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Editorial

We are pleased to announce that in this edition of the Journal we are introducing a new section entitled *Classics Revisited*. This section will be an opportunity to review classic papers in our literature from a contemporary perspective. We are fortunate to have the first essay written by the editor of this new section, Noel Hess, who has chosen to revisit Herbert Rosenfeld's 1971 paper, 'A clinical approach to the psychoanalytic theory of the life and death instincts: an investigation into the aggressive aspects of narcissism'.

We continue the theme of destructive narcissism in two of the papers in this issue as well as in our Arts Review. Stanley Ruszczynski, in his paper 'States of mind in perversion and violence', focuses on the psychic structure of patients who carry out acts of perversion and violence and raises the question as to whether such psychic functioning is present, although to a lesser degree, in many of, if not all of, our patients. He offers some thoughts as to why some patients actually do act out in extreme and disturbing ways. In Jessica Sacret's paper 'Trauma and terror: a matter of life and death' she argues that an understanding of terrorism in the world today can help us acknowledge aspects of destructiveness in ourselves and our patients. She elaborates on the forces of life and death instincts in the consulting room, focusing on patients who experienced trauma at an early age and whose destructiveness gives the appearance of 'terrorists on the couch'. Jan Harvie-Clark's paper 'Neuroscience and psychoanalysis: a view from a consulting room' is an account of her growing interest in neuroscience and of ways in which she is using the new concepts in her own psychotherapy practice.

In our Arts Section Jay Smith sees the film *The Truman Show* as a drama concerning a traumatized man's sterile inner world. It echoes, she says, a description by Borges about Citzen Kane: '...A kind of metaphysical detective story, its subject (both psychological and allegorical) is the investigation of a man's inner self, through the works he has wrought, the words he has spoken, the many lives he has ruined.'

We have our usual Book Review section, and in our Clinical Commentaries we have more lively discussion of the clinical material by psychotherapists from different Sections of the BAP.

The Editors

Erratum

The editorial in the last issue of the *Journal of the British Association of Psychotherapists* made reference to Jan Harvie-Clark's paper, which for reasons of space was not then published and which now appears in this issue. We apologize to our readers for any confusion caused.

States of mind in perversion and violence

STANLEY RUSZCZYNSKI

ABSTRACT

In this paper the author explores the idea of what he calls a perverse state of mind, *which is present, he suggests, in the psychic structure of patients who carry out acts of sexual perversion and violence. He outlines the nature of this psychic structure using Glasser's notion of the 'core complex' and Money-Kyrle's delineation of certain irrefutable 'facts of life'. He suggests that sadomasochistic and violent enactments might be thought to be perverse solutions to the difficulty of tolerating certain psychic realities. At the end of the paper he addresses the question of why some patients actually do act out in perverse and violent ways and why many do not.*

Key words attacks on psychic realities, containment, 'core complex', 'facts of life', mentalization, perversion and violence, states of mind.

A defining feature of perversion and violence is the sometimes extreme and disturbing acting out that takes place, which is directed externally on to the body of the victim and sometimes on to the body of the self. This is always accompanied by an attack on the mind of the victim and of the self. As with borderline and psychotic patients, perverse and violent patients overwhelmingly *act on* their environment, both physically and psychically. In the clinical situation it is necessary to have in mind both the nature of the perverse and violent behaviour and what might be the nature of the patient's psychic organization with its particular anxieties, defences and internal object relations. Because of the psychic toxicity of the sometimes very disturbing violent and perverse behaviours enacted by some patients it is often difficult to maintain this psychoanalytic attitude.

Stanley Ruszczynski is a Full Member of the Psychoanalytic Section of the British Association of Psychotherapists and works in private practice. He is a Principal Adult Psychotherapist at the Portman Clinic (Tavistock and Portman NHS Trust, London), an outpatient forensic psychotherapy clinic. Versions of this paper have been given at teaching events at the Portman Clinic and at a Scientific Meeting of the British Association of Psychotherapists.

In the psychiatric DSM-IV categorization, the hallmark of 'sexual deviation' or 'sexual perversion' is stated as being 'recurrent, intense sexually arousing fantasies, sexual urges, or behaviours generally involving, i) nonhuman objects, ii) the suffering or humiliation of oneself or one's partner, or iii) children or other nonconsenting persons' (Frances, First and Pincus, 1995: 317). It is noteworthy that in this purely psychiatric description of 'sexual perversion', reference is made to particular, I would say more primitive, types of object relations. The DSM-IV categorization refers to a dehumanized object; it refers to generational differences and raises the issue of dependence; it refers to sadomasochistic suffering and humiliation; and it implies that there is a lack of concern for the object.

All of these considerations, familiar to us in our psychoanalytic thinking about more primitively disturbed patients, are central to our understanding of the unconscious meaning of their perverse and violent fantasies and activities. Thinking about and working with actively perverse and violent patients presents the clinician with the complexity of these conditions reflected in the widely held view that there is probably no unified theoretical framework that helps the understanding of these patients (Rosen, 1979; Hyatt-Williams, 1998; Perelberg, 1999; Cartwright, 2002). In this paper I give one perspective that I have found useful in my work with some such patients.

Initially, Freud understood perversions as residues of infantile component drives that had not been sublimated. In his 'Three Essays on Sexuality' (Freud, 1905), he describes as perverse that sexualized behaviour whereby, either directly or symbolically, the ordinary and developmentally appropriate polymorphously perverse instincts of childhood, sexual and aggressive, remain or become prevalent in the adult's sexual life. It is this regular interference with relatively integrated genital sexuality by these instincts, which are ordinarily present in childhood but are sublimated in adulthood, that is, he says, fundamental to the perverse act. Such 'partial instincts' make up aspects of the ordinary sexual play of children and some such behaviour may also be contained in adult fantasies and in the foreplay of some people in their ordinary sexual lives. What significantly differentiates a perversion is that the activity is compulsive, fixed and does not usually culminate in heterosexual intercourse leading to orgasm.

For example, in the course of a recent assessment with a voyeur/exhibitionist, the patient described how he spends between 4 and 6 hours every day, either in his home or walking the streets, seeking out windows where he might possibly see a woman undressing. He then, at some distance, stands and looks into the window in the hope of seeing something. He very rarely actually sees anything but he repeats the activity the next day and the day after and the day after that. He lives in a house with a number of other people and describes how, when he first moved in, he spent a whole day, using a number of mirrors, getting his chair in the communal dining room into exactly the right position,

so that when he sits in that chair, in the morning, in his short dressing gown, he 'inadvertently' exposes his genitals to the women who share the house.

Another patient, addicted to telephone sex lines, ended up in court with telephone bills totalling tens of thousands of pounds. He used the phone all night, ringing numerous telephone numbers, which are available in various magazines, obsessively searching for *precisely* the right voice of a woman with *exactly* the right attitude to his request for her to verbally abuse and taunt him while he masturbated. He could tell, he said, within moments, whether the voice would be right – usually he would feel that it was not right, would put down the phone and dial the next number. This would be repeated literally hundreds of times until he got the 'right' voice.

It is not unusual for perverse activity and fantasy to have this significantly compulsive nature and to be mirrored symbolically in the whole personality structure of the perverse individual. This has clear implications for the treatment of such patients, as during the course of treatment the internal object relations of the perverse psychic structure will become re-enacted in the transference and reappear in the countertransference. 'Where is the perverse object relationship in the treatment situation?' is a very useful question to have in mind, whether it be asked of the one-to-one clinical situation or in the context of a group of patients and staff on a ward when the patient is in an institutional setting.

An important advance in the understanding of perversion took place when Freud developed his first understanding of perversion as residues of infantile sexuality, and began to describe its essentially defensive functions, defending primarily, he said, against aspects of the Oedipus complex. In 'A Child is Being Beaten' (1919) and 'Fetishism' (1927) Freud refers to the child's anxieties about becoming aware of sexual difference and of the Oedipal situation, with sadomasochism coming to be used as a defence. A number of writers since then have paid particular attention to this understanding and have stressed the perverse patient's distortion and misrepresentation of reality, in particular the reality of the difference between the sexes and between the generations (Chasseguet-Smirgel, 1981, 1985; Steiner, 1993).

We might now say that what is perverted is knowledge of reality – internal and external reality. This disavowal of reality represents a hatred of it and is likely to be the product of both the narcissistic and omnipotent aspects of the perverse patient's personality refuting life's realities, but also a defensive reaction to the unbearableness of the pain, humiliation and subsequent sense of rage and murderousness that he is likely to have experienced in his upbringing. Successful disavowal of reality requires both sadistic control of the object, who has to be recruited into the patient's perverse worldview, and a splitting of the ego that disavows reality. This creates an unconscious object relationship based on this control and misrepresentation and, hence, it is sadomasochistic and perverse.

It is tempting to think that perversions are primarily sexual and driven by sexuality. Perversions are better understood as activities that hijack sexuality to accomplish ends that are fundamentally aggressive and destructive (Caper, 1999) and often involve humiliation. The major element in the aetiology, and therefore in the understanding, of perversion, is humiliation, aggression and hatred. Stoller emphasizes this point by referring to perversion as the 'erotic form of hatred'. He writes,

> Think of the perversions with which you might be familiar: necrophilia, fetishism, rape, sex murder, sadism, masochism, voyeurism, paedophilia – and many more. In each is found – in gross form or hidden but essential in the fantasy – hostility, revenge, triumph and a dehumanised object.... *(W)e can see that someone harming someone else is a main feature in most of these conditions.* (Stoller, 1976: 9; emphasis added)

Sex, therefore, is recruited in the service of aggression and the subject or patient himself or herself is also a victim of this violence and hostility, certainly in their mind and sometimes in their body.

Mervyn Glasser held the view that central to the perverse structure is a dynamic psychic organization that he called 'the core complex', in which aggression is an integral feature (Glasser, 1979, 1998). Its components persist from infancy into adulthood even though psychological development might modify some of their manifest appearance. Glasser described the normal phase of development in which the infant has an intense longing for intimate closeness with another person, usually mother, amounting to what might feel like a merger or union. This longed-for state suggests gratification and safety, with complete security against dangers of deprivation or rejection. However, this normal developmental phase might go wrong if, for example, the mother uses the infant as her own narcissistic or sexual object, or if she is engulfing and smothering, or, on the other hand, rejecting and abandoning of the infant. Sometimes, it might be a combination of all these features. If development does go wrong in some such way, the sought-after closeness might raise in the infant a terror of a loss of his existence as a separate, independent self, with the other person coming to be seen as acquisitive and consuming of the self (Glasser, 1998). Henri Rey described a similar psychic conflict when he referred to the 'claustro-agoraphobic' dilemma, which, he says, leaves the patient feeling that he cannot find a place where he is secure: close to his objects he feels claustrophobic and separate from them he feels agoraphobic (Rey, 1994).

Glasser goes on to describe that this threat of annihilation may be dealt with in one of two ways. One way is that the threat to the self may lead to a defensive narcissistic withdrawal. However, this is likely to produce a sense of isolation and abandonment, leaving only the self (both body and mind) as the focus for the aggression previously directed at the object. This may lead to a profound level of depression that Mervin Glasser considered to be a common

reason for such patients to seek treatment. Alternatively, the threat of annihilation by the engulfing object may provoke intense self-preservative aggression which, while aimed at securing the survival of the self, involves the destruction of the object, usually mother. Such aggressive enactment might produce the behaviour that brings the patient to the attention of the legal or medical authorities, or the feelings of violence night alert the patient themselves to the dangerousness of their fantasies and impulses.

Both of these defensive manoeuvres, however – the narcissistic withdrawal and the self-preservative aggression – result, in fantasy, in the loss or destruction of the desired object. To avoid this consequence the object may come to be protected from the destructiveness by being sexualized. This sexualization creates the fantasy of there being an interpersonal object relationship, rather than engulfment or abandonment.

However, this introduction of sexuality into the process results in masochism or sadism. If there has been a narcissistic withdrawal, there is then only the self available for the aggression initially directed at the threatening object. When this is sexualized it leads to masochism. The masochist has a sense of control over the degree to which he will suffer; he may also have a fantasy that he can control the threat of annihilation. In addition, the masochist may feel that he is clearly not being aggressive to the object, which is then safe from his murderousness. On the other hand, the sexualizing of self-preservative aggression results in sadism, a wish to hurt and to control. This, however, preserves the object, who is now no longer threatened with destruction but is engaged with, albeit sadistically.

Hence the sadomasochistic relationship might be thought to be an attempt to deal with the twin terrors of engulfment and abandonment by trying to maintain a safe distance from the object while tenaciously holding on to it.

It is probably clear that these anxieties about engulfment and abandonment arise from the more infantile and primitive aspects of the personality which dominate the adult mind. Mervin Glasser wrote that, 'the core complex occurs within an essentially narcissistic context and among the consequences of the individual being fixated at this point is that his sexuality cannot be employed to help him in his development and in establishing object relationships' (Glasser, 1985: 413). Freud had already described the creation of a fetish as 'a turning away from reality – a procedure which we should prefer to reserve for the psychoses. And it is in fact not very different' (Freud, 1940: 277). Chasseguet-Smirgel considers perverse behaviour as an attack on reality and an attempt to create a *substitute reality* (reported in Leigh, 1998). We are referring, therefore, to an underlying psychotic structure with narcissistic and omnipotent features, and a preponderance of more primitive or psychotic anxieties, defences and object relations. Intrusiveness and mastery are more likely to be present than a capacity for concern or intimacy.

Let me give some brief clinical vignettes to illustrate this. A masochistic man, who uses a dominatrix to torture and humiliate him, and who is some time into treatment now, is beginning to express the terrifying horror of his sense of emptiness, loneliness and unworthiness. As a child he was repeatedly abandoned and humiliated by his parents. The pain and punishment he receives from the dominatrix, which he scripts and pays her to carry out, temporarily relieves him of these feelings because, with the dominatrix, he is the author of his suffering and humiliation and his eroticization of it offers him some sexual pleasure. He creates a situation whereby he has ultimate control over what is done to him rather than feeling himself to be a victim, hence substituting the sadomasochistic fantasy of control over the object as an alternative to the unbearable reality of his childhood experiences.

A female patient, who was grossly abused sexually, physically and psychologically, by both parents and other carers, actively seeks out and engages in the most frightening and humiliating sexual abuse. She shows her desperate attempt to gain some sort of equilibrium when she talks of how she gains relief when she engineers being used and humiliated, by men and women, because, as she puts it, 'there is then a balance between the way I feel inside and what is happening to me outside'. The illusion of controlling the object rather than of being at its mercy is central.

The sexualization acts like a binding force, organizing and securing the object relationship. Sadistic and masochistic relating are ways of engaging intensively with another so as to militate against the dangers of separateness, loss, loneliness, hurt and destruction. Excited, intense feelings and experiences are used as substitutes for love and care. The excited eroticized repetition serves to defend against feelings of destructiveness, both one's own or that of the other. There is pretence that it is a kind of loving relatedness, an exciting exchange sought by both parties. In reality, of course, true intimacy is precluded. There is a danger, of course, that the sexualization may fail and when this sadomasochism breaks down there is likely to be a reassertion of the self-preservative aggression and violence, with the object's fate of no interest to the subject as he searches for psychic survival at any cost.

Glasser emphasizes that this differentiation between self-preservative aggression and sadomasochism is crucial in understanding the object relating of the perverse or violent patient. The differentiating factor is the attitude to the object at the time at which the act is carried out (Glasser, 1979). The *aggressive* act seeks psychic equilibrium; it is in fantasy self-preservative and its purpose is solely to eliminate the other who is perceived as life threatening. This is a violent and cruel state of mind, often related to a profound sense of humiliation, and at the extreme it is murderous. The *sadistic* act, on the other hand, causes torment and, as it is based on the control and domination of the other, it requires some capacity to imagine the other's state of mind. Here the relationship to the object

is crucial and therefore, unlike with self-preservative violence, the object must not be allowed to be eliminated.

These states of mind are, of course, never quite as clear cut as this in reality. Domination and control are essential features in both aggression and sadism. In aggression they are sought only to negate the danger whereas in sadism they play a central role in entrapping and engaging the object. The centrality of aggression to the perverse act cannot be stressed enough.

Let me give two further illustrations. A young female patient was referred because of depression but also because she often found herself in disturbing sadomasochistic relationships. She had been raped on at least four separate occasions during her adolescence and early adult life, once by a group of men. As a child she had been abused, emotionally and physically, first by her father and then, after being taken into care, by two sets of foster carers. She described herself as generous and self-effacing, willing to put herself out for anyone – friend, neighbour or even strangers. Her masochism, however, was barely hidden behind this pseudo-caretaker role. She ignored clear and obvious signals of danger so that she was constantly in positions in which she could be hurt, abused or raped. She often missed her sessions and, although she did not work, she complained that I was not offering her times that she could manage, making me into an inconsiderate and uncaring object. Often when she did attend she would say that it was for my convenience and not hers. In the transference I became the sadist and she the victim but her attack on me was only just beneath the surface in her near-constant complaints that I was not quite getting it right for her.

Her partner abused her emotionally in various ways and, in effect, rapes her for his sexual satisfaction. She masochistically sustains their relationship in the face of obviously cruel and violent treatment and triumphantly tells me how she is prepared to survive his abusive behaviour because, she says, she has never felt as loved by anyone as she does by him!

In the clinical work we saw that in this masochism there is, in fantasy, a secret triumph over her neglect, abuse and rape. But to sustain this illusion of control and domination over her situation, she has to deceive herself about the degree of abuse she suffers. Very occasionally this perverse structure begins to break down and she becomes physically ill, at which point, briefly, she feels murderous fury at her partner, who pays no attention to her neediness and continues to use her simply for his own needs. In the transference I also become the object of her fury when she accuses me of making her ill and needy and robbing her of the capacity to manage herself in the way she was familiar with and hence exposing her to her vulnerability. Quickly, however, unconsciously terrified that her murderousness will destroy her object, she reconstructs the masochism and re-establishes her benign view of the relationship. In the process, she evacuates her own feared aggression. To do otherwise would require

her to face the pain and rage at the many losses, betrayals and abuses that she has experienced and that fundamentally threaten her sense of psychic and bodily survival.

Another illustration. A homosexual paedophile patient who uses homosexual male prostitutes, as young as he can find, starts off his contact with the newly found male prostitutes with a mutually consensual sadomasochistic relationship, in which he takes the overtly masochistic role. Initially, the patient believes that this encounter will turn into a mutually loving relationship and that this might eventually help the prostitute to develop a better life. (It is not difficult to see in this aspiration both mania and omnipotence, revealing the primitive nature of the thinking.) When the prostitute inevitably lets him down, my patient begins to fear the loss of the contact and initially he increases the extent of his masochism, in reality often at great personal cost, both psychically and financially, in an attempt to secure the relationship. As this inevitably fails to secure the continued interest of the prostitute, my patient then finds himself having extremely violent, sadistic and even murderous fantasies. It was his anxiety about acting on these fantasies, together with a growing sense of oscillating murderous and suicidal despair, that eventually led him to seek treatment. In the transference I am often an object to be placated and seduced and I would often come to feel that the very benign picture he presented of his attitude towards others actually hid a profound hostility. As is not unusual with such patients, once he began to come to know about this masochistic deception, feelings of profound despair and suicidality emerged. At this time in the treatment the patient fell down the stairs in his home and badly broke his leg. This damage to himself unconsciously acted to limit and restrict his aggression but it also, to some degree, got him looked after.

