary order, 'from the world of words alone, to the scene itself' (p.123). The child fears regression from the verbal to the imaginary, when the mother transforms herself from the teller to the shower. This links up with the child's earliest sense of important evidence – that the truth comes through what one sees, that seeing is believing.

Two of the final chapters, titled 'Transference Addicts' and 'Seduction and the Therapist', are particularly rewarding, as they include more detailed clinical material. In the first chapter Bollas turns his attention to the psychoanalytic treatment of hysterics. He states provocatively that if analysts felt free to write up their failures, this would include a large number of certain types of hysterics who defeat the analytic process. To the entrenched hysteric the suffering is a passion, an expression of the patient's erotic life. Although brief, this chapter brings together several strains of Bollas' thinking. For example, he returns to the importance of absence and how untreatability becomes a way for the patient to absent himself. The absence is meant to affect and also excite the analyst, who is meant to share in the suffering of the patient. When the analyst provides a successful interpretation, which might remove certain areas of pathology, the patient is likely to re-represent the problem in a slightly different form. This is also the type of patient, according to Bollas, who can move from one analysis to the next, seducing the new analyst by presenting a picture of how misunderstood they have been in their previous analysis.

Bollas returns throughout the book to comparisons between different disorders. For example, he explores how the borderline patient is experienced as persecuting and infuriating, putting the analyst into a defensive frame of mind, while the hysteric on the other hand is often charming and disarming, inviting thoughts of an affectionate type. These kinds of comparison are very helpful as they encourage the reader to think of hysteria in the context of a spectrum. In the final chapter Bollas returns to Freud, who was the first psychoanalyst to compare hysteria and perversion. Bollas explores the relationship between the two with clarity and eloquence.

It would seem unfair not to comment on the author's prose, which at times is quite breathtaking. Bollas has an ability to move between two different axioms in his writing, to keep the reader engaged. At times he uses a dense language, rich in imagery and lively symbolism; at others he condenses complex phenomena into a brief sentence where anything redundant has been stripped away.

VIVEKA NYBERG

A Life of Jung

By Ronald Hayman
London, Bloomsbury, 1999, pp. 522, hbk £25

Hayman provides us with interesting, sometimes new, information on Jung's life, taking us through his life chronologically, and at the same time weaving in themes through each age that connect with other themes. He does not separate the man from the work. Hayman's researches and wide-ranging sources are impressive, and 50 pages of notes at the end of the book bear witness to this. Apart from what was available in Jung's *Collected Works*, he has found new sources from little-known correspondences and through Jung's interviews with Anthony Storr, Michael Fordham and John Freeman among others.

What picture of Jung emerges in this book? We are told that as a child of four he had a split personality and a strong will to recovery. At that time he had a powerful dream of a rectangular stone-lined hole in a nearby meadow, leading to a descending stairway. Behind a heavy curtain he found a red-carpeted chamber and on a platform stood a throne. On it was a thick thing, so tall it nearly reached the ceiling and was made of skin and flesh. Hayman tells us that Jung only identified it much later in life as a *ritual* phallus. As a child he kept this dream, and his feelings about it and many other matters, a secret that he shared with no one. He dealt with this and his other significant dream of God squatting on a golden throne and dropping a massive turd that shattered the dome of Basel Cathedral, all by himself. He was then only 12 years old and was shocked by the blasphemy of the images.

Women were always important to Jung. Hayman describes his mother's dark moods and how the young Carl was frightened by some of these. The olive-skinned maid who looked after him when his mother was in a mental hospital was a positive image that was later reflected in the looks of women who were inspirations to him, mainly Sabina Spielrein and later Toni Wolff. His cousin Helly had similar looks and she is said to have shared with Jung's mother a predilection for the paranormal. Jung as a teenager held seances and put his cousin into trances. Later on Jung used these experiences for his inaugural doctoral thesis. Hayman says (p. 58): 'Jung did not admit he had taken an active part in the seances, or even that he had gone on participating in them for four and a half years', and (p. 60) 'Even if he now believed he might have harmed her by encouraging her tendency to dissociation, he could hardly confess this in a thesis designed to win him a doctorate.' Is Hayman implicitly questioning Jung's integrity? He doesn't quite say so.

We are also told that Jung's father, a Protestant pastor, did not know about the seances, nor did he know that one of his own friends made a homosexual attack on the 18-year-old Carl. According to Hayman, these were inauspicious beginnings. Presumably he means that they may be inauspicious for his future career and happiness. Jung's teaching in later life made it clear that one

can turn inauspicious circumstances into advantages. His life demonstrated it. After his father died, Jung decided to study medicine and financial help came from an uncle.