As is implicit in both of these brief clinical vignettes, there is always deception involved in masochism – a secret contempt and desire to control is hidden behind the presented appearance of humiliation and submission. Beneath masochism there is always an unconscious fantasy of omnipotent mastery, which gains pleasurable gratification from suffering. Sadomasochism dramatizes the relationship between powerlessness (the masochism) and immense power (the sadism). Because sadomasochism is understood to be such a central feature of all perverse activities, we are led to the conclusion that there is always deception, misrepresentation and an attack on reality in the perverse act.

A female patient, who was grotesquely abused and violated in her childhood and adolescence and who gets herself sexually abused by picking up men in the street and parks, or in sex clubs, said to me recently, 'I can't stop doing this because I would then have to know what I was doing'. She often refers to herself by a different name when she describes her very dangerous and perverse activities and says that she does not know who this person is who engages in these frightening masochistic behaviours. In the transference I become extremely dangerous

to her, she says, whenever I make any reference to it being her who behaves in the terrifyingly dangerous ways that she does – I am under enormous pressure to go along with her splitting off her gross self-abusiveness from her 'ordinary' self. I have to be complacent and collude with her and if I am found to have and to use my own separate mind I become a profound threat.

A number of writers have paid particular attention to this understanding of perversion as being the product of distortion and misrepresentation of reality, stressing in particular the disavowal of the reality of *the difference between the sexes and between the generations* (McDougall, 1972; Chasseguet-Smirgel, 1981, 1985; Steiner, 1993).

We are all aware, for example, of how the paedophile denies the reality of the differences between adults and children, and of how, in doing so, he or she denies one of the fundamental fact of life – that of the difference between generations. A transvestite patient describes how successfully he divides his life between his male self and his female presentation. When he is cross-dressed he thinks of himself as a woman and acts out various scenarios as a woman. When he is not cross-dressed he says that he leads a normal life as a man. He is married with children, has a sexual relationship with his wife and is professionally successful. He considers himself to have complete mastery over whether he is a man or a woman. He wants to be both, with whichever gender role he is in being the gender that he considers himself to be. Although he talks of the differences between the two genders in his representations of them both, we are beginning to understand that he actually denies the differences between the sexes, believing that he can be either or both, more or less as he wishes. In his mind the differences are actually spurious or marginal – really there are no differences – and he can transcend what differences there are at will. Interestingly, what is now emerging in the clinical work is the exact opposite of this: a view of such a gulf between the genders that they each constitute separate universes, which cannot be bridged. This suggests a very disturbed internal model of the parental couple – a fused and undifferentiated couple or a couple who are so totally different as to have no possibility of relating with one another. His cross-dressing might in part be understood as a desperate omnipotent attempt to bridge this unbridgeable gulf but more perversely as a sign that linking does not actually need to take place because he has the power to be in whatever position he wishes. This patient would often miss clinical sessions as a way of disrupting and fragmenting the therapeutic process – connections would be broken, continuity undermined and understanding eroded, all in an attempt to prevent me and him from making links and connections between the different parts of himself.

Misrepresentations of reality are central to an understanding of the perversions and arise from a quite specific mechanism in which contradictory versions of reality are allowed to coexist. Freud initiated this understanding of the coexistence of competing realities in his study of fetishism (Freud, 1927), but

the mechanism described is also applicable more broadly (Steiner, 1993). The fetish is a substitute for the mother's penis that the little boy once believed she had. This is a belief that he does not want to give up, even when faced with material reality, because it raises castration anxieties. In his discussion Freud also suggests that a powerful assumption held by the child is that there is no difference between the sexes. To accommodate this assumption after the child is confronted with his observations of the reality of the differences, the child may come simultaneously to hold the belief that the mother does have a penis while he retains his knowledge that she does not. The fetish in effect takes the place of the now missing penis. This is achieved by what Freud calls, 'a rift in the ego, which never heals but increases as time goes on. The two contrary reactions to the conflict persist as a centre-point of a splitting of the ego' (Freud, 1940: 276). Chasseguet-Smirgel has suggested that the perverse psychic structure might be thought of as being graphically represented by a vertical split in the personality, with the perverse disavowal of reality existing alongside the recognition of reality (Chasseguet-Smirgel, 1985).

Steiner (1993) has used Money-Kyrle's delineation of three fundamental 'facts of life' to further understand this perverse relationship to reality. The three facts of life are 'the recognition of the breast as a supremely good object, the recognition of the parents' intercourse as a supremely creative act, and the recognition of the inevitability of time and ultimately death' (Money-Kyrle, 1971: 443). Money-Kyrle goes on to say that, of these, 'two are of particular analytic importance: the good breast and the good creative intercourse' (Money-Kyrle, 1971: 447). I will refer to these for the purpose of this paper.

The first fact, that the source of goodness required for the infant's initial survival comes from outside of him (usually from mother), challenges omnipotence and narcissism and requires the toleration of dependence and gratitude. In the paranoid-schizoid position, mechanisms of splitting and projective identification allow illusions of omnipotence and narcissistic self-sufficiency to continue. In the course of development, however, there begins to be some integration of the omnipotent wish for self-sufficiency and the realization of attachment and dependence. It is at this point that reality might feel to be too threatening and so a perverse defensive structure is created and adopted such that there is *both* a partial acceptance of this reality of separateness, difference and dependence, and also the belief in self-sufficiency that retains a primacy.

Aspects of this disavowal of separateness and dependence are often part of the psychic structure of abusive and violent marriages. In such marriages there appears to be a relationship between two separate people, but in reality one partner, or usually both partners, is relating narcissistically, whereby, as a result of intrusive projective processes, the other person is actually seen as an extension of the self. This is a perverse relationship, with the partner being colonized and related to parasitically (Ruszczynski and Fisher, 1995). When this colonization is felt to be challenged by the partners' ordinary separate

behaviour, it might feel very threatening to the narcissist because it requires a toleration of separateness and dependence and hence a loss of omnipotence and control. If this is felt to be intolerable, aggression and sadomasochism emerge as ways of dealing with the reaction to, and fear of, separateness and dependence. If the sadomasochism does not deal with the feared loss of control over the other, the other's separateness comes to be experienced as the presence of an intrusive and threatening object that feels so dangerous that, in the service of self-preservation, it has to be eliminated. A violent or even murderous attack might then take place.

The second fundamental fact of life described by Money-Kyrle is that of the true reality of the Oedipal situation. This involves, first, tolerating knowledge of the parents' sexual relationship and tolerating being excluded from it; second, tolerating the generational differences between adults and children; and third, recognizing the differences between the sexes, which includes coming to know that babies come from heterosexual intercourse. The reality of these facts of life can be denied by the solutions offered by some of the sexual perversions which can be thought of as attacks on the sexual parental couple whose separateness, difference and procreativity cannot be tolerated. For example, the differences between the generations are ignored in paedophilia, incest and child sexual abuse. Homosexual intercourse might be understood in the clinical situation as an attempt to deny the differences between the sexes and to deny that new life is the product of the intercourse of these two sexes. Transvestism might sometimes be thought to be an attack on sexual difference; for other patients cross-dressing represents an attempt to regain contact with a lost maternal figure. Rape may be a vicious attempt to instil powerlessness and humiliation into the other, as a way of projecting a sense of being small and insignificant. Stalking, 'flashing' and exhibitionism might be desperate attempts to invade the other's mind as a way of dealing with feared separateness and abandonment.

A transvestite patient states with total conviction how, when cross-dressed, he believes that he is a woman. He recently described the very specific way in which he held his penis when masturbating, and so simulating, he said, a woman masturbating using her clitoris. When cross-dressed he straps his genitals in such a manner that they are, in effect, forced back into his body, demonstrating his abhorrence of his penis and his attempt to eradicate the reality of its existence.

As outlined earlier, sadomasochism is turned to defensively when ordinary psychological development inevitably moves the patient towards the necessity of recognizing and tolerating the losses involved in integrating some of these facts of life. The disavowal of the facts of life, and of the mind's capacities to perceive and tolerate them, is both sustained by and allows for some sexual perversions and acts of violence. Denial and aggression are turned directly against the mind of the patient and through projective processes against the

mind of his or her objects. Developmentally this locates such patients at the paranoid-schizoid level of functioning rather than in the depressive position (Klein, 1935, 1946). Rather than love and hate becoming ambivalently related to, as required in psychological maturation and development, sadomasochism emerges, distorting and perverting these states.

Some patients act out perverse solutions in grossly sexual or violent acts, whereas others do not. There is no agreement on the difference between those patients who act out their fantasies and those who do not, but it is generally agreed that destructiveness in the character is crucial in the perverse personality. Whether this excessive destructiveness is constitutional or whether it is the result of parental and/or environmental deprivation is also not agreed on. Probably an element of both is present. The crucial difference might be related to a failure in infantile containment (Bion, 1962), the failure in the capacity to achieve some depressive position functioning and a failure in the capacity for symbolization – some patients can manage to turn the perverse solutions into fantasies or dreams, but others have no capacity for such mentalization and so have no option other than to act them out.

Hyatt-Williams has suggested that enactments of aggression, violence and murderousness are induced by the psychic toxicity resulting from certain emotional experiences being unprocessed as a result of a failure or lack of containment (Hyatt-Williams, 1998). Fonagy and Target also assert that violence is a product of the person's lack of a capacity for reflection or mentalization (Fonagy and Target, 1995).

Without the experience of containment, no development of a *psychological self* (a self that can process and think about experiences and psychic states) can take place because such development requires the primary experience and perception of oneself, *in another person's mind*, as thinking and feeling. In a recent publication Fonagy and others make this point very powerfully when they write that, 'Freud, arguably, saw infancy as a time when the self saw others as extensions of itself ... our emphasis is the reverse – we see the self as originally an extension of experience of the other' (Fonagy et al., 2002: 8).

In the absence of a psychological self, what results is a 'mindlessness' – an empty or inanimate sense of the self rooted not in the mind but in the body. The incapacity to reflect on and integrate mental experiences results in only the body and bodily experiences being available to be used to provide a sense of relief, release or consolidation. It is not unfamiliar to hear from borderline patients about their profound sense of relief and peace following an act of violence or a suicide attempt.

This lack of the containing function (Bion, 1962) or the capacity for mentalization (Fonagy and Target, 1995) leaves persecutory and toxic object relationships in the mind, a cruel and threatening presence that has to be annihilated for reasons of self-preservation. This cannot be dealt with psychologically, as that capacity is extremely fragile or does not exist – it can be dealt with only

physically, using the body. If projected, it may result in a sadistic, violent or murderous attack on the body of the victim. If identified with, it becomes masochistic or results in suicidal attack on the physical self (Campbell, 1995).

With violent and perverse patients we are often seeing patients whose developmental history was more pathological than simply the lack or failure of a containing parental object. With many such patients we might often discover the highly disturbing *reversal of the normal container–contained relationship*, where the infant is failed not only by the unavailability of maternal containment, but by being obliged to become a container for the mother's own undigested and often highly toxic states (Williams, 1997). The toxicity of these states might have been expressed by acts of physical or sexual abuse, or in the projection of narcissistic or psychotic anxieties, and sometimes by all of these. Such patients then often have an urge to evacuate their psychic states into the mind and body of the other so as to expel their own toxic states. At best this might be sadomasochistic but it might also be more destructive, violent and murderous.

In thinking about failure in containment and the resulting sadomasochistic and violent interactions, we should probably also keep in mind the nature of the death instinct, which, at its strongest, attacks and distorts the capacities for perception and judgement, both in the potentially available containing object and in the self. It is a controversial concept, but in the clinical situation the concept may be useful if it is thought of as referring to a destructive *psychological* force (Segal, 1993; Feldman, 2000). What is destructive about the death instinct is the way in which meaning, and specifically difference, is attacked. As a result, ordinary developmental processes, which would eventually result in the development of a thinking psychological self, are retarded or undermined (Feldman, 2000). This perspective seems useful when thinking about the perverse or violent patient's inability to come to tolerate the emotional facts of dependence, separateness, the necessity of mourning and the toleration of loss. Respect for, differentiation from and the toleration of the need for the other would suggest that these facts of life have become tolerable in the mind and would result in the capacity for relatively mature relationships, rather than sadomasochistic or violent ones based on hatred and domination. The sexualization of this avoidance of mutuality may be seen as central to the perverse and violent state of mind (Parsons, 2000).

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Trauma and terror: a matter of life and death

JESSICA SACRET

ABSTRACT

This article explores some links between primitive mental states as they manifest in patients with early trauma, and some aspects of the deep unconscious as they appear through actions that may seem alien and mysterious – for example, through fundamentalism and suicide bombing. It is argued that studying these manifestations can help us to understand patients with early failures in containment. Such patients can exhibit destructiveness and self-destructiveness, becoming 'terrorists' on the couch. Aspects of the life and death instincts in the consulting room are also elaborated.

Key words destructiveness, life and death instincts, terrorism, trauma.

Introduction

The title of this article makes an explicit connection between the personal experience of trauma and the global phenomenon of terrorism. To begin, I want to draw attention to how the word 'terror' has evolved. While the word 'trauma' has retained its solely subjective meaning, the word 'terror' has expanded to refer also to the perpetration of terrifying acts. Surely this shift in meaning indicates an unconscious recognition of our own terrorist propensities – that we identify with and project our own desire to terrify.

The shock waves from the terrorist attack on the Twin Towers in New York on 11 September 2001 have diminished, and we have mostly come to accept that we are living with the constant threat of potentially catastrophic events. As I write, we are edging towards the end of the war with Iraq, which, many people believe, will have as one consequence an increase in terrorism. While I use the word 'terrorism' in its common usage, I subscribe to the view elaborated by Noam Chomsky (2001), among others, that by any definition of terrorism nations can also be terrorists, albeit in a much more organized way.

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Terror exists now for ourselves, our families, our friends and for our patients. There is the trauma that we have witnessed then and since, through the coverage of the tragedy in the media of 11 September, the subsequent war in Afghanistan, and the attack on Iraq. We have undoubtedly seen less of the trauma and terror of the Afghan and Iraqi civilians, with whom we have less cultural connection and potential for identification, as they suffer the bombings and the shootings and the loss in catastrophic circumstances of their loved ones.

The events of 11 September and their consequences brought the external political world into our lives and consulting rooms in a way that few, if any, other events have done. Many of us were probably touched personally through knowing someone involved, or through having a patient knowing someone involved, and we had to work out ways of dealing with it all. There is clearly an ongoing threat – how large or small we cannot know – to our personal safety. Of course, life has to go on. We have to put fears and personal associations aside and carry on with our work. To some extent, most of the time, we split off from awareness our own fears and our knowledge of the enormous destructiveness and suffering, through dictatorships, war, famine and political oppression in other parts of the world. But in the present climate how as psychotherapists do we relate to this?

There is probably nothing we can do as psychotherapists to alter world events. But it seems to me that we could do more as individuals and as a profession to keep alive an awareness of the connections between our personal lives and the social and political context in which we live. We are also well equipped, because of our psychological knowledge, to understand underlying unconscious factors that drive the large social and political issues that now press so disturbingly in the world. One thing we can obviously do as psychotherapists is to try to understand better, and think more, and perhaps communicate more, about the phenomenon of destructiveness in ourselves and others and how to stay human in the face of it.

In this article I focus on destructiveness and its toxic amplification through group processes, with war and terrorism the seemingly inevitable consequences. I make some connections between the deep unconscious and terrorism, exploring the symbolism of 11 September, and I illustrate this with a clinical example. I aim to delineate some of the crucial aspects of early trauma that have developed due to the specific phenomenon of lack of containment.

Destructiveness and the death instinct

In the consulting room powerful unconscious forces are aroused. But I think that Bion showed that the most primitive aspects of the human psyche are stirred up and expressed through groups. It is in groups, small or large, where the deepest and most unconscious aspects of the human psyche are manifested.

It also seems clear that the deepest destructive forces that get stirred up tend to get projected out on to other groups, who are then felt to be a threat, while they in turn are doing the same thing, in an escalating cycle of fear and hatred. War between nations, and now terrorist activity, is the paradigm of this dynamic. The more distance there is between people, personally, socially, culturally and geographically, the easier it is to dehumanize, project and evacuate our unwanted feelings and impulses. This happens on a personal level as well as at the political level. The extremes of primitive love and hate manifest as desires to invade, possess, occupy, devour, and to destroy, smash up and annihilate; these are difficult to live with personally and professionally. Hanna Segal (2001) has said recently that in her view the most important thing for us in our work is to think about the primitive, psychotic levels of functioning.

The notion of the death instinct is controversial in psychoanalysis. In my understanding it is to do with primary, innate destructiveness on an equal par with the libidinal instincts. Interestingly, this view of the death instinct seems to have become identified with Kleinians, although Freud also talked of the death instinct in exactly these terms towards the end of his life, in 'Civilization and its discontents' (1929). Freud and Klein both believed that there is a death instinct paralleling the life instinct that gets projected outside the organism at the beginning of life. In this view there always exists in the human mind a tendency to attack others and the self. We live, and something in us clings to life; and something else in us hates life and wants to destroy it, in others and in ourselves.

In our wish to protect ourselves and our personal relationships from our capacity to hate, these difficult emotions are readily projected on to the other who is less known, with whom we do not have personal contact. Our primitive destructiveness is hard to live with and it gets denied and projected, often as far away as possible, with wars and terrorism the consequence. There is never a shortage of reasons, real and imagined, that we can use to legitimate the expression of our innate aggression in retaliatory indignation and revenge. This has its own pleasures and is easier than trying to think about more constructive ways of dealing with grievances. In our personal relationships our motivations to contain our aggression may be stronger, especially with the benefit of an analysis. But at a national and international level, sites that are ripe for receiving projections and destructive and retaliatory forces – the death instinct – seem to demand expression.

Some of us noticed a horrified excitement as part of our response to the attack on the Twin Towers. Some of that horror must be linked with our recognition that something in us enjoyed the sight of such elemental destruction. It seems important to think carefully about how the way that the personal, psychological issues we are grappling with in our work connect with the political violence we have been witnessing. It is also important to distinguish, even if only theoretically, between primary aggression and situations when destructiveness is linked

with defences that have been necessary for a patient's sense of psychic survival. Destructive behaviour in the consulting room, as well as expressing innate aggression, may fulfil a vital defensive function for the patient.

The events of 11 September, witnessing fundamentalism and suicide bombings, forced me to think about phenomena that seemed alien and primitive, and about primitive states of mind that we all share by virtue of being human and that are particularly present in patients who suffered severe early trauma.

I cannot hope to do justice either to the thinking that has been done in recent months about terrorism, or to all the complex thinking that has been done since Freud on the subject of trauma. Instead I will confine my comments to parallels I see between aspects of terrorism in the wider world and the way a patient with significant trauma may become a sort of terrorist on the couch.

The patient I discuss in this paper had a dream some years ago that echoed 11 September. In this dream, she was with me in my car, with me driving; she then seized the controls and drove the car at great speed against a building, presumably killing both of us.

Global issues

A rather obvious point is that with the attack on the Twin Towers in New York we had a very powerful experience: of hatred and destructiveness and horror, certainly, but it was also surely a communication from a part of the world that I, at least, knew little about. It forced us to suffer the experience of living with the fear of violent death, or the possibility of a long-drawn-out and painful one. This is a routine fear in that part of the world, where death is commonly linked with political conflict or starvation. We know that the terrorists themselves, and Osama Bin Laden, did not come from poor and materially deprived backgrounds. But whether or not their actions indicate personal trauma, leaders who are particularly destructive seem to gain power and influence in cultures that are poor, where solace can be sought in the certainties of a fundamentalist religion that promulgates the idea that life after death compensates for the miseries of this life. Terrorism also seems to gain a hold where a nation has been humiliated and traumatized through occupation or defeat. I am thinking of Germany and the rise of Hitler, and of course Afghanistan, and the Palestinians. The Israelis' militarized response must also surely be partially a legacy of the Holocaust.

The intrapsychic personality of a main player in world events must have a complex interrelationship with their particular social, national and political history. I would not want to suggest that the relationship between individuals' experiences and their political actions is at all simple. There must be inter-penetrating influences at different levels of experience. But it seems to be true that the issues of humiliation, defeat and occupation are themes that resonate for the traumatized patient. Such a person may have their own version of an

internal, militaristic or terrorist grouping in the form of a defensive, pathological organization of the personality (Steiner, 1993).

It is not my job here to go into the politics of it all; but I simply make the obvious point that as humans inhabiting one earth, different peoples and cultures at different periods of the history of humankind manifest different aspects of the human psyche in their beliefs and actions. Different cultures foster and reinforce different aspects of our universal primitive potential. As well as being sometimes horrified, we can also learn from some of the less familiar and less salutary aspects of human behaviour. We ourselves may not actually be dropping bombs, but we may be implicitly supporting the US government via our own government, which many people believe has been destructive in its foreign policy. Hanna Segal (1987) argues this point in her paper 'Silence is the real crime'. The psychoanalytically minded sociologist, Stanley Cohen (2001), details the multitudinous varieties of denial that we all engage in. This is particularly serious now if the murderousness in the world has the will and the capacity to threaten the continued existence of humankind.

One can see how the Twin Towers could have symbolized a wealthy and powerful nation that has often operated destructively in the world to increase its own power and wealth. As such it provided a focus for terrorist groups to act out their own destructiveness. From a psychoanalytic point of view, the Twin Towers resonated with powerful unconscious symbolism. There were two, as with breasts, but they were tall and thin and phallic in shape. Henri Rey (1979) and Dana Birksted-Breen (1996) have described how omnipotence in the unconscious is symbolized by the phallus, representing power and control, rather than the constructive capacities for action of the penis. At the deepest level, these buildings may have represented disturbing fantasies of the breast fused with the penis, where resources, linked with the breast, are used for purposes of power and control and appropriation rather than for the care and nurture of the deprived and less powerful.

At the same time, societies of the western world in their domestic life can seem to represent a valueless hedonism and pursuit of pleasure, a life ruled by the pleasure principle, free of guilt; while the foreign policy often, to the contrary, expresses a ruthless pursuit of power and self-interest. On their side, terrorist groups act out a destructiveness that uses the profound failures and aggressiveness of western society as an excuse to kill and maim thousands in the name of retaliatory justice. It now seems that both sides of the cultural divide are willing to put the very survival of the world at risk with the use of nuclear and biological weapons.

Trauma and failures in containment

Bion's notion of containment involves the idea that the infant can come to know, contain and own his or her own emotional experiences by means of a

parental function that can take in, accept and modify through internal reverie those unmentalized, raw experiences that the infant projects into its mother's mind. In ideal circumstances, the most terrifying experiences of an infant such as intense need, terror, rage, and vulnerability linked with almost total dependency, including the fear of death, are made tolerable and able to be known and ultimately thought about by means of the mother's ability to contain them. There is also the importance of the father or other helpful external or internal object in the mother's mind here. Although the mother is crucially occupied by the child, she also needs to have in her mind a good enough other that she can depend on. This creates the 'third position' that Ron Britton (1989) talks about, an internal space where the possibility of thought connected to feelings can arise, and where there can be an acceptance of separation, psychically or in reality, which does not entail disconnection and rejection. If a mother has not had good experiences herself of being contained, she will be unable to offer this to her infant.

Usually, some experiences will be contained and some not, where the projection is, so to speak, refused. And infants will differ in the degree to which they can from the start bear strong feelings and their non-containment. All infants will experience some trauma; it is a matter of how deep, or prolonged, or how many aspects contribute; and also whether subsequent experience reinforces or mitigates the original problem.

When the mother cannot contain, or actively rejects, or is angered by the projections, or uses her own child to evacuate into, the infant is forced to reintroject terrifying, non-understandable experiences, which Bion (1962) described as 'nameless dread'. These psychic experiences are split off and encapsulated. Henri Rey (1979) describes this as having to choose between living with a fantasy of incarceration – as if being trapped in a deathly container – or of disintegration – as if being totally exposed in a shattered world.

In therapy, when one gets closer to these experiences, they are actively defended against. The very enterprise of trying to make conscious and to verbalize can feel to the patient like a painful assault. This is when a patient may resort to what can seem like endless attacks on the capacities and hope of the therapist. The dangers of hope and trust for a traumatized patient are profound. If psychic safety has always appeared to reside in denying the need for contact, the attempt to establish a meaningful relationship can feel to the patient as if they are being invited into a catastrophic state.

Some essential aspects of early hidden trauma

The picture is of a split off and encapsulated area of fragmentation. If this takes over the mind, the experience is of disintegration, which may be mild – as we probably all experience from time to time – or profoundly disturbing and psychotic. Trauma means by definition that the ego has been overwhelmed. In

essence, a traumatized patient is one who cannot bear to know their own experiences and will defend themselves, it sometimes seems to the death, against insights generated through a relationship that threatens to come too close, like the therapeutic relationship can.

A serious trauma is therefore inevitably defended against with the killing off or the deadening of the knowledge of libidinal needs for care, contact and for dependency on a helpful figure. The therapist may be kept at a distance; but the deep fantasy is of being 'at one' with the therapist – that is, projectively identified, as if controlling from the inside, or having the therapist inside them. This results in strategies that are essentially of total compliance or total rejection. This avoids the reality of separation, which threatens a repetition of the original breakdown, where the parent/therapist and the relationship itself are unconsciously felt to be frighteningly bad and evil.

This is linked with the original failures in the containment of primitive rage and death instinct phenomena and also can be the result of the rejection of intense need and vulnerability. The defence against awareness of bad internal objects, which are saturated with hatred and rage, and the corresponding anger against them is characteristically that of idealization, where there is a fantasy of identification through projection with the earliest idealized breast. Here we can see the fundamentalist dynamic, where the sense of identity with an ideal, God, defends against an underlying hatred and murderousness. Rather than religion causing murderousness, as people sometimes say, they are two sides of a coin.

The patient in such a psychological predicament is having to deny psychic reality at the deepest level. The unconscious belief is that the therapist will also be unable to bear the patient's own experience of profound suffering, intense need and desire, and feelings of murderous rage. When these feelings begin to emerge in the form of projections into the therapist, difficult as they are, one knows that a tenuous trust has begun to develop, and that the patient feels confident enough to use the therapist as a figure who can be communicated with in this way. A consequence of the denial of trauma at the deepest level is that patients may not believe in the reality of their own experience. One of my patients, whose father made regular, violent suicide attempts that he often witnessed throughout his childhood, constantly worries that he is exaggerating his sense of distress and anger, and apologizes for dramatizing. He has not been able to allow himself to know how bad it was.

Similarly, a patient may seem to be exaggerating in a highly melodramatic way, but I think it is worth considering the possibility that this is often a sign that there is an underlying belief that the therapist will not understand. The dramatizing may be a response to this, and to an internal defence that has deadened the feelings in order to survive the unbearable. The danger is for a therapist to misinterpret this as merely hysterical, or to collude unconsciously with the patient's deadening defence, and indeed the patient's own wish not to know.

If the patient is to allow reality to impinge at the deepest level, particularly the reality of separation, this involves having to live through psychic experiences that may feel as if their core being is under threat.

The identity as victim

A particular problem for a patient who has experienced an early trauma links with the fact that the trauma will be internalized in the form of disturbed and violent internal figures. These internal figures act as receptacles for the patient's own primitive aggressive and destructive fantasies. Normal aggression that could be used in normal, realistic ways is unavailable; the patient is terrified of his or her own aggression which is now linked with these violent internal figures through identification. The conscious sense of identity has been overwhelmingly forged in terms of being a victim, and the patient overvalues this identity in order to protect against knowledge of the underlying identification. The identity as victim also serves to rationalize the anger.

But of course this anger does have a basis in reality, in being a natural response to traumatic experiences, however constituted, and this has to be fully acknowledged by the therapist and explored in depth. It is easy to retraumatize a patient by treating a defence against unbearable feelings as if it is solely primary aggression; and until such a patient feels that the therapist totally understands the suffering experienced, interpretations about anger will meet only with rejection or compliance.

It is probably the hardest thing for such a patient to bear his or her own aggression and capacity to traumatize. My experience is that guilt about aggression, although it is not fully conscious is extremely powerful and painful and constitutes one of the biggest obstacles to insight at this level. The primitive superego keeps the split alive by means of this persecuting but unconscious guilt. One function of this is to ward off experiences of deepening dependency and meaning in the therapy, which would lead to feelings of pain and sadness.

Encapsulation and fundamentalism

An American analyst named Michael Paul (2002) has elaborated on early trauma as the result of what he describes as 'projective mothers' – that is, mothers who project or evacuate their own unmanageable feelings into the child. I would add that the mother who cannot contain is likely also to use her child as a container, or, at the least, will be unable to process the child's projections. Paul characterizes the encapsulation as a 'barriered area', barriered against incursion, originally from mother's projections, but now in the therapy it becomes a resistance against meaningful contact. (The usage here of spatial imagery is a concretization, but it is useful for thinking about these processes.)

I think this barrier can be felt quite concretely in one's countertransference, but I think it is also important to recognize that it is where the patient feels a powerful need for total certainty. The area of fragmentation is where there is no good object and nothing safe to hold on to, and uncertainty means the possibility of being landed in a catastrophic state. So the defences here are very strong. It can be easier for a patient to believe that a therapist will let them down, and to try to provoke them into doing so, than to trust that they will not. And of course we do inevitably let patients down – in their terms; we will never live up to the ideal figure that is so longed for, and the relationship will never have the exclusivity that is so passionately desired.

This need for certainty is part of the primitive splitting between good and bad that characterizes the fundamentalist attitude. Listening to much of the discussion around 11 September, it is clear that it is not just the terrorist who holds the belief that right is absolutely on their side, while all the badness is in the other. The process of demonization works both ways. And the pressure is strong to give in to that primitive splitting that wants everything to be neatly dichotomized between black and white, good or bad.

Clinical material: Mrs A

The patient was in therapy for eight years, mostly three times weekly. She came from an old established upper-class English family: her father was a top civil servant and her mother was a teacher. She came into therapy when she was 32 years old because of difficulties in her marriage and she left at 40 because her husband was posted to a job abroad. A prominent feature of her upbringing was the violent rows between herself and her mother throughout her adolescence. As the therapy progressed, it became clear that the patient had provoked these rows, which had led to violence on both sides. I was alerted to something potentially traumatic when I learnt that when the patient was one year old, the two parents went on a business trip abroad, lasting six months, leaving the patient in the care of a nurse who was subsequently found to have been seriously alcoholic at the time and had probably left the child alone to cry for long periods.

The patient thought everything had been fine during her early childhood; indeed, she reported a sense of total harmony with her mother. However, this seemed to exclude awareness at some level of her father's and two siblings' existence, so I concluded that there had been a powerful fantasy of fusion with her mother. But when the processes of adolescence forced her into awareness of separation, she had developed a policy of total noncooperation and provocation of her mother, precipitating the violent rows. She would laugh as she told me how she would get her mother to hit out while she would nimbly evade the blow, taking the opportunity of her mother's loss of control to lash out in return. That is, she dealt with the trauma by triumphing over it and any part of

herself that would feel pain at this terrible relationship with her mother. The triumph was also a cover-up for her guilt at the profound hatred she felt for her mother, her sense of betrayal, and a desperate need for love.

My hypothesis became that there had been an early traumatic loss of contact and containment. Her early fantasy of at-oneness with her mother – that is, a massive projection into her mother of her own vulnerability, dependency and anger – was created in order to deny and split off the pain and rage, linked with violent and abusively neglectful internal objects. This her mother had been unable to bear or contain, perhaps because of her own guilt about her early neglect of her daughter. My sense of it was that this mother evacuated her guilt into her child in a violent and concrete way when she hit her. I think that the process was that the original uncontained, violent and unbearable or unborn rage, and the consequent shattering of her ego at the early neglect, was denied in Mrs A's early childhood. But once separation had to be acknowledged as she approached adolescence, the evacuation into her mother of these feelings led to her perceiving her mother as overwhelmingly persecuting. She then provoked the mother in order to concretize the experience of persecution, and in order to give expression to the rage that existed in a split-off way in her mind.

Needless to say, in the therapy I came in time to feel very provoked and felt like attacking her with harsh interpretations. Sometimes I found it impossible not to identify with the rage and the harsh superego that was being projected into me. There were seemingly endless periods when she was as she was with her mother – extremely provocative, and inviting criticism and attack. And there were other times when she was totally uncooperative, making me useless and impotent. Yet at other times she could be very thoughtful and there seemed to be a genuine wish to understand which did not seem to be merely compliance. At such times we would glimpse the enormity of the pain she had been carrying all her life.

The resistance took different forms as we progressed and I will describe the different phases in the therapy as examples of the different levels of resistance as we got closer to the original trauma.

For the first year the patient was at pains to tell me, regularly and at great length, that she was coming only because her friends insisted on it. She could not admit to any wish or need for help. She acted out constantly, getting very drunk and having one-night stands with other men, which she reported with an air of triumph. There was often an air of excitement. She did not seem to want to think about anything I said and my interventions seemed in some subtle way denuded of meaning. She seemed to treat the whole therapeutic enterprise as an exciting game that she was determined to win. There was a tricky, triumphing sort of behaviour, where there would be an appearance of thought, but not the reality. There was a habitual aggrandizement of herself and unconscious denigration of me. Through these means she communicated to me her under-

lying terror of her internal world, of its sterility and its disturbance, and her sense of humiliation at her desperation and intense neediness. Her fear that I would let her down and her conviction that I would reject her made her do her best to make me do just that.

There were a variety of manoeuvres that held us up. She took to stopping for a long time in the middle of a sentence, leaving me hanging. She took to telling me – clearly genuinely feeling this – that she couldn't hear what I said almost every time I said anything; and, notwithstanding my sometimes quiet voice, I felt that the problem was to do with her unconscious hatred of my separateness and her fear of me demonstrating that I had different thoughts to hers, and thus a separate mind. So she smashed up the part of her that could understand.

Happily, during the cooperative sessions there was a sense of working together, with good contact and good insight on her part, which I could use during the uncooperative times. But there was always a negative therapeutic reaction after one of these sessions, and the experience in the countertransference was that the good relationship had to be destroyed. On the other hand, I wondered whether sometimes the negative therapeutic reaction included a demonstration of increased confidence that I might be able to bear more of her negativity that she then brought to bear on me. This experience was prolonged, but I always had the sense that a part of the patient did want help, although she had to test me to the limit. A session that was experienced as helpful and that was allowed to flow and contain good feelings was followed by the stuck, holding up responses or with underlying rage and contempt.

Finally, the quality of the sessions changed to enable me to notice an underlying set of resistances which seemed not so much to do with active rage, as with something I experienced as fixed and impervious. It seemed like an absolute determination not to allow contact at the deepest level, so she could close herself off and keep absolute control. Dreams and material at this time indicated her terror of being broken into on the one hand, and her fear of emerging from an enclosed area on the other.

These fixed resistances connected with what I have described as the barriered area, and her anxiety that this barriered area was in danger of being breached, with devastating results. In my countertransference I felt that there was something truly unbearable invading the room and me. I could hardly think and I felt an overwhelming desire not to engage with the patient. I often felt very angry and judgemental and had to work hard not to enact this with punishing interpretations. Sometimes my mind seemed to feel shattered and even the silences had a shattered quality. At other times, by contrast, the atmosphere was quite different and, in spite of the patient speaking apparently normally, I felt deadened and lifeless.

I mostly felt I could do little at these times but live through them as best I could and speak to the patient in rather simple terms about her terror and her

rage that she could not control me and her wish to destroy me, as well as her fear that I could not stand her and would want in turn to destroy her.

I came to think of what was going on as exemplifying an experience that Bion (1962) refers to when he talks about the violent expulsion of fragmented parts of the ego into the therapist as primary object. I could now also recognize the dual fantasy, described by Henri Rey (1979), of being either incarcerated in a coffin or exposed in a shattered world. Her problem in hearing me I took to be an example of what Bion (1962) also talked about, when he says communications can get 'stripped of meaning', which is attributed to problems in containment.

In spite of all these difficulties, the patient finally improved quite a lot during her therapy and I felt that she did allow herself to make use of what I could offer, in contrast to other patients in whom I detect a greater resistance to help. Although the very early experiences of anyone are impossible to ascertain, I believe that Britton (1992) is right when he distinguishes patients with early trauma from those whose problems stem more from death instinct-generated resistances. He finds the former more responsive to help. Although I am arguing for the possibility of early trauma, especially linked with loss of containment, to be considered when confronted with a very destructive patient, I would not want to suggest that this is always the case. The pleasures of destructiveness are a manifestation of the death instinct that I believe we all share.

For this patient it seemed important that I analysed the reality of the relationship, and for me to be able to offer enough in terms of genuine caring to make it worth her while to live with the limitations and frustrations of the therapy relationship. Once this was accepted, it opened up the capacity to experience and bear the psychic pain that accompanied the experience of deepening meaning in the relationship with me and with others.

Twin Tower symbolism

Returning to the symbolism of 11 September, I looked to see what parallels there might be with the primitive forces involved in early trauma. As I suggested earlier, the Twin Towers could be seen as symbolizing uncaring capitalism, triumphing in its own power and resources, rather than using them to help others, while the terrorists attack in an act that dehumanizes ordinary people so they can be killed with impunity. This attitude is supported by a fundamentalism that permits murder in the name of religion.

The fundamentalist attitude seems to offer a certainty that is, or that borders on, psychotic, linked with idealization; the terrorist is at one with the god ideal, and kills in its name, so we see again the two sides of the split I have described in traumatized patients – a murderousness that is defended against by idealization. Equally, in a patient with early trauma, the encapsulated area and defences against it are constituted by primitive omnipotent defences that

mirror these dynamics of idealization, murderousness and an almost psychotic certainty which defends against the terrifying uncertainty that constitutes the fragmented area.

Mrs A defended herself against contact with the fragmented aspect of her mind by evacuating it, and by maintaining a conscious, rigid attitude of good feelings and idealization. At the same time, I was evidently a kind of Twin Towers therapist in her unconscious mind, as she behaved as if I was wanting to control her and keep all my resources to myself. The Twin Towers therapist represents the intense projected narcissism of the early relationship with the breast, where there is split-off primary process mental functioning that carries hidden certainty. Because it is split off it can be hard to see in the transference.

The terrorists took over and gained control of US resources and used them to attack the Twin Towers. This seemed to mirror my patient's dream in the car where she takes me over from the inside, hijacking my resources, but then explodes with rage in an intensity that was expected to kill us both.

There seemed to be a parallel between the reality of the terrorists smashing into the towers and the feeling I had of being smashed into by Mrs A, which I have interpreted as the desire to communicate the continuing intolerable existence of her sense of traumatic neglect by means of the violent expulsion of fragmented parts of the ego. The Muslim fundamentalist point of view of some, we are told, is the belief that this murderous and suicidal smashing into the Towers attack would result in the terrorists going to a primitive notion of heaven. The towers in this association stand for the therapist felt to maintain a barrier – the projection of the patient's own barrier – against her, which has to be smashed through to gain access to the inside of the therapist/mother's body; perhaps another fantasy version of heaven, the mother's womb.

I believe also that the barrier that has to be broken by her represents the limitations imposed by the realities she cannot bear.

Conclusion: issues of life and death

The most powerful defence and the most difficult to work through seems to me to be the fantasy of being 'at one' with the therapist, standing for the early and idealized mother/breast. To avoid the psychic consequences of separation, the patient avoids a full encounter with their own libidinal and aggressive wishes, which are deadened or killed off. The patient then is living in a sort of half world where she cannot fully inhabit her own life, as A.S. Byatt has said in relation to Flaubert's Madame Bovary, who lived her life dominated by narcissistic fantasy, idealizing herself. Aliveness and the sense of reality are leached out of the patient's life. Madame Bovary finally killed herself, exposing the suicidal murderousness at the other side of this fantasy; and I think one has to be aware that at a certain point a patient with this kind of difficulty can become suicidal.

In this context, I think also of Freud's (1920) notion of the Nirvana principle, which connotes a sense of blissful union with the universe, the extinction of human desire, and the abolition of individuality. At first Freud thought this was an expression of the life instincts; but he later changed his mind and recognized that the oceanic feelings and submerging of the sense of identity in something or someone else, as patients can in their therapist, and terrorists can in their religion or their nation, is a manifestation of the death instinct. The devastation of the Twin Towers attack expresses the other side of this, the explosive, shattering force of elemental rage.

In conclusion, terrorism on the couch can be evidence of a profound struggle between the life and death instincts, while global terrorism can mean life or death for many people, and, not inconceivably, for the world as we know it. There is in both contexts a background of life-threatening vulnerability, often in response to the loss of a voice, whether personal, as with the patient I have been describing, or political, as with the Palestinians, or the Catholic population in Northern Ireland, to cite just two examples. There is the humiliation of being occupied, whether by a parent's evacuations into the child, or by a superior power's occupation of land belonging to an indigenous people.

It is not difficult to understand the hatred generated in these contexts, both personal and political, where inferior strength is exploited by those with superior resources in the service of narcissistic or colonial aims. At the same time, these real grievances are exploited in the service of the expression of death instinct forces, which need to be contained rather than acted out, so that real thinking can take place.

I want to end with some thoughts about life and death forces in the consulting room. I have talked of the need to survive, and to stay present in a lively way with a patient, especially one who is trying to kill off lively parts of themselves. As we all recognize, being alive involves having to live with conflict, sometimes unbearable pain, and the inevitable limitations of life. And in therapy, both patient and therapist have to live with the limitations of the therapeutic process. I think it helps a patient like this for the therapist to be actively involved in a way that can be recognized as essentially human, even while, at the same time, it is the therapist's humanity that arouses the most hatred. The therapist's humanity represents the absence of certainty that the patient has clung to all their life in a deathly way and forces awareness of the fragility and limitedness of life. It also means trying to remain alive with a patient, however difficult they are being, and holding on to the alive part of them that wants to be able to live and love. Primitive object relations, where this problem has its origins, mean that good experiences are idealized and bad experiences are deeply hated; and the split between them has had the function of keeping the good from being overwhelmed by the bad. As the original terror is of hatred being stronger than love, I feel it is my job to try to demonstrate that life and trying to bear things, or living with the unbearable, can be

stronger than hatred and destructiveness. This struggle between the life and death forces within us all is one that is never finally resolved.

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Neuroscience and psychoanalysis: a view from a consulting room

JAN HARVIE-CLARK

ABSTRACT

In this paper the author explains some of the new findings from neuroscience. In an attempt to show the vitality and importance of the research, she describes ways in which it is contributing to her clinical understanding. The research findings that she focuses on in particular concern the importance of the therapist's attunement to the patient: how this fails and is regained. Most important for intensive treatment, she holds, is the research finding that this therapeutic experience takes a long time and many repetitions before a faulty original experience can be changed.

Key words attunement, mind and brain, neuroscience, therapeutic effect.

A patient arrives for the first time in a state of confusion and unhappiness, soon after a suicide attempt in midlife. She spends three years lying on the couch, four times a week. She is 'babbling along' (as I have come to think of her state of being-on-the-couch). I need to keep the help of my peer supervision group in mind to stay alongside her without interrupting her, to allow her to be, 'babbling', in my presence. There was little break in her flow of stories from her childhood, so I was not required to make many comments: which was fortunate, because I could not keep my mind on what she was saying. I felt guilty, and puzzled; she was coming to me for help, but what was I doing for her, beyond just being there? My mind wandered and I sometimes had to force myself to stay awake to try to think about my patient. If she had had such a distracted mother as my countertransference was telling me, how was it that she appeared to be, in many respects, well functioning?

After about three years, I found that I could begin to engage with the sessions. I was becoming interested in events and experiences in her current life that began to show quite dramatic positive changes. Four years from starting

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she wanted to end. I felt in a quandary; I was not sure what had happened to make these changes possible (no interpretations that I might have made, as I could hardly recall saying anything), and I felt I could not know how secure the changes were. My patient put them down to her therapy, but I could offer myself no conceptualization of this treatment that made sufficient sense to satisfy me. Some time later she has continued to keep me in touch with events in her life and shows the continuing good use she makes of her talents and experiences, and the greatly increased pleasure she gets out of her life. It now seems to me that by being there and surviving, with the help of those important others, from Freud to my supervision group colleagues, that I was able to become part of her internal dialogue; so allowing her to find her own 'personal idiom' (Bollas) of self-expression.

A second patient comes once a week for about a year, before withdrawing from treatment. In retrospect I can see that I failed to understand his deep-seated psychic fragility. Some time later he contacts me from a psychiatric hospital. He maintains contact by telephone until he is discharged some months later, and he comes to see me. Now both his medication has changed and my perception of my patient has changed. His faith and hope in the psychotherapeutic process, to my surprise, have not changed. I was profoundly moved by this hope as he sat opposite me for another two years. I struggled to understand his continual outbursts of fear and rage with objects outside my consulting room, although they became closer as time moved on, and eventually he had all kinds of experiences in my presence which made him angry.

During this period I learned from Mark Solms' seminars at the Anna Freud Centre (2001) about emotional locations in the brain, and how neuronal pathways ('what fires together wires together') to these centres are laid early in life; that they can be changed, but not easily or quickly. I realized that we were in for a long slog, my patient and I, and I stopped expecting anything to happen. I could understand from my lack of ability to provide a 'protective shield' (Freud, 1920) for my patient that I could not protect him from the confusion imposed on him from such bewildering and, to him, incomprehensible experiences. In fact it seemed that by inviting him to leave the safety of his own home and make the hazardous journey to my consulting room, I was exposing him to more than he could manage at this stage. To his huge enjoyment and my great surprise, his life began to take on a new and different shape: in his words, he 'got a life', after spending his adolescence and early adult life in one drug-induced or psychiatric crisis after another. He moved on to the couch and began to seem more like a 'normal' patient.

My experience of being with these patients has been, and is being, affected by understanding something of what the neuroscience research informs me of the development and workings of the brain. Mark Solms states in the foreword to Regina Pally's book *The Mind Brain Relationship* (2000: iii): 'Psychoanalysts

who fail to assimilate the new knowledge will be increasingly marginalised both scientifically and professionally, and will be unable to participate in this important intellectual revolution.'

I find that the difficulty with neuroscience is that it comes in a different language and speaks on a different wavelength from anything I have known before. Pally helps as she provides a readable, accessible guide to some of the main research findings that impact on our terrain. I find the Solmses' own book, *Clinical Studies in Neuro-Psychoanalysis*, more difficult, with its long descriptions of the anatomical damage suffered by the patients they describe, and of their resulting psychological suffering. It does seem, however, that this help from science will in the end aid our discipline by enabling us to describe to a sceptical world what can and does go wrong at various points in normal development; and perhaps what we hope we can do to help to alleviate the damage.

We are used to learning and thinking about psychological development when we think of human development. But I think we will soon add to this what is now known of the concurrent brain development:

> Old notions of dichotomy between mind versus brain, nature versus nurture, have been supplanted by a rich web of synergistic relations between mind and brain, nature and nurture. Specifically, according to modern neuroscience, this means that all mental phenomena are assumed to be the result of biological activity of neuronal circuits in the brain ... recognition of the remarkable degree to which brain development is experience-dependent is a striking example of how neuroscience can be integrated with psychoanalysis. (Pally, 2000: 1)

Elphis Christopher's paper, 'Whose unconscious is it anyway?' (2002), provides an outline of the science we are being asked to integrate into our general knowledge, and emphasizes that these findings have to have an impact on our thinking in these changing times. How neuronal circuits in the brain are established over the early months of life; how the limbic systems of the brain stem which are active from birth are connected to the right hemisphere so that messages from the body state are transmitted to the brain initially; how the other parts of the brain come on stream in turn during the first two years of life; what functions these have and how they are all connected up depending on the environmental provision: all this is bewildering and new to us, but clearly relevant to our attempts to understand our patients' communications about something which has gone wrong. As patients tell us how they experience their distress, knowledge of brain development will help us to understand and visualize from another point of view at what stage in emotional and brain development, and what impact that may have had, on the wiring of the brain circuits.

Now I can postulate that perhaps my female patient was able to consolidate a sense of herself in the vital early months that she spent with her grandparents. And that my male patient was subject to extreme confusion and perhaps

violence around him in his early months so that he was continually distressed and did not have space in his environment to gather a sense of self.

It seems to me that most of the neuroscience supports our theories, although not always and we may have some rethinking to do. Other of our theories seem well justified – most importantly, the existence and magnitude of unconscious processes. The Solmses attempt, in the final chapter of their *Clinical Studies*, to describe 'A Neuroanatomy of the Mental Apparatus'. This offers an anatomical model of Freud's models of the mind: where the ego, id and superego reside in the brain structures, how they are formed and how they grow. Unless one is familiar with brain structures it is very complicated, much more so than Freud's topographical, structural and economic theory.

I want to try, at this early stage in our struggle to encompass this wealth of new information, to explore some reasons why I think this is an exciting opportunity for our profession. Although there is a great deal of interest in psychotherapeutic circles, many colleagues seem unmoved by it. At this stage we may not 'need' this intruder into our psychoanalytic psychotherapy. We expect to be able to hold the sceptical response of a patient to some aspect of treatment within the transference/countertransference dynamics. However, I do not feel so protected, either from my internal sense of inadequacy in being able to account for change, or from external doubts and scepticism, that I can afford to ignore this opportunity to gain credibility. Sometimes in the consulting room I resort to explaining to a patient why I think it may be as they experience it to be. For instance, my male patient frequently experiences paranoid anxieties and rage in the face of what we come to understand together as situations in which his experiences with me remind him of when he was abandoned as a child to his envious sadistic father. Increasingly I become either the abandoning mother or the sadistic father. It has been helpful to us both I think to have an understanding from 'outside' of what is so often repeated in here; as I abandon him during my holidays to face the confusing external/paternal world alone, or as I am required to contain his rageful response until we can try to understand what has happened. We understand these states of mind in the transference situation of today, and as repetition-compulsion of a past experience; but we may also understand them in terms of neural pathways to dynamic locations in the brain. We understand from our experience, but also from the neuroscience, that there have to be many repeated experiences of being heard and understood before the pathways may be modified. An interpretation may be helpful and may bring relief temporarily, but the response to such a situation will not change until the new experience of being understood can become more predictable than the original. The earlier the original experience, the longer it will take in therapy to alter, and, I suspect, the more likely it is that the original pathways will be reactivated after new ones are established when the organism is under stress. We might put this process in our own language, but it can be useful to find an explanation for what is going on in a language that belongs to neither therapist nor patient. Perhaps this is like a

parent needing support from the other parent from time to time; one can manage on his own, but a second makes the job much easier.

I am beginning to find my understanding of brain functioning useful in several ways. It does help me, as I have tried to indicate, to hold my own position in the consulting room, and to be able to find support for my feelings about what is going on for a distressed or disturbed patient from what I know of the brain science. I may or may not share this with a patient, and would always precede any such 'explanation' with something to indicate my own beginning knowledge and understanding. But as I consider the activity of the consulting room to be a joint venture between patient and therapist, any such cautiously offered understanding can lead to more exploration on both sides. Maybe as my understanding grows I will feel more confident with this kind of explanation. It might be thought to be anti-analytic, but it seems to me more likely rather to enlarge the dialogue and curiosity (as it is inspiring my curiosity), rather than cut short some psychoanalytic process. Perhaps the classic interpretation precedes any scientific one, which should only be used for further consideration; but maybe there are times when an understanding of, for example, a particular traumatic incident and its impact, may helpfully be understood in more ways than our classical stance. Although I think that most mutative work is done in the transference, it may be that a 'good enough' transference background allows much good extra-transference work to go on. It may be that such considerations take us to the often-maligned area of supportive work. I would argue, with Harold Stewart (1992), that a great deal of our work is supportive of a patient's valuable ego functioning, that an occasional interpretation of one type or another, or a reconstruction, are all agents of psychic change.

Both within and outside the consulting room there is worry about how long our treatment takes. It is expensive treatment in terms of time and money, for both parties. In this country certainly psychotherapists do not grow rich on their therapeutic earnings; we have to be convinced on some other measure about the value of our work. We know it is valuable through our own experience. I think of my own infantile trauma in terms of sensory memories carried deep inside my brain and body. This makes sense of how I experience myself and why I trip up in the particular ways that I do. My analysis in a way clarified myself for myself and enabled me to see and hear and feel, and even sometimes to remember that I have seen, heard, felt that before. It allowed me to discover an identity instead of being condemned to wander through my life like little girl lost. Now I can begin to understand from neuroscience why it was so hard for me to work through all of this, and why it is so hard to maintain it under stress.

I do not think one's own personal experience is enough to convince other people, although implicitly it must affect our patients deeply. I suspect that we need the neuroscience research results. They may be the most potent tool at

our disposal to convince a wider public of the validity and necessity of our intensive treatment. This might have benefits – for attracting patients, for convincing funding bodies, for establishing training schools – all vitally important to our profession's continuing existence, let alone for the opportunities to find effective help for distressed people. But I also think it might bring grave difficulties for the maintenance of training standards. Few people are really suited to this intensive type of work, which entails a long, slow, hard personal journey before a therapist is qualified to help another on their road. If we understand the neuroscientist Allan Schore's explanation (below) of what has to go on in our consulting rooms, it is to understand that he poses us with a challenge in different words to those we would normally use, but maybe we can all follow it from our various theoretical orientations:

> Recall that attachment is fundamentally the right brain regulation of biological synchronicity between organisms, and thus the empathic therapist's resonant synchronisation to the patient's activated unconscious internal working model triggers, in the clinician, the procedural processing of his autonomic visceral responses to the patient's non-verbal non-conscious communications. (Schore, 2001: 318)

This is not a familiar way of describing our function. The next quotation is a little easier:

> I propose that non-verbal transference-counter transference interactions that take place at preconscious-unconscious levels represent right hemisphere to right hemisphere communications of fast-acting, automatic, regulated and deregulated emotional states between patient and therapist. (Schore, 2001: 315)

His understanding of why this must go on is stated in this way:

> Empathic resonance results from dyadic attunement, and it induces a synchronisation of patterns of activation of both right hemispheres of the therapeutic dyad. Misattunement is triggered by a mismatch, and describes a context of stressful desynchronisation between and destabilisation within their right brains. Interactive reattunement induces a resynchronisation of their right brain states. (Schore, 2001: 316)

This is all in a paper that Schore gave as the Seventh Annual John Bowlby Memorial Lecture, which is more accessible than his scientific books. Schore seems to be on a mission to explain to all of us who are prepared to listen to him how neuroscience impacts on our psychoanalytic understanding. His central theme in the paper is that the nature of the primary attachment is decisive for the infant's future mental health, the primary building block for all future brain development; and that attachment is built up in the first few weeks and months of extra-uterine life by experiences of attunement, misattunement and repair. This is what we know happens in a good treatment; empathy and understanding, which form the basis of the therapeutic alliance, inevitably cannot be maintained at all times through every session. Here perhaps I can find an

understanding of my female patient; maybe she was able to withstand my misattunement because of her early adequate attunement with her grandmother, and to wait until I could catch up with her with 'interactive re-attunement'. Some patients forgive our 'mistakes', maybe tell us we are wrong and move on; others cover up our mistakes for us and pretend not to notice them (more difficult to discover); still others experience a catastrophe, an impasse. Schore expects and demands our emotional response:

> This model clearly suggests that the therapist's role is much more than interpreting to the developmentally disturbed patient either distortions of the transference, or unintegrated early attachment experiences that occur in incoherent moments in the patient's narrative.

He is insisting that these experiences of attunement, misattunement and repair, or what he also calls synchronization, desynchronization leading to disregulation, and repair, repeated many times, are the fundamental building block of the therapeutic relationship and of the therapy itself; just as it is for the infant with his primary caregiver, when 'the mutual dyadic experience' is all important.

The vital link for us is the scientific finding that the neuronal and synaptic pathways that are established in the early days of life are able to change all during life; although they can be altered only by a prolonged different experience from the first one. Schore writes:

> It is important to note that the right hemisphere cycles back into growth phases throughout the lifespan and that the orbitofrontal cortex retains a capacity for plasticity in later life thereby allowing for the continuing experience-dependent maturation of a more efficient and flexible right frontal regulatory system within the growth-facilitating environment of an affect regulating therapeutic relationship. Over long term treatment this neurobiological development may, in turn, mediate an expansion of the patient's unconscious right mind and the transformation of an insecure into an 'earned secure' attachment. (Schore, 2001: 320)

This seems to me what we battle with in our work with our disturbed patients, whom we maybe think of as 'borderline'. But to understand this in terms of early attachment 'pathology' (Schore) is to explain the rollercoaster experience of the therapist in the consulting room with some patients who allow us to know of their own terrifying and desperate experiences in our presence. These could be thought to be caused by our 'misattunement'. We have to hear and contain these experiences and work through our counter-transference; we are unable to stay 'attuned' all the time, despite our very best training and supervision; we say or do something that may be correct but that is out of tune, or at the wrong time or place. We work to understand what has gone wrong, to repair it, and so to be able to work on. The scientific research results that show that a prolonged exposure to a different experience is essential

must in time impact on psychiatric and funding authorities; endless repeat prescriptions of pharmaceuticals can be useful, even essential, so that a patient's overwhelming affect can be reduced or controlled, and so that he or she can begin to think and work therapeutically. This is evident for me in my work with my male patient. But if or when we are able to show on a screen the changes in brain functioning that are faulty or necessary, when some measure of change is available, it may show what is possible. But it will be possible only after long, hard work, and of course the outcome then, as now, will be uncertain.

Pally writes that she thinks neuroscience will be an additional tool for understanding 'the experience-dependent brain' – additional to our own psychoanalytic understanding. I think perhaps that it provides an understanding in a different language and as yet it is impossible to translate directly. This is borne out by my experience of attending the first two annual conferences of the new 'Neuro-Psychoanalytic Society'. I found it hard to concentrate and follow the scientific arguments, although if they are well presented they can be enthralling; but of little clinical use. The first conference was on Affect, and was an exciting experience as it was the first gathering of many diverse professionals interested in this area, the mind. It was interesting to see how the scientific findings so often support Freud's formulations and our clinical observations, but hard as yet to see what we might learn from them. The second conference in New York on Memory was even harder. On the other hand, I feel that to find our psychoanalytic formulations supported by 'even the most conservative neuroscientists' (Solms in seminars on The Brain at Anna Freud Centre, 1999) offers the potential for a turn-around in the standing of our profession. We need spokespeople who can converse in these different languages to convince other influential people, but it may happen when we have an observable, provable body of evidence. For instance, if it is possible to measure the growth in the orbitofrontal cortex in the brains of children before and after treatment, or to show with scanning the changes in the neuronal pathways in damaged adults, we may be able to demonstrate to those other than the patient whom we have treated what changes we have effected. As the brain damage of early trauma and deprivation can be seen on a screen, so may the repair also be seen, and measured, rather than merely felt by a patient or understood by us. The neuroscience that is particularly useful to us so far is those research projects that explain the early development of the brain, how the brain is shaped by genetic factors and 'to a startling degree' (Pally, 2000: 5) by interactions with the environment; and the nature of those interactions and the lifelong effect of them:

> Illustrations of the experience-dependent nature of brain development exist at every level of brain functioning, from the rapid growth of the brain in early childhood to the subtler modifications that occur throughout the lifespan. (Pally, 2000: 5)

The early interactions that are so vital concern the attunement of the primary caregiver in early life, which we attempt to use in the consulting room; the right brain to right brain communication of the infantile period, the method by which the 'good-enough mother' (Winnicott) becomes immersed in her infant; and what we call unconscious communication and projective identification, which Freud explained as: '...the therapist should turn his own unconscious like a receptive organ towards the transmitting unconscious of the patient' (Freud, 1912: 115).

Schore emphasizes that it is this attunement that is vital to the efficacy of a therapy. We have to share 'the feeling of what happens' (Damasio) with our patients so that we can begin to find words to talk about the feelings and memories, just as a mother has to tune in to her infant in order to contain and thereby modify the desperate anxieties of this period of total dependence. It is this re-experiencing of dependency that patients so often fiercely resist, which is both so terrifying and yet may be so rehabilitating, and which is the hallmark of our intensive work. Because 'throughout life every part of the nerve cell, from soma to synapse, alters its dimension in response to environmental stimulation' (Pally, 2000: 10; quoting the work of Diamond, 1988). We have a chance of effecting an alteration. Here is confirmation from another scientist and psychoanalyst working in this area:

> We have pointed out that the new discoveries in memory research seem to support the clinical psychoanalytic evidence of the last decades that therapeutic changes do not come about merely by means of uncovering the traumatisations of early infancy ... but that working through in the transference relationship to the analyst (including the sensory motor and affective experiences in the therapeutic interaction in the sense of embodiment) is the decisive factor ... these conceptualisations make it plausible that the needs and conflicts that arise in early socialisation should be so persistent and determining and why psychoanalyses that change structures need time. After all, changes of biological processes need their own time. (Leuzinger-Bohleber and Pfeifer, 2002)

One of the fascinating outcomes of Schore's work concerns the particular sensitive periods of early growth for emotional development. He proposes 'a sensitive period of between approximately six months and one year for the developments of circuits in the prefrontal cortex that subserve the capacity to self-regulate high positive affect states' (Pally, 2000, quoting Schore, 1994: 9). He suggests that it is within this period that the infant experiences intense excitement with interactions which need to be modulated by the 'mother's responsiveness'. It sounds to me like a patient who arrives in emotional state, or becomes so during a session, but if I can quietly hold the space open for whatever may come next, maybe by talking but maybe by keeping quiet, the patient calms visibly and audibly and is able to leave in a more contained state of mind. This is what happened with my male patient, time and again, before he felt sufficiently contained to risk the couch. It has sometimes seemed mystifying to me to understand what I have been able to do, or to provide; but in these terms, I have perhaps been able to provide an opportunity for 'self-regulation' to take place. 'What

neuroscience emphasises is that emotion and the experience of emotion are involved in all human endeavours ... what these neuroscientific findings suggest is that emotional non verbal exchange may play at least as much importance in analytic treatment as verbal exchange' (Pally, 2000: 99). Maybe this does not tell us anything new, but I find this supports my own view of what I believe to be important in our work; that we are, and struggle to remain being, emotionally accessible to our patients, even when we find it difficult, as with my female patient. As I become more secure analytically I am less concerned by my sometimes wandering attention. It is always interesting, why it wanders and whither, but as often as not I do not find time in the hurly-burly of a session for self-analysis. What I increasingly find is that my 'wandering' is all part of the session. I am more able to keep quiet until I feel that I have something to offer, just as I am more able to join in a dialogue if it feels right to do so, and to think about why I am being unusually active. I enjoy my work much more as I have become more relaxed with my place in the room. It is a privilege to be allowed to join in with someone's innermost thoughts and feelings. It is about making available a part of myself to another human being, in an attempt to be with them at an emotionally intimate level. It can be a mutually helpful and reassuring process, a coming together of human beings on a deep level that does not happen anywhere else in quite the same way: a sharing of human psychological mindedness. And it works. If this scientific way of putting this process into words makes it more understandable and better respected, it can only be to everyone's advantage.

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CLASSICS REVISITED

Introduction

This new section of the *BAP Journal* will be devoted to so-called 'classic' theoretical and clinical papers in the field of psychoanalysis and analytical psychology. By classic we mean a paper that made a significant, perhaps seminal, advance in analytic thinking and understanding.

For each paper the main 'argument' or thesis will be described and the ideas evaluated in the context of subsequent work in the same area, as well as, perhaps, in the context of the author's later work and ideas. The paper's 'classic' status will be explored through questions such as: Do we continue to find the ideas valuable and useful in our work? Has the paper been superseded by later work in the field? Is it still a living text? This section will, in a sense, be looking at the history of ideas and the complex factors that influence the fate of those ideas.

Occasionally, new ideas in analytical psychology, psychoanalysis and psychoanalytic psychotherapy take root quite quickly – Melanie Klein's 'depressive position' and 'paranoid-schizoid position', W. Bion's 'container–contained', John Steiner's 'psychic retreat', Esther Bick's 'second skin', Andre Green's 'dead mother' and Ron Britton's 'third position', for example. The ideas rapidly find a place in our language and thinking, presumably because they are felt to capture the essence of something important that had not previously been conceptualized. Other ideas find a place of importance more gradually, often through a dynamic process of discovery, neglect and rediscovery – Alex Strachey's 'mutative interpretation', Donald Meltzer's 'claustrum' and D.E. Kalshed's 'self-care-system', for example.

This new section of the Journal may help us to rediscover some important ideas in analytic thinking and possibly rescue others from neglect or misunderstanding. Hopefully, it will deepen and enrich our awareness of the ways of thinking available to us in our work.

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'A clinical approach to the psychoanalytic theory of the life and death instincts: an investigation into the aggressive aspects of narcissism', by Herbert Rosenfeld (1971)

NOEL HESS

This paper was given by Herbert Rosenfeld at the Vienna Psychoanalytic Congress in 1971 and prepublished in the same year. I do not know how it was received when first delivered and published, or how long it took to establish its reputation as a very influential text, but certainly by the early 1980s Rosenfeld's Kleinian colleagues (for example, O'Shaughnessy, 1981; Joseph, 1982; Steiner, 1982; Segal, 1983) were quoting the paper as a significant advance in psychoanalytic thinking. It is also difficult to judge how much effect it had on non-Kleinian thinking both in this country and elsewhere, but I think it is true to say that it is now accepted across the schools of thought as a major contribution to our understanding of narcissism – which has itself come to be accepted as a concept of fundamental importance in psychoanalysis.

It is a relatively short paper – barely nine pages – and is written in Rosenfeld's characteristically simple and straightforward prose. This does not, however, make it an easy read, for much of what Rosenfeld is describing is complex and difficult. I have noticed that the paper seems to have a reputation among some as daunting or even obscure, which has perhaps more to do with Rosenfeld's use of the concept of the death instinct, a concept that seems to raise hackles and cause divisions more effectively than almost any other in psychoanalysis. It is also to do with the difficult concept of the fusion and defusion of the instincts, which is a cornerstone of the argument of the paper.

Although titled 'A clinical approach', the first half of the paper concentrates wholly on the theory of the life and death instincts and how they can be thought to relate to one another. Beginning with Freud's notion that the life and death instincts are 'always mixed or fused in varying degrees' and 'hardly ever appear in a pure form', Rosenfeld states that he wants to discuss: 'The destructive aspects of narcissism and relate this to Freud's theory of the fusion and defusion of the life and death instinct' (1971: 169).

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Following a thread in Freud's work which relates the death instinct to, variously, moral masochism, resistances against recovery in analysis, narcissistic withdrawal and the Nirvana principle, Rosenfeld concludes that: 'From all this it is clear that Freud must have realized the obvious relation between narcissism, narcissistic withdrawal and the death instinct' (1971: 170).

Whether the neutral reader would agree that Freud must have realized this connection and, indeed, whether or not the connection is as obvious as Rosenfeld states, it does become clear that it is this very connection that underpins the paper.

From here Rosenfeld moves on to discuss Abraham's work on the hidden negative transference in narcissistic patients, manifested mainly as aloofness, haughty superiority and devaluation of the analyst; this is linked with Reich on aggression and envy in narcissism and also with Klein's idea of narcissistic withdrawal as representing an identification with an idealized internal object. What Rosenfeld finds to be more useful in Klein's work, however, is her emphasis on the role of splitting in early development so that idealized and persecuting objects are split and kept wide apart, 'which would imply that the life and death instincts are kept in a state of defusion'.

Splitting of the ego also keeps the instincts in a state of defusion. As these processes originate in paranoid schizoid functioning, one would expect to encounter 'the most complete states of defusion of the instincts in conditions where paranoid schizoid mechanisms predominate'. What Rosenfeld means by 'complete ... defusion of the instincts', as I understand it, is destructive hate unmodified by love or dependence so that it becomes more potent and toxic. This, he goes on to say, is most clearly seen in envy, which Klein regarded as a direct derivative of the death instinct and which Rosenfeld describes as 'representing almost completely defused destructive energy'. It is (through) the analysis of the negative transference, whereby such silent envy and aggression can be brought into the open, that enables some movement towards integration, so that 'the defusion of the instincts has gradually to change to fusion in any successful analysis'.

Rosenfeld's previous work on narcissism (1964) also highlights the role of envy, although the focus there is mainly on defences against separateness of self and object, as separateness leads to an awareness of dependence which in turn stimulates envy. There is no discussion in the earlier paper of the role of the instincts nor of the permutations and combinations of how they interrelate. These permutations are then discussed in the 1971 paper and Rosenfeld introduces a startling and original idea: 'The concept of *pathological fusion* [is introduced] for those processes where in the mixing of libidinal and destructive impulses *the power of the destructive impulses is greatly strengthened*, while in normal fusion the destructive energy is mitigated or neutralized' (1971: 172; emphasis added). This, I would maintain, is possibly the single most important

sentence in the paper. It is what is new and original and what has been keenly taken up by other workers in the 30 years following the paper's publication.

From this point Rosenfeld emphasizes the importance of differentiating between the libidinal and destructive aspects of narcissism. Although there is this reference to libidinal aspects of narcissism – described as based on an idealization of the self – and indeed the title of the paper indicates a focus on the life and death instincts, in truth Rosenfeld's primary interest is in destructive narcissism as a manifestation of the death instinct. Perhaps he thought that libidinal narcissism had been covered in the earlier paper.

Idealization of the self is also a prominent feature of destructive narcissism, but here what is idealized is 'the omnipotent destructive parts of the self' which are directed against 'any part of the self which experiences a need for an object and the desire to depend on it'. Violent envy arises when the reality of the separateness of the object and its valuable qualities is experienced, shattering the narcissistic self-idealization. This envy appears in destructive narcissistic states – for example, in the analytic relationship – as a wish to destroy the analytic work and also to destroy the self. Suicidal impulses are openly expressed and death is idealized as a solution to all problems.

Is this, Rosenfeld asks, an example of the death instinct in complete defusion? Apparently not:

> The state is caused by the activity of destructive envious parts of the self which become split off and defused from the libidinal caring self *which seems to have disappeared.* The whole self becomes *temporarily* identified with the destructive self. (1971: 173; emphasis added)

This 'dangerous defusion', as Rosenfeld calls it, is lessened and the destructive impulses mitigated by working through in the transference so that loving parts of the patient can be reclaimed and helped to come alive.

Here there is some confusion for the reader. The passage just quoted would seem to argue that the libidinal (loving, caring, dependent) self has not disappeared, been killed off, or been evacuated but has become temporarily submerged under the weight and strength of the destructive self. But where has it gone, and how clinically can it be retrieved, if this dangerous defusion is to be lessened?

Rosenfeld attempts to address some of these questions in the next paragraphs but first describes a dream of a narcissistic patient in which:

> A small boy in a comatosed condition [was] dying from some kind of poisoning. He was lying on a bed in the courtyard and was endangered by the hot midday sun. The patient was standing near to the boy but did nothing to move or protect him. He only felt critical and superior to the [boy's] doctor, since it was he who should have moved the child into the shade. (1971: 174)

Rosenfeld understands the dream as depicting the relationship between the patient's dependent libidinal self (the dying boy), his destructive narcissistic

self (a critical and superior figure) and the analyst (the doctor). The destructive narcissistic state is maintained in power by keeping the libidinal self in a dead or dying condition, and using this to triumph over the analyst and show him up as a failure.

This internal relationship between the destructive narcissistic self and the libidinal self is further detailed in a much celebrated passage, in which Rosenfeld uses the metaphor of 'a powerful gang dominated by a leader who controls all the members'. The 'highly organized' destructive narcissism of these patients is likened to such a gang whose members must be controlled in order to keep itself (the gang) in power, to prevent defection to the positive parts of the self and to prevent betraying the secrets of the gang to the police (that is, the analyst). The primary function, however, is to maintain the idealization and superior power of the destructive narcissism – that is, to keep itself in power. Although at times in this passage Rosenfeld uses the terms 'destructive narcissism' and 'narcissistic organization' confusingly – sometimes synonymously, sometimes differentiating between them – the picture nevertheless clearly emerges of a destructive part of the patient's mind organized rigidly but cohesively with the aim of protecting and preserving its own supremacy, and which is committed to narcissistic self-sufficiency and against any object relatedness or dependency.

In considering more pathological versions of this same structure, which might be linked to a psychotic organization of the personality, Rosenfeld describes the destructive narcissistic part as ruthless, omnipotent and omniscient and as offering the (delusional) possibility of 'complete painlessness but also freedom to indulge in sadistic activity'. This is being offered to the libidinal self, also described as the dependent self or the 'normal sane parts of the personality', which are described as imprisoned, trapped or completely dominated by this omnipotent destructive structure. In extremis, the destructive narcissistic self seeks to not only prevent the sane or needy self from any object relating but ultimately from any contact with external reality and with life itself:

> Sometimes the patient develops an acute hypochondriacal fear of death which is quite overwhelming. One has here the impression of being able to observe the death instinct in its purest form, as a power which manages to *pull the whole of the self away from life* into a death like condition by false promises of a Nirvana like state. (1971: 175; emphasis added)

This, Rosenfeld argues, may appear to be a state of complete defusion of the instincts but is actually a pathological fusion, in which the power of the destructive process is greatly increased by the complete domination of the sane self. Here we return to the important relationship detailed previously in the paper between destructive narcissism, pathological fusions of the instincts and suicide.

How, clinically, do we address this situation? Earlier in the paper Rosenfeld recommends 'very detailed exposure of the system'. Later he adds that it is crucial 'to help the patient to find and rescue the dependent same part of the self from its trapped position'. Furthermore, it is important to help the patient to 'become fully conscious of the split off of destructive omnipotent parts' he is dominated by and which prevent him from achieving growth and development by keeping him away from contact with objects who could facilitate this.

Finally, Rosenfeld reports some case material (the only clinical material in the paper, apart from the dream mentioned earlier) to illustrate some of these ideas. The patient, consciously cooperative with his analysis but with a chronic and elusive resistance, demonstrated his destructive attacks on the analysis by acting out with multiple affairs and missed sessions. It was through his dreams that his destructive narcissism was most clearly conveyed: depicted in one dream as a powerful arrogant man, nine feet tall and demanding absolute obedience, in another as a brother and sister who are unprincipled, nasty and intent on interfering and misleading. Through the interpretation and exposure of these split-off, omnipotent and narcissistic parts of the self it was possible for the patient to strengthen his dependent self, represented in a dream as a receptive and appreciative child.

This clinical material demonstrates well the operation of the destructive narcissistic self as a silent but malign force opposing the analytic work; it perhaps depicts less vividly than the 'dying boy in the sun' dream the particular nature and quality of the internal relationship between the narcissistic self, the dependent self and the analyst – and which is presumably why the dream is more often quoted in other papers on the subject. Hinshelwood (1994), however, sees this clinical material as describing well a central feature of destructive narcissism, which is the sexualization of destructiveness.

Having spelt out in some detail the central arguments of the paper, I want now to turn to a discussion of some of the aspects of this argument which have continued to be controversial.

Libidinal versus destructive narcissism

Rosenfeld describes the need to differentiate between the libidinal and destructive aspects of narcissism as 'essential', though he also adds that: 'In the narcissism of most patients libidinal and destructive aspects exist side by side *but the violence of the destructive impulses varies*' (1971: 173; emphasis added). One important way in which these impulses vary is that the violence of libidinal narcissism arises out of the discovery of the separateness of the object, challenging the self-idealization and causing the patient to feel humiliated, defeated and small. In destructive narcissism, however, the envy (presumably arising from the same discovery) is more violent, appears as a wish to destroy the object, and also gives rise to self-destructive impulses. To die is preferable to

being dependent, or, as Britton (1998) quotes Milton's 'Satan': 'Better to reign in hell than serve in heaven'. This, then, would seem to be a useful clinical distinction. However, Steiner (1989) sees this distinction as artificial, in that both libidinal and destructive aspects of narcissism are always present and the former can quickly change into the latter if the idealization is challenged. He also argues for a 'complex collusion' taking place between the libidinal and destructive aspects, rather than one being the imprisoned victim of the other. Similarly, Sohn (1985) described what he calls a 'collusive pseudo alliance' taking place between the destructive narcissistic self and the analyst, to jointly criticize the hated dependent self who is viewed as ill and contemptible. This paints a somewhat more complex picture of these internal interrelationships than Rosenfeld describes and implies that a clear differentiation between libidinal and destructive elements is not always easy to arrive at.

Spillius (1988) also questions this distinction, stating that 'all but the most temporary states of narcissism are basically destructive, suffused with death instinct'. Segal (1983) agrees with this position: 'all persistent narcissism is based on the death instinct and envy'.

Technical issues

As previously described, Rosenfeld says little about how to address the pathological structure of destructive narcissism, apart from a detailed exposure of the system so as to rescue the sane dependent part from inside its trapped position, and the importance of helping the patient to become 'fully conscious of the split off destructive omnipotent parts of the self ... because this can only remain all powerful in isolation'.

This latter issue has provoked some disagreement, not least from Rosenfeld (1986) himself, who, as Tuckett (1989) described, warned in his later writings of the danger of over-interpreting or only interpreting the patient's destructiveness for fear of overwhelming the patient with guilt and driving him deeper into a narcissistic position. Rather, it is recommended to uncover the confusions, or pathological fusions, between the libidinal and destructive parts of the self.

This theme of confusion is taken up by Garvey (1998), who, while applauding Rosenfeld's paper for 'bringing deadliness to life' and helping us to be more equipped to bring it out into the open, none the less sees destructive narcissism as often a defence against psychotic anxieties to do with death, confusion and madness. She describes a case of a narcissistic patient who for a long period in the early part of the treatment rejected all transference interpretations with polite disdain. Progress was achieved not by interpreting the patient's destructiveness but rather by tolerating the countertransference feelings of being made to feel small and helpless and by the patient's encounter with an object who could tolerate these feelings without becoming cruel or aggressive.

Segal and Bell (1991) describe a central technical problem we face in treating narcissistic patients:

> Whenever the analyst talks to them of anything needy in themselves, they experience this as an attempt to make them dependent – that is, to forcefully reproject dependency into them. Such patients, if they do allow themselves to be helped, often feel they are in terrible danger from the powerful gang [of the destructive narcissistic self]. (p. 167)

Bell (1999) has also described the technical difficulties in circumventing what he calls 'the internal surveillance system' of the destructive omnipotent part of the self in attempting to gain access to the needy and dependent parts. How this is best achieved therapeutically is a question of fundamental importance and one that continues to be argued over.

In conclusion, it does seem that this paper, rightly given classic status, opened up a rich and fruitful seam for us to explore; especially helpful, I think, in the treatment of not only narcissistic but also borderline and suicidal patients. Although the instinct theory it draws on is difficult and at times unclear, none the less the idea of a pathological fusion of the life and death instincts, whereby destructiveness is heightened by idealization and excitement and thus made more potent, while imprisoning a needy and vulnerable self, is a clinically helpful framework for thinking about a group of patients who we all find difficult to reach and help.

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CLINICAL COMMENTARIES

Clinical material: Lesley

It is just three years into a twice-weekly therapy with a woman in her mid-50s.

Session one

This is the second session of the week, in the early morning, a short while after the Christmas break. In the consulting room my patient arranges the couch to her liking with her usual deliberation by removing the top cushion and placing it on the chair. As she is doing this she comments on the scent from the hyacinths on my desk; how nice they smell. I am surprised because she has never commented on anything in the room before, nor has she ever really spoken to me outside the boundaries of the session apart from 'hello' and 'goodbye'. My patient suffers from a chronic physical illness, the onset of which was prior to starting therapy. Her fingers are quite distorted, and on the couch she holds them together over her chest. Because she lies so flat and still with her hands in this sort of crumpled praying position, and crosses her ankles, she can look like a memorial statue. However, she is plump and quite pretty and dresses well so the sense of deadness is both there and not there at the same time.

She sighs hard and fast as she usually does – the sound is almost vocal.

'Well, I suppose I've got to go on thinking about my relationship with my mother, as it does seem to be the same as all my other relationships. That's not a very nice thought.'

I murmur, 'Got to?'

'Well,' she says, again with a sigh, 'I do seem to be fixed in this. This is what we've been thinking about isn't it, how I don't seem to be able to get beyond this.' She has spent part of the recent holiday with her widowed mother and since her return we have understood much more clearly how both of them try to control one another. She had previously seen her mother only as wanting to control her, which as far as I can make out she does with enormous bossy energy. Now she has begun to see that she too wants to and does control her mother, and this awareness has upset her.

After a pause, and in the same flat, tired voice, she tells me how difficult she finds it to think about her sessions and her therapy when she's away from here;

as soon as she leaves here she's thinking about her next work meeting; it's only when she is travelling that she can think about it and it often makes her feel so miserable that she doesn't want to think about it at all. Although she can sometimes remember what we've talked about, she can't hold on to it.

I say that I wonder whether she is saying that she doesn't always feel she can hold on to the meaning of what has gone on in her session so that what she does remember can feel a bit hollow and meaningless.

She agrees but then says, 'I don't know what to do about that.' After a bit she continues: 'I know you think that when I say that I am kind of putting a stop to things but I don't know where to go with it.'

I realize that what has happened is that she has succeeded in taking the meaning out of the previous exchange, which was about the loss of meaning – in other words she has just demonstrated to me what she was talking about.

She continues to talk more about how thoughts and ideas don't develop in her mind, and to remind herself and me of how we had been speaking in her last session of her tendency to close down her mind so that she just cannot let the thoughts and feelings flow, how they seem to come to a stop. She says she can now understand what I have been saying, that this is probably a defence against knowing what is really there in her mind, but although she can understand that, it doesn't change anything and she does find it very frustrating.

I say that I'm wondering whether her need to control other people, and her feeling of being controlled by them, turns up here with me in that she might have the idea that I have decided what I think is in her mind – something beyond the block of the defence – and, as a result, she may be feeling that I'm saying I know better than she does that there's something else in her mind. This may lead her to feel determined that she is not going to let me see or understand anything other than what she wants me to.

She replies with a rather scornful laugh, saying, 'I know what you're saying but you're not a bit like my mother. She says things to me like, "Now listen to me", or "This is what you ought to be doing", or "You are completely wrong about that, and I'll tell you what's right." You never say things to me like that, you're not like that.'

The quotes from her mother are spoken with great anger and energy. I find myself feeling quite strongly that I want to pursue this because I fear that we're about to lose the point and be drawn into some acting out. I manage to control this, but it is a bit of a struggle.

She goes on to tell me about the consultancy work she was doing the previous day with her friend and colleague T. The day had gone well and despite a considerable disagreement between herself and T about the work, they did manage to sort it out. She explains to me, as I have heard many times, how she and T also try to control one another *vis-à-vis* their work together, but that they can work through their disagreements, even though it can sometimes feel like quite a struggle or even a fight when they shout at each other. However

things are always sorted out in the end and there are never any bad feelings that stay around, no sulks or emotional withdrawals, as there are with her mother. Then, unusually, she begins to reflect that in fact, even though things can be worked out with T, she really is very like her mother and she hasn't thought about that before. She goes on to tell me about other colleagues she has worked with in the past year, two in particular where none of this mutual desire to control seems to appear. Those working relationships seemed to be mutually supportive, encouraging and quite straightforward.

'Mm,' I say, acknowledging what she has said, and the session ends.

Second session

This second session takes place the following week, mid-afternoon on a Monday. My patient is wearing a bright red jumper. Once on the couch she sighs a lot in short, sharp bursts and eventually begins to tell me about her day so far. She has been working very hard typing up reports, dealing with phone calls and arranging two rather important meetings. This is what I glean from a rather incoherent account, but it becomes clear that she is telling me how difficult it is to break off her work when she has got herself up to speed, as it were, with the typing, 'It is a problem to have to take two hours off in the middle of the afternoon to come here.'

As she talks on I have little to say, but I listen carefully to try to detect her tone and mood. She suddenly says, 'I can't get up to it.' I don't know what she means so I repeat,'You can't get up to it?' in the hope that she will clarify, but she only says, 'Yes.' She goes on to talk about the reports she is writing which she should have finished before Christmas but didn't and so has to hurry to do them now.

I say that I am wondering whether 'not being able to get up to it' might mean not being able to let herself 'get up' to being in the right state of mind for her session because of the work demands, and that perhaps she feels she can't reach me and talk to me about herself. She readily agrees and I'm surprised and relieved – we have understood each other, so I elaborate this a bit, going on to say that perhaps she feels that her need to hold on to her 'work mind' is in fact depriving her of her session and her connection with me even though she has managed to get herself here for it. She agrees again. Things now feel a bit easier in the room.

After a bit she goes on to tell me about one of her new colleagues with whom she has been working recently on a project in which she has been very successful and who she likes a lot and who was telling her, 'You really do get on with it, don't you?'

I say that she does feel that she can find me and that she and I can make sense of things together, even though she prefers to see success located in the outside world because she believes that that alone holds her together, and that

if she didn't make herself 'really get on with it' out there she wouldn't know what would happen to her, except that she fears it would be terrible.

It's time to stop. She gets up and as she leaves the room she looks at me and laughs a bit and says, 'Back to the typing.' And then with a slightly ironic shoulder shrug and a continuing smile she says, 'I'm sorry', and leaves.

Clinical commentary: Lesley

ANNE TYNDALE

When I first read through these sessions my thoughts focused on the difficulty of treating a woman in her 50s whose defences have become quite rigid and whose pain is manifested in what sound like rigid symptoms. Her wish to feel some control is evident from the outset; the therapist says she 'arranges the couch to her liking' and 'with her usual deliberation'. This sounds different from removing the top cushion because it is uncomfortable; she is determined to have her way. Already in my own countertransference I am feeling immobilized. The patient is immobilized too. She 'can look like a memorial statue'. This image is striking. A memorial to what or to whom? Into my mind comes Masud Kahn's description of the hysteric living in a 'cemetery of refusals' (Kahn, 1989: 57). Is she a memorial to a petrified relationship of her early years in which she is still protecting herself by refusing dynamic interaction?

This very unpromising start is mitigated, however, when the therapist goes on to say, 'the patient is plump and quite pretty and dresses well so the sense of deadness is both there and not there at the same time'. Here is a therapist in touch with the two selves of her patient; who can hold the whole of her together in their mind. This is a prerequisite for helping the patient towards integration. Alongside the stultified middle-aged woman is a softer, more appealing person. Is she a little girl, plump and pretty? She also dresses well: we are not sure if she thus brings a cared-for and artistic self into the adult world or whether she is, as Joan Rivière first described, a little girl dressed up as a woman. We know nothing of the patient's attitude to men from these sessions; all we hear about and experience is an unresolved relationship between the patient and her mother. I also noticed when I had finished writing this commentary that I had assumed that the therapist was a woman but of course a man could just as well provide the steady, containing atmosphere witnessed in these sessions.

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'Hysteria', writes Kahn, 'is not so much an illness as a technique of staying blank from and about oneself with symptoms as a substitute to screen this absence' (Kahn, 1989: 57). Perhaps this patient's crumpled and distorted hands are a substitute symptom for a blanked-out self which feels crumpled and distorted; a self in need of an all-caring God to whom she 'prays'. As the session continues we hear about the patient's difficulty in entering into a continuous relationship with her therapist for fear of traumatizing maternal intrusion being repeated. According to Kahn, the mother's emotional neediness precludes the possibility of her attending to the ego needs of the child; these get muddled with id wishes and sexualized. Intrusion is experienced as a phallic attack or seduction, and the therapist's interpretations, in the patient's mind, constitute just such an intrusion. 'Hence the hysteric has to refuse the whole relationship and return to the safety of that blankness which is a negation of both the self and the object' (Kahn, 1989: 58).

The patient begins the session aggressively. She says she has got to go on thinking about her relationship with her mother. A false self seems to comes into play as she parodies the therapy by pretending she must please the therapist. There is then a glimpse of the feeling she thus tries to avoid: misery. She does not want to get in touch with the crumpled wreckage of her relationship with her mother. Until recently she has seen herself as a victim; now she recognizes she is also an aggressor. Refusing to hold on to the meaning of a session therefore seems to have the double purpose of protecting her against intrusion from the therapist and intrusion into consciousness from the rage, guilt and unhappiness within her. She does, however, try to work and talks about 'not being able to let her thoughts and feelings flow', which she recognizes as a defence. Her therapist takes this insight further by elaborating the nature of the defence: a need to control the other in case there is an attempt to take over the contents of her mind. The same mechanism is then used to reject this probably accurate interpretation and the therapist has to struggle to resist a wish to break through it by arguing, which would, of course, have been experienced by the patient as a re-enactment of the very intrusion against which she is protecting herself. She could have thus triumphantly justified the validity of her refusal to hold on to any meaning in the interaction between herself and her therapist. At the same time she is wanting to maintain a split in the transference between the bad invasive mother and the good sweet-smelling therapist (the two sides of the split are brought nearer together at the beginning of the session when she makes the comment about the hyacinths *while* rearranging the pillow).

The therapist's awareness and use of the countertransference feeling pay off. The tone of the session changes into one of mulling over; a capacity to think in a safe place. The patient reaches the conclusion that there might be different ways of relating and shifts from wanting to control the other as if she were a thing, to being able to consider the possibility of mutual support between two

separate people. 'The therapeutic process, as I understand it,' writes Ogden, 'involves the establishment, re-establishment or expansion of a dialectic relationship between different modes of experience' (Ogden, 1992: 29).

Discussing people who have by and large a depressive mode of operating, Ogden describes a similar dilemma when he writes of an 'unconscious anxiety that aspects of oneself are so private and so central to an endangered sense of being alive, that the very act of communication will endanger the integrity of the self' (1992: 15–16). He adds that there may also be a terror of relinquishing control over life-sustaining ties with internal objects by sharing knowledge of them with another, and emphasizes the importance of the countertransference experience in working with such patients. This patient seems to be having difficulty in relinquishing her un-nourishing internal mother whom she tries to recreate in the relationship with her therapist who, momentarily at least, manages to liberate the patient enough to allow her to consider different ways of relating.

The bright red jumper in the second session does not seem an appropriate garment for a tombstone. I wondered if it heralded raging fury or a burst of passion. Neither (just yet) as it turned out. The patient's rather flamboyant presence, however, could hardly be missed and this may be very important as she describes her sense of inadequacy, which could in itself be an offshoot of the blanking-out process. She has been working hard to arrange *two* meetings at work and it is difficult to take *two* hours off to come to the sessions. I think she is referring to her two sessions and possibly the difficulty she experiences when they end. She has to work hard to struggle against the refusing side of her that cannot let her feel any longing and then, when she is just beginning to settle down, as at the end of the last session, she has to 'break off', which feels like an interruption. The therapist sensitively takes up her feeling that she is missing something by not being able to 'get up' to enough feeling of trust to use the session fully. Afraid of being crushed, she is resistant, as, I imagine, are her crumpled hands when she types. A third session would probably be useful to diminish the chance to build up her refusals but, because of her terror of feeling intruded on, optimally the idea would need to come from her rather than from the therapist.

At the beginning of each session this patient lets out several short, sharp sighs. I speculate that she may be trying to make room for a new experience; exhaling the mother of her inner world. I think of children with asthma, a symptom arising from a difficulty in breathing out; in my experience they often cannot exhale or separate from intrusive mothers.

My initial feeling of immobilization in relation to this patient was also tempered by her comment about the smell of the hyacinths. A whole paper could probably be written on the issue of flowers in a consulting room – the jealousy aroused by the therapist's nurturing of them, the disappointment if the nurturing evidently fails and the terror of seeing them removed when they

cease to please. All these might be considered, as well as the personal statement by the therapist in having them there in the first place. However, such issues might also be taken into account as 'grist to the mill' of the analytic session. This therapist does not draw any conclusion from the patient's comment; they keep an open mind as to what it might mean. There are many possibilities; is the patient feeling envious of a sweet-smelling intruder into her space and making a patronizing remark to cover it up? Is she admiring of a possibly rather idealized aspect of the therapist? Does she feel the hyacinths were put there for her? Towards the end of the second session I am considering that her remark, the first of its kind that she has ever made, may signify an emerging ability to bear change in the environment and therefore to start to see her therapist as a person. She has not blanked her therapist out completely by any means, and is even taking the risk of allowing that there might be something sweet smelling in their relationship. The therapist, evidently feeling some warmth and connection in the countertransference, uses it to interpret the positive transference by pointing out that the patient does feel that she can find her and that they can make sense of things together. I suspect that the patient was half laughing at herself and her antiquated need to do her usual blanking when she said 'Back to the typing' and then apologized.

We are left in no doubt of a well-established working alliance between this therapist and patient; at times it is out of sight but it reappears and provides an essential basis to the therapy.

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Clinical commentary: Lesley

ANN KUTEK

A window

Here is a glimpse of two back-to-back sessions after a holiday break. Looking in on this process, I was struck by the strength of the images conveyed by the 'voice-over' of the therapist. It worried me too that I should have access to this experience, albeit that the protagonists are quite unknown to me. The therapist has had the courage to expose his/her work, but is the patient aware that she is gazed upon through a window, as it were, and that this onlooker is commenting on their being together? I am reminded of passers-by who sometimes stop in the street in front of a baby in a buggy and make unsolicited comments to the presumably connected adult, or worse, try to interact with the baby! The unease of my countertransference in this task is partly determined, I suspect, by the nature of the relationship revealed here by the authentic voice of the therapist and by the perceived vulnerability of the unseen patient.

The therapist is presumably inviting comment from colleagues because there is something vertiginous here. He/she is in a struggle to maintain continuity and meaning with a patient who returns from a renewed encounter with her mother and their long-established archetypal exchanges. We are told that the patient is in physical decline; her hands are distorted by a chronic and possibly progressive condition. The therapist likens her to a memorial statue; there are intimations of deadness, but her almost vocal sighing speaks of an as yet unmet longing. Is this an echo of a baby who has cried and whined so long and so often in an effort to get mother to meet her needs and to understand her, and has been continuously thwarted, that the crying is now formalized into a hopeless whimper?

This formalism appears to have invaded the sessions at this juncture. They are fragmented – the therapist reports 'how difficult [the patient] finds it to think about her sessions and her therapy when she's away from here'. On the odd occasions she does recall her sessions, usually in transit between assignments,

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they are painful to her as if free-associating about them were to leave her unheard and unheld, as if the journey may not lead to the intended destination. The preoccupation with fending off miserable disappointment therefore vitiates the scraps of togetherness, of holding, that she does experience with the therapist. For the therapist this must be like the baby who cannot be satisfied with a feed, firing it up with colic and barely able to absorb any nutrition.

Unlike the mother, however, the therapist is able to point to the patient's 'indigestion'. He/she wonders whether she is saying that she can sometimes feel that she cannot hold down the feed/hold on to the meaning of the content of the session so that the memory of it resonates as hollow and meaningless – she goes around feeling hungry. Any feeding is therefore persecutory and the patient's response, 'I don't know what to do about that' in turn persecutes the therapist/mother. A further utterance by the patient, acknowledging her awareness that she somehow nullifies/cannot use the exchanges, allows the frustrated therapist to realize in just this one fragment the patient's doubtless repeated enactment of not being able to feed on whatever passes between them, which of course includes the theme of 'loss of meaning' on this occasion. The therapist resumes the chase and hazards the idea that the patient's need to control other people and her feeling (fear) of being controlled by them occurs in the sessions and may suggest to the patient that the therapist has a privileged window on to what may be lurking in her mind apart from what she is willing to share.

Intimations of the shadow

At this point, the therapist has managed to get a foot in the door or at least wedge a spoonful of nourishment in the protesting infant's mouth. Nevertheless, the patient parries this with a diversion on to an apparent comparison between therapist and her mother with a vehement denial that there is any. The therapist understandably gathers a head of steam about having the exchange distorted, but, regrettably in the view of this onlooker, represses what he/she views as 'acting out in the countertransference' in an attempt to 'save' the point. The acting-out happens anyway, because the narrative informs us that the patient carries on with an oft-repeated account of a positive if conflicted relationship with a colleague, which shows in the patient's terms that she is capable of working through disagreements without bad feelings staying around – even if, on reflection, there are similarities between this colleague and the patient's mother. She amplifies this new insight with a description of recent examples of other satisfying working relationships. The patient has had the last word in the session even if the concluding 'mm' belongs to the therapist. Having elided the therapist's offering in this session, she leaves her with some hope of better times, as long as he/she remembers who is boss. There is almost a tinge of comedy as the process described gives added piquancy

to the earlier description of the patient's actions at the opening of the session: 'In the consulting room my patient arranges the couch to her liking with her usual deliberation by removing the top cushion and placing it on the chair.'

This session shows how, long into a therapy, even if grudgingly and covertly, laying false scents all the while, a patient can eventually profit from the sustained meaning that the therapist offers, in spite of occasional 'errors' or 'lost trails'. This patient will not be told, even if she appears formally cooperative, but she has inklings of what analytical psychologists call 'shadow aspects of the Self'. In other words, she is beginning to see that she is not merely a lifetime victim of a Terrible Mother, but that those shame-inducing feelings of frustration and diversionary habits come from her own unconscious and that she has some choice in how she deploys them. She has learned from and by her mother and, little by little, she finds herself able to learn from the therapist/mother.

The shadow aspects of the patient on the one hand – often seeking to protect the core, sometimes venturing out unadorned – and of the therapist occasionally sucked into a maelstrom on the other, resonate in their simultaneous vulnerability with the words of W.B. Yeats:

> I have spread my dreams under your feet;
> Tread softly because you tread on my dreams.

Over a hump?

The account of the ensuing session, notably briefer than the first, after the interval of a weekend, brings back resentment as it surely must. Even if things are going well in the outside world, and there are humdrum activities to do, coming to her session is a distraction for the patient. The observation that she is wearing a bright red jumper while occupied by mundane things and prattling incoherently in the session signals the therapist's grasp that the dominant 'function' in this segment of their work together is not 'thinking', but more likely to be 'sensation'. In spite of the patient's addressing her therapist with a further obscure negative, 'I can't get up to it', the therapist's sustained search for sense/meaning wins through and another 'mouthful' reaches its target. But even then, the patient's as-yet-unconscious identification and competitiveness with her therapist leads to an amusing 'theft' of a comment she makes of herself, 'You really do get on with it, don't you?', which is met by the therapist's generous acknowledgement that this must be so, because not succeeding in the outside world would be too terrible for the patient to contemplate for now. The patient is able to receive this and even offer some appropriate embarrassment and an expression of regret in exchange, which suggests that she is perhaps realizing that she is not easy. She is at last acknowledging the therapist as a separate person, rather than the usual 'mother/baby combo'.

Something about the word 'function'

Talking about *thinking* or *sensation*, two of the four 'functions', is a reference to Jung's elaboration of his theory of Psychological Types. Michael Fordham (1978) has helpfully explained that this theory gained importance in the explanation of differences that make for particularly virulent conflicts. Its twin concepts of attitude and function, whereby people have a specific attitude towards objects, be they extraverted or introverted, seem apposite to the understanding of what might have been going on in these two vignettes and the long-drawn-out struggle they depict.

Any commentary on such a brief snippet of someone's work is necessarily conditional and carries with it risks of misunderstanding or infringement. Yet a certain authenticity comes through the therapist's narrative and generosity which enables one to recognize something sufficiently familiar and to associate to a number of possibilities about the state of the therapist and his/her relationship to the work described at a particular point in time. We can also thereby revisit some of the theoretical aspects suggested by the reader's counter-transferential responses, even if at one remove, and this is perhaps valuable as it is the closest we can come to sharing ourselves and how we work.

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Clinical commentary: Lesley

MICHAEL MORICE

The narrative starts with the patient's comment on the scent of the hyacinths, before she lies down on the couch. Then a description of how she lies, her distorted fingers and hands joined in a praying position (a 'memorial statue'), evokes the image of a dead person lying, with flowers, in a chapel of remembrance. The therapist says that the sense of deadness is only partial, but is it that the patient has already deadened her chances of starting the session as a patient by commenting on the flowers before the formal start of the session? Does the sense of semi-lifelessness allude to the fact that her remark obscures the difference between them, including the difference in their roles?

The session proper, in contrast to the previous remark about the flowers, starts with the patient's passivity and flatness dominating the proceedings. She supposes she has to go on thinking about her mother and how they control one another. She feels 'fixed in this'. My thought here was which mother is she talking about? Is there something in the here and now, with the therapist, that feels stuck and that really needs sorting out? The session is prior to a weekend and shortly after the Christmas break. The patient is saying much about her difficulty in holding on when the therapist is not there, implying that she cannot hold on to the therapist's words without experiencing a lot of pain and therefore resorts to her 'work' defence when she leaves the session.

The therapist, whom I shall now begin to refer to as 'she' (at least, this is a maternal transference and I wonder whether women are more likely to have flowers in their consulting rooms), has worked with this patient for three years and no doubt has her reasons for not interpreting the Christmas break or the weekends. I imagine that after three years a repetitive diet of 'break' or 'weekend' interpretations might, with this patient, have become drained of meaning. But I also wonder whether there was something so sensitive and painful about the direct mention of separation, perhaps connected with despair about chronic illness and a sense of life closing down, that the therapist is taking pains to find another kind of language to support her.

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However, I also think that it is worth considering whether there is a more available 'needy infant' in the session that felt that she wasn't heard. Is there, for instance, the beginnings of a reproach implied by 'I suppose I have to', addressed to a therapist who is felt to expect her to pick herself up between sessions, which in her own way she does, but who doesn't hear her when she says 'I can't hold on to it?' This and statements such as 'I don't know where to go with it' (that is, ostensibly, what they've talked about) make the therapist begin to react, I suspect, with helplessness, and also in her countertransference there seems to be annoyance and potential criticism.

Here I thought about the question of confusion as against that of perversity. The therapist, in saying that her patient has yet again attacked the meaning of things, gives an impression of a perversely repetitive pattern in the patient's responses. Given that perversity and confusion are closely linked (for instance, in the idea of 'wilful confusion'), I wonder whether the patient, at this moment at least, may be lost in a confusion of self and object that is helpless more than it is perverse. Thus, when she says, 'I don't know where to go with it', I would like to suggest that there may be a confused child who has identified herself with a know-it-all mother/therapist in her absence but then in the session finds herself still too immersed in the projective identification to be able to think with the therapist.

'Being' some version of her therapist/mother in her absence is possibly a matter of survival for this patient. What it appears she cannot let herself do for more than a moment is to be herself and miss her therapist, for this must spell unbearable misery. I wonder whether the patient makes it very hard for the therapist to verbally acknowledge her sense of aloneness and isolation, and then finds it hard to believe that the therapist knows what it's like for her, because she (the therapist) has said nothing directly to address this.

Be all this as it may, my early impressions on reading the first session were of an arduous treatment in which the therapist has to bear a constant burden of helplessness and despair. In contrast to the idea of a 'know-it-all', exemplified more by the description of the external mother, the 'flat, tired voice' bears signs of identification with a drained and exhausted object, perhaps in line with the kind of therapist she thinks she has created and then internalized. A relevant point may be that the patient has a chronic illness, and I wonder whether, among other things, the patient is projecting into the therapist her experience of chronic physical paralysis.

Further on, where the patient says, 'I understand but it doesn't change anything', the therapist attempts an interpretation that addresses the battle for control in the transference. This is a supportive interpretation about how the patient experiences the therapist as thinking that she knows the patient's mind better than she herself does. She then adds a second bit to the interpretation, about the patient's determination *not* to let her know, which I think is instrumental in precipitating a new energy in the session. Perhaps the patient feels criticized by the second remark, enough to launch an open assault.

There are two sides to what happens next. The passage strikingly illustrates the way in which some patients' identifications with victim and aggressor alternate with lightning speed, with a corresponding alternation of projections into the therapist, which challenges to the hilt the latter's ability to continue thinking and containing. On the one hand, the patient does 'extract meaning' in attacking the broadly symbolic content of the therapist's words. She concretizes the therapist's suggestion that she (the therapist) may be *experienced* as an *aspect* of the patient's mother, and in the same breath *becomes* the mother that, with omniscient scorn, puts down and dismisses, with 'enormous bossy energy', the overtures of her therapist/child.

On the other hand, the patient is in touch with her rage. The anger and the energy are her own and she puts the therapist under pressure to act out the part of the bossy hypercritical mother. In the first instance the projection into the therapist is that of a crushed child; in the second it is that of a crushing mother. Whichever way round it is, the therapist works hard to hold the projection and not respond verbally because she realizes she is being pulled into a potentially sadomasochistic exchange.

In the final part of the session the patient, in talking of the fights with her colleague and friend that she can resolve, is surely talking of the fight she has just had with her therapist. When she reflects that T is really like her mother, she is now talking of an experience of a modified mother in the transference who contains her projections and doesn't bite back. Interestingly, the therapist doesn't say anything about this. Perhaps a further piece of 'understanding' might have quite upset the applecart, and ending with a supportive 'Mm' was the wisest course.

The second session follows the weekend. The first impression is of a patient identified with a therapist who is felt to have turned away from her at the weekend to perform her busy and more important home tasks (children, husband, family?) and only returns to the patient with grudging reluctance.

In view of the state of the patient's hands and fingers, which I see as linked with her illness, the image of her typing up reports and 'getting herself up to speed' lends added pathos to the picture of her immersion in her work and to what she may be fighting in herself in order to come to terms with her illness.

While the patient complains, there are other signs observed and recorded by the therapist: the sighs in short, sharp bursts, the bright red jumper. What are these exhalations; has she been holding on to something all weekend? Is it, beneath the busyness, some recognition of her dependency? No sign of the 'flat, tired voice' here, so I wonder whether the bright red jumper is a sign of a more lively libidinal attachment at play in the session and available to help her think.

I imagine the therapist is quite surprised by 'I can't get up to it', said out of the blue and with no explanation forthcoming. My own thought is that this is an echo of the statements of the previous session, 'I can't hold on to it', and 'I don't know where to go with it'. 'It' seems to be the operative word here, and I imagine it refers to the therapist's mind. In this instance (that is, the second

session), it is as if with these few stark words she is able to let her therapist know that she felt dropped by her not only at the weekend but at Christmas too. That she resents always having to get up to speed once she is back after an interruption not of her own making. In saying that the writing she should have finished before Christmas is still there to do, she also seems to be saying that the work in therapy on the pain of rejection leading up to the Christmas break should surely have been done by Christmas, but in fact the pain persists and the work is still in progress. So she feels dropped, she feels she can't get up to speed, up to the therapist's mind, unless the therapist picks her up, and I think that, metaphorically speaking, she is holding up her arms for the therapist to do this.

The therapist responds with a generosity appropriate to the moment. She acknowledges in effect that the projective identification is not so deep or pervasive that the needy child is unavailable. Without wrenching away at the defence, she gently points out that there is part of the patient actively at work depriving her of easy nourishment (the 'work' self), but supports and acknowledges the part of the patient that knows she wants a session and gets herself to it.

Again, as in the previous session, there is a reflection, following a sense of containment by the therapist, that speaks of a sense of work well done by both of them, that this therapy project can, after all, in patches at least, be a successful one.

The therapist ends up by pointing out that there are really two versions of 'getting on with it', one that is possible in the middle part of a session, to do with being in touch with dependency; the other, the work self, that she feels she needs at the beginning and end of sessions, and when she is alone, in order to fend off catastrophe. It is almost as if she is giving the patient permission to re-don her defensive habit before she leaves, in the sense that she is letting the patient know that she realizes how awful it is for her on her own unless she gets right back to work and all that implies. The patient confirms this as she leaves by saying 'back to the typing', but it may be with a sense of irony that augurs a possible loosening of the knot. The 'sorry' seems to be saying she is helpless to stop doing this, but also that she knows what she is doing.

In conclusion, I must say that at the start I thought I was reading about a patient addicted to a semi-lifeless state as described by Betty Joseph – the kind of patient who will 'try to create despair in the analyst' who then colludes in the despair or 'becomes actively involved by being harsh, critical or in some way verbally sadistic to the patient' (1989: 128). In the same paper she says that a masochistic exploitation and use of misery has to be differentiated from real misery and anxiety. In the former, the near-destruction of the self takes place with considerable libidinal satisfaction. In this material, however, I don't think that the 'back to typing' and the 'sorry' with which the patient departs are said with any obvious pleasure. I wonder if she is in physical pain and feels crippled by this as well as by the disability itself. Thus, in saying 'sorry', she may be

alluding to the 'cruelty' of her pain both psychological and physical, and apologizing for what she may feel is her own cruelty in leaving the therapist yet again to carry a burden of helplessness to do with an irresolvable external situation.

On the positive side, we see a patient who is able to move from a position of negative passivity to a sense of being in touch with a thinking therapist by the middle of the first session. She also shows signs of being able to carry a sense of liveliness through the weekend to her next session.

Among other things, what must surely be at stake at this stage of the patient's life is her ability to mourn the loss of her former youthful and healthy body. A sense of loneliness comes across in that she clearly struggles with a paucity of good internal objects – surely at a premium when it comes to fighting a chronic illness. Thus, I suspect that a certain emptiness prevails in which the patient holds on to the externals of life, her work and her colleagues. We have no clues of family life other than an ageing problematical mother and a dead father, so I wonder how alone she is in the external world.

It seems reasonable to think that, in beginning to understand how she controls her mother (and therapist in the transference), the patient is on the threshold of a depressive position in which a sense of guilt and a drive toward reparation would have to sit uneasily with the knowledge of the irreparability of her body. The word 'acceptance', in this context, for this woman, has deep implications for her ability in the long term to internalize her therapy and her therapist as good objects.

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ARTS REVIEW

'On the air, unaware': narcissism and transformation in *The Truman Show*

JAY SMITH

Introduction

Peter Weir's film The Truman Show (1998) was a commercial and critical success: Andrew Niccol was nominated for an Academy Award for his script and the film was praised by critics as an original exploration of the intrusion of the media into modern life. But watching the film brought to mind some comments made by Jorge Luis Borges (1999: 258–59) about an Orson Welles film:

> *Citizen Kane* (called *The Citizen* in Argentina) has at least two plots. The first, pointlessly banal, attempts to milk applause from dimwits: a vain millionaire collects statues, gardens, palaces, swimming pools, diamonds, cars, libraries, men and women ... He discovers that this cornucopia of miscellany is a vanity of vanities; all is vanity ... The second plot is far superior ... A kind of metaphysical detective story, its subject (both psychological and allegorical) is the investigation of a man's inner self, through the works he has wrought, the words he has spoken, the many lives he has ruined.

One could argue something similar about *The Truman Show*. While the manifest story is not exactly 'milking applause from dimwits', it is not exactly earth-shattering either. But if, as Beebe (2001: 212) suggests, we understand the various characters in the film as parts of a single personality whose internal object relations are undergoing change, a second and far superior story emerges. It is a drama concerning a traumatized man's sterile inner world and the painful conflicts he endures in his endeavour to develop. Truman is a victim of early abandonment who has been raised without genuine love or relatedness and thus the psychological world he inhabits has been constructed on the foundation of an early narcissistic wound. The world of *The Truman Show* is a

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world dominated by what has been described in the psychoanalytic tradition as a destructive narcissistic structure (Rosenfeld, 1987) or, from the Jungian perspective, an archetypally-based self-care system (Kalshed, 1996). The drama is set in motion by a woman who forms a connection with the 'true man' inside Truman, a connection that provokes his eventual escape from a barren paradise ruled by an omnipotent despot into a state where more creative life is possible.

The story

The plot of the film is carefully constructed so that the full truth is revealed to the audience only shortly before it dawns on Truman. For the purposes of this article, I will recount the plot in a straightforward way, as the loss of some of the writer's artistry is necessary in order to lay bare the underlying themes.

Truman lives on the tranquil island of Seahaven – 'the way the world should be', as one of the characters describes it. He is married, works selling insurance, and spends his spare time drinking with his childhood friend Marlon or visiting his widowed mother. As becomes apparent, however, Truman's equilibrium has been disturbed by an encounter with a woman, Lauren/Sylvia, who is forcibly removed from the island before their relationship can develop. During his search for Sylvia, Truman (and the viewer) discover that the world he has accepted as reality is, in fact, completely illusory. Truman, an unwanted baby born prematurely, has been adopted by the OmniCam Corporation and brought up by actors, unaware that his every waking and sleeping moment has, from his birth, been broadcast to the outside world as the immensely popular 'Truman Show'.

The 'conceiver and creator' of Truman's world, the all-powerful Christof, struggles to keep Truman in the dark about his true situation as his star becomes increasingly restless and disturbed. In a desperate attempt to find Sylvia, Truman makes a disorganized attempt to escape from the island. Christof deals with this insurrection without too much difficulty and Truman returns to Seahaven life.

Truman plans his next escape more carefully. In the climax of the film he eludes the cameras, overcomes his phobia of the sea and sails away from the island. Christof and his organization are thrown into panic. A life and death conflict between Truman and Christof ensues, in which the tyrannical Christof is overthrown and Truman leaves his encapsulated world to be reunited with Sylvia, waiting faithfully for him in the real world outside.

The setting

The first four minutes of the film, in a wonderfully condensed way, act as a kind of first analytic interview, during which we are introduced to Truman, his relationship with the outer world, the structure of his inner world and his

habitual modes of defence. In a series of rapid intercuts, Christof, Truman, Truman's wife and Marlon speak directly to the camera, telling us exactly what is going on psychologically, although we cannot yet fully understand it. Christof says: 'While the world he inhabits is in some respects counterfeit, there's nothing fake about Truman himself.'

Truman, engrossed in a childish fantasy of climbing a mountain, says to his bathroom mirror, 'I'm not going to make it, you'll have to go on without me.' Truman's wife refers to her life as a 'truly blessed' one. Marlon says earnestly, 'It's all true, it's all real. Nothing you see on this show is fake ... it's merely controlled.'

We are immediately drawn into a scenario ruled by a false god ('Christ-of'), where control replaces truth, a 'blessed' illusion replaces reality, and the 'true man' at the centre of the drama lives in despair ('I'm not going to make it'). The next minutes of the film depict the sterility of Truman's relationships and hint at the way his defences shield him from disturbing reality. His stereotyped cheerfulness towards his neighbours as he leaves his perfect house for work: 'good morning – and in case I don't see you, good afternoon, good evening and good night' is the epitome of meaninglessness. On his journey, we see the first signs that his world is beginning to malfunction, and this scene shows us the conflict that is already at work within Truman, as his defences falter and then are immediately repaired. A light falls from the sky, puzzling and disturbing Truman; but, as he drives on, this strange event is immediately explained away by the radio announcer ('an aeroplane has been shedding parts over Seahaven') and a soothing piece of music is played to distract from the perils of air travel; an easily comforted Truman unquestioningly continues his journey. As Christof later says of Truman, 'If he was absolutely determined to discover the truth there is no way we could prevent him ... Truman prefers his cell.' We thus see someone who, as Steiner (1993: 104) describes, has a sane but weak part of himself that is in collusion with the narcissistic gang represented by Christof and his organization.

A striking feature of the film is the way in which visual qualities have been used to evoke psychological experiences and states of mind, and this is most obvious in the care with which Truman's physical world is constructed. Truman lives on an island, which is, as Stevens (1998: 207) notes,

> A place of peace and sanctuary ... protected from enemies and predatory beasts as well as from the raging seas (the passions and the unconscious). The island is a hermitage, a place of solitude and isolation, a temenos for contemplation, and, ultimately, a Land of the Dead.

It is, in short, a psychic retreat (Steiner, 1993). The island is called Seahaven, a shelter from the sea, which is a powerful archetypal symbol of the unconscious psyche with its life-generating potential (Stevens, 1998: 157). Truman is phobic of the sea, indicating his fear of the unconscious depths of his

own nature, a point made by Schwartz-Salant: 'It is crucial to understand that the narcissistic character is defended not only against outer object relations, but equally against the inner world of archetypal reality' (1982: 19).

Filmed on a disused Disney set of the classic American small town, Seahaven has a disquieting perfection, a polished facade that hints at falsity and artificiality. A bright, unnatural sunlight bathes the island as the radio announces 'another day in paradise'. Bridges play an important role, telling us more about the state of Truman's psyche. Several important scenes take place on an unfinished bridge, and one of the difficulties for Truman in leaving the island is his fear of crossing the bridge to the mainland. Bridges, as Gordon notes, are 'the most vivid symbol of something that connects "this" with "that"' (1993: 4). Truman either lacks bridges to his own self or to other persons, or is too terrified to use them. But the bridges that form an important aspect of the setting of the film give us a hint that Truman may eventually be able to move from his isolated state into a more connected one.

The truth about Truman

It is not until relatively late in the film that we learn the details of Truman's early life. His 'eagerness to leave his mother's womb', Christof explains, meant that he beat competing unwanted babies in the race to be 'adopted' by Christof's corporation. We see an infant Truman lying in a cot and staring into the camera suspended in a mobile toy above him. We are thus made aware that Truman's relationship with his mother was one of mutual rejection. As an infant, he lacked a close caretaking relationship that could mirror him and contain his infantile anxieties; instead, he was forced to mirror those around him, a process vividly illustrated by the camera whose eye follows him everywhere. In this situation, 'often the child feels that he has something special the parents want, yet this specialness must be subverted to mirroring the parents, to giving back responses that make the parents feel secure' (Schwartz-Salant, 1982: 48). We might then see that Truman, having lacked appropriate mirroring, has developed a grandiose-exhibitionistic self which invites the whole world to watch his every movement, and that this part of him colludes with Christof's project.

We begin to understand that Christof and his organization represent what Kalshed (1996: 3) refers to as the progressed part of the ego which caretakes the regressed 'Truman' part. This internal constellation forms a defensive structure of a desperate type, which has allowed Truman to survive at the expense of development; 'each new life opportunity is mistakenly seen as a dangerous threat of re-traumatization and is therefore attacked' (Kalshed, 1996: 5).

This is well illustrated in the relationship between Truman and Sylvia. She has many of the characteristics of the cinema *anima* figure (Beebe, 2001: 210–11), including the desire to make emotional connection, the giving of

advice and the exertion of a therapeutic effect. Truman and Sylvia make brief contact at a dance before Sylvia is hustled away by a 'gang' of men. Later, they meet surreptitiously on the beach, where Sylvia attempts to tell him about the truth of his situation: 'They're pretending, Truman, everyone's pretending ... It's fake, it's all for you.' Before Truman can really understand or respond, Sylvia is again forcibly removed, this time by a gang member masquerading as her father, who tells Truman that Sylvia is schizophrenic and not to be believed. The presence of gangs in this and other parts of the film recalls Rosenfeld's (1987: 111) description of the internal 'gang' that may be seen in individuals in the grip of a destructive narcissistic structure.

Kept away from Truman, Sylvia engages in a conflict with Christof, which characterizes the conflict at work within Truman. In a television phone-in ('Trutalk'), Sylvia challenges Christof, 'What right do you have to take a baby and turn his life into some kind of mockery?' But Christof is confident: 'I have given Truman a chance to lead a normal life,' he replies. This echoes Kalshed's attitude to the persecutor/protector 'Christof' figure seen in the inner world of individuals who have been traumatized. 'We can imagine,' he writes, 'that his "intention" is to encapsulate the threatened personal spirit within a world of illusion, in order to prevent it being dismembered in a too-harsh reality' (1996: 40). But the contact with Sylvia has left Truman restless with his world of illusion and he begins to make efforts to leave Seahaven. This provokes the 'protective' Christof into revealing his persecutory aspect as he thwarts Truman's attempts to escape.

The climax of the film concerns itself with Truman's final, successful attempt to leave behind his encapsulated, ego-based illusory world for a more authentic engagement with his own depths and the external world. In keeping with the heroic nature of this task, this segment is filled with archetypal symbols of the self, and elements of dramatic heroic mythology.

In secret, Truman embarks on a night journey by boat, a well-recognized element of the hero myth (Neumann, 1954: 408). The author spells it out for us as the ever-calculating Christof describes the sight of Truman at the helm as 'our hero shot'. We see the prow of the boat, carved with the head of an eagle. This is the first of a plethora of Christian symbols and allusions to come; the eagle is an ancient symbol of the divine nature of Christ and of regeneration by baptism (Coleman, 1999). It would seem that the use of these particular symbols here reflects a cultural language about the relationship between ego and self, in the sense that Edinger has described: 'In fact when the Christian myth is examined carefully in the light of analytical psychology, the conclusion is inescapable that the underlying meaning of Christianity is the quest for individuation' (1972: 131).

Christ conforms to the pattern of the hero archetype, and as such is a bringer of a new consciousness, one who represents the capacity of the psyche to build up a new mirroring relationship between consciousness and the uncon-

scious (Schwartz-Salant, 1982: 46). Truman's boat is named the *Santa Maria* in reference to the Virgin Mary, who is a symbol of the vessel through which the divine was incarnated into the world. There are allusions, too, to another hero, Ulysses, as Truman ties himself to the boat to face his supreme test during the ferocious storm the ruthless Christof sends to deter him. As the storm abates, we see a seemingly lifeless Truman lying in a crucified posture before he comes back to life and resumes his journey to the limits of his false world. The last few minutes of the film make powerful use of a number of symbols to indicate to us that Truman has successfully passed through the 'supreme ordeal' of the hero, 'forging a link between the unrealised spiritual potential hidden at the core of each individual life and the mundane historical existence in this body, this place, this time' (Kalshed, 1996: 143). He seemingly walks on the surface of the sea until he climbs a stairway into the sky to enter a door for his final meeting with Christof. The stairway evokes Jacob's dream in Genesis 28: 13: 'And he dreamed that there was a ladder set up on the earth, and the top of it reached to heaven; and behold, the angels of God were ascending and descending on it.' In other words, a new and mutual exchange between the perceived world and the world of transpersonal energies has opened up for Truman, and we are not surprised when he says goodbye to his false world and walks through the door towards the possibilities and uncertainties of his future.

Conclusion

'Film-making, at least in the hands of its acknowledged masters, is a form of active imagination drawing its imagery from the anxieties generated by current concerns, and film watching has become a contemporary ritual that is only apparently a leisure activity,' writes Beebe (2001: 212). *The Truman Show* makes use of current concerns about personal privacy, covert surveillance and reality TV to create a subtle meditation on one of the dominant preoccupations of our time, the nature of narcissism and its potential role in human development.

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Books reviewed

Ordinary People and Extra-Ordinary Protections: A Post-Kleinian Approach to the Treatment of Primitive Mental States
By Judith L. Mitrani
The New Library of Psychoanalysis. London: Brunner-Routledge, 2001, pp. 186, pbk £17.99

Many tributaries add to the flow of Mitrani's book. Its theme is an investigation and demonstration of the idea that residues of very early infantile anxieties, from a time preceding integration, pervade the analytic experience. Mitrani proposes that if these factors are left unattended then certain consequences will follow: core anxieties will not be addressed and analytic impasses may occur.

In the first section the author has interesting things to say about beginning analysis. She uses clinical examples to show how her understanding of analytic material as being to do with very early anxieties, associated with fears of not being supported or of falling apart, is more effective than a directly 'educative' method in inducing the patient into the analysis. More than anything else, she asserts, this method will help patients shift from infrequent sessions to full analysis. Mitrani's approach does raise some questions. I wondered at times whether she was stretching her point in that it seemed to me that while the clinical material she presented could be interpreted in the way she proposes, it might also be interpreted in other ways. But I am getting ahead of myself here. What are Mitrani's views on early anxiety?

Mitrani merges Klein's and Bion's ideas with those of other analysts including Bick, Winnicott and particularly Tustin. She holds the view that whereas Klein's ideas have been crucial to the development of the psychoanalytic understanding of disturbance, there are traces in adult patients of anxiety states laid down in the psyche that precede the paranoid-schizoid position. Early states of 'raw unmitigated panic' can lead to Tustin's 'autistic areas', Grotstein's 'black holes' in the psyche, or 'adhesive pseudo-object relationships'. This latter term, coined by Mitrani, is destined, I think, not to 'stick'. It is unlikely to displace the more vivid Winnicottian 'false-self'. Mitrani believes that these residues of early states are not, as Klein proposes, determined by the

process of intrapsychic development but are the result of traumatic failures of containment.

There has been a historical trend in psychoanalysis to scan analytic material for evidence of earlier and yet earlier disturbance. Of course, this has led to the increased ability of psychoanalysis to understand patients who might previously have been regarded as untreatable. I wonder sometimes whether there is a tendency to stake a claim in more and more remote territory. It is as if the earlier the bird then the greater the worm to be caught. This can lead to some philosophical problems that may go unexamined. Mitrani says (p. 42):

> it is important to keep in mind that each of our patients has come up against situations, usually in early infancy or even before – at birth or perhaps in utero – that they were not psychically equipped to deal with at the time. Consequently these 'happenings' become walled-off from conscious awareness.

Evidence cited by Mitrani that the fetus in utero responds to stimuli does not necessarily imply that any associated mental activity is taking place. Even if it does, what agency creates the 'wall'?

Mitrani's approach rests on a theory of anxiety. It is not a sexual theory. It could be said to be as reductionist in its own area as was Freud's in the area of sexuality. On the other hand sexuality is certainly mentioned. In two of her case histories she says that, having analysed these very early 'black hole' anxieties and the way they are made manifest in the transference and countertransference, she felt it was time to introduce the idea of the 'father'. I think that some readers might think, as did I, that there was plenty of evidence at a much earlier stage in the analysis of a walling-off of awareness of the father or the 'third' object which could suggest a later defensive organization against unacceptable Oedipal reality.

In spite of these possible objections Mitrani shows an impressive ability to understand and interpret the patient's anxieties as they are expressed in her countertransference through projective-identification. She shows how she avoids the unhelpful head-on interpreting of defences of an aggressive sort that might drive the patient further into her shell. Instead, although she does not name them as such, she uses her countertransference to make delicate 'analyst-based' interpretations.

I found one of the later chapters difficult and it probably requires more than one reading. In it Mitrani extends an idea put tentatively by Bion that certain communications by patients of a superficially aggressive sort may usefully be regarded not as an envious attack on the breast-analyst but as an expression of the patient's early need to have her infantile 'reverence and awe' (love?) recognized by the mother who has failed in this containing capacity. I found this idea more understandable and clear in terms of Winnicott's description of states of 'pre-integration' in which the infant/patient may be aggressive (that is, discharging an aggressive attachment drive) but there is *no destructive aim*. (For

a good account of this see Sue Johnson's chapter in *Psychoanalytic Psychotherapy in the Independent Tradition* (Johnson, 1999).)

The most interesting chapter, I think, is the penultimate one, 'Changes of Mind', in which the author discusses clinical material from a female patient who produces a critical comment about her analyst. There is a detailed discourse on this analytic event in terms of its importance as a communication by the patient that contained a perceived truth about the analyst. Mitrani shows how she processed her painful reaction to the patient's comment and used it to further her own self-analysis and the analysis of the patient. (This process is similar to that described in a classic 30-year-old paper of Harold Searles (1979), cited by Mitrani in her bibliography and rather neglected here in the UK, 'The Patient as Therapist to His Analyst'.) Thus psychoanalysis at its best is also self-analysis.

For me this is not a 'must have' book, but it is worth reading.

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SIMON ARCHER

Archetype Revisited: An Updated Natural History of the Self
By Anthony Stevens
London, Brunner-Routledge, 2002, pp. 386, pbk £18.99

This book is a revision of a work first published in 1982 under the title *Archetype: A Natural History of the Self*. Having read this in the original form, I was interested to see what Stevens would now do to bring it into line with more recent research on issues such as human 'nature' and 'nurture'.

The author is a Jungian analyst as well as a psychiatrist. He has sought to take the concept of the 'archetype' out of the narrower confines of analytical (that is, Jungian) psychology and extend its terms of reference to the fields of psychiatry, ethology and biology. Indeed, 'archetype' becomes for him a vitally important linking concept. As he says in the preface of this new edition:

> The findings of the two new disciplines, evolutionary psychology and evolutionary psychiatry, in no way contradict or supersede Jung's original insights into the nature and influence of the archetypes which make up the human collective unconscious: on the contrary they corroborate and amplify them. They confirm that human experience and human behaviour are complex products of environmental and hereditary forces. The

> environment activates the archetype which mediates the experience and the behaviour. Archetypes are intermediate between genes and experience: they are the organising schemata by which the innate becomes personal.

In Part I, 'Archetypes in Theory', Stevens draws strong connections between the work of Jung and the ethologists, particularly Darwin. He sees Darwin as not only providing a coherent account of how human beings developed, but as providing us with a contemporary myth, enabling human beings to re-establish the connection between ourselves and nature in general. Jung's view of human beings as myth-making (meaning-seeking) creatures resonates strongly with Darwin. I am reminded here also of Teilhard de Chardin's vision in *The Phenomenon of Man* of humankind continuing the process of evolution on a psycho-social – that is, conscious – basis (Teilhard de Chardin, 1965: 310ff.). This is fully in accordance with Jung's concept of the teleological nature of the archetype, as it seeks its realization on both an individual and collective basis.

Inevitably this book, in its attempt to address non-Jungian readers, devotes much of its space to the exposition of Jungian ideas, and this the author does very well, particularly in Part II, headed 'The Archetypes in Practice'. Here Stevens devotes separate chapters to the archetype of the family, the mother and the father respectively. Other chapters in this part cover 'the frustration of archetypal intent' arising from deficient parenting, personal identity and the stages of life, the archetypal masculine and feminine, and shadow: the archetypal enemy. Significantly, this last chapter is the longest in the book, and approaches the issue of evil, personal and collective, from many different angles. The necessity for making the shadow conscious is stressed: 'Without some acknowledgement of the devil within us, individuation cannot proceed: coming to terms with one's own evil is the first and indispensable stage in conscious realization of the self' (2002: 277). His update of this chapter takes into account the ending of the Cold War and the identification by the West of new enemies, particularly in the light of 11 September 2001. Projection is rife and scapegoating is the inevitable outcome on all sides.

With regard