We also learn that, financially, Jung was in no position to propose to the wealthy Emma Rauschenbach, but that her mother encouraged the couple in spite of this. They married in 1903. Jung worked and lived at the Burgholzli mental hospital. Although Emma understood little about her husband's work, she was his first volunteer subject for his Word-Association-Test in 1905. She was pregnant at the time. Hayman writes (p. 68) that she revealed what she most wanted to hide in the experiment, namely 'her nervous anticipation and her love for her husband together with slightly jealous fears'. She had good reasons for 'slightly jealous fears'. We are shown in the book how, in time, she learned to be tolerant. A loyal wife, she managed to hold on to the contradictions in her life with dignity.

In 1904 Jung, who was interested in Freud's method of psychoanalysis, took on his first analysand, the deeply disturbed 18-year-old Sabina Spielrein. Hayman writes (p. 73): 'Within four and a half months, Jung said he had analysed Sabina. He had apparently given her one or two hours every other day.' We are told that Jung saw Sabina as exceptional in that she wanted intellectual independence. He took Sabina out for walks and talked to her about his life. She made a rapid recovery. Again there is a subtle suggestion here by Hayman that analysis is hardly meant to be like this. Well no, not in our times. However, the early pioneers like Freud and Jung worked with patients for much shorter periods of time.

Looking to the future, Hayman writes (p. 75): 'Perhaps for the first time, Jung was making full use of his ability to give a patient a more flattering image of herself than she would have found without his help' and he goes on to comment, 'for the next fifty years, female patients would discover a new identity by looking at their reflection in his eyes', and adds 'In making it possible for them to achieve it, he was doing what their mother had failed to do for them, and his mother had failed to do for him.' Women had few opportunities at that time to express themselves intellectually and Jung helped to bring about a different era. 'Spiritual rebirth' was a serious need of intelligent women of the pre-feminist years and Jung was a champion of a number of bright women. Fifty years later John Freeman, who, after the 1959 BBC interview with Jung, became a friend, tells us that Jung was preoccupied in those late years with the idea that 'this is the Marian age in which the female is going to dominate'.[1] Sabina was the first patient Jung invited to assist him with his work. Was it a first step towards Jung foreseeing the Marian age of the late 20th century?

Hayman shows that Jung's journey from early youth's fascination with spiritualism to the middle-aged Jung building his tower at Bollingen, hewing stones, are two aspects of the same man. Half of him went to Zurich to lecture to a sophisticated and lively audience, the other half needed to stare at the water of the lake in solitude for long periods, before he could write.

Freud's life too seems well researched by Hayman and described in intimate detail. Freud's sister-in-law Minna is said to have had to go through the Freuds' bedroom to get to the bathroom and to have complained to guests that she had to go on holiday with Freud on her own. Looked at from the point of view of a Victorian maiden aunt in the early part of the last century, what are we to make of it? Hayman sees a connection between the homosexuality inherent in the Fliess–Freud correspondence, the 50-year-old Freud's low self-esteem and the affectionate expectations he had of the younger Jung. Both men were great pioneers, made mistakes and learned from them.

Jung left us many concepts that became ubiquitous. Hayman writes (p. 439): 'Nothing was more central to his thinking than the idea that we cannot fully experience goodness without experiencing evil.' Contradictions of diverse aspects of Jung's personality are interwoven in this book in an arresting way. An example, on the one hand, is Jung's role in Nazi Germany, and, on the other, is his cultivating the company of a number of eminent Jews, especially after the war. This is seen by Hayman (p. 313) as 'not admirable' but 'understandable', and he comments 'he did not know how long they were going to be in power'. It is hard to know whether Hayman is being ironic, accepting of human weakness or simply factual.

In old age Jung regarded himself as a prophet. In a letter to Victor White dated 24 November 1953 and quoted by Hayman (p. 425) Jung wrote: 'Somebody is entrusted with the task of looking ahead and speaking of the things to be'. Jung was acquainted with the ideas of modern physics. He was also in touch with his peasant roots and believed in the intuitive healing powers of the natural environment. Hayman (p. 418) quotes Jung: 'We must completely give up the idea of the psyche's being somehow connected with the brain, and remember instead the "meaningful" or "intelligent" behaviour of lower organisms that are without brain.'[2] Many young people today try to find their genuine inner voice and seek inspiration through contact with the natural environment. Some of them look for it in the works of Jung.

I like the way Hayman throws light on how Jung's ideas were developing and his life unfolding. I respect his scholarship and research. However, I feel unhappy about the way some of the details are presented. It allows little privacy to its subject. Putting the spotlight on great men's 'feet of clay' has become contemporary literary fashion. Jung, who was a man of contradictions, taught us that secrets can be poisonous. Some of his are revealed here. It seems to me at times more like a damning or denigration than a description of what happened. A biographer cannot help interpreting his evidence. He can, however, choose what he leaves out. How relevant is it, for example, to be told that old Dr Jung emptied the contents of his chamber pot from his upstairs window, at one time narrowly missing his grandson below? The truth about a person is always Janus-faced. Whether you will like this book or not will depend on your perspective. I personally enjoyed reading it and recommend it.

MARIETTA MARCUS

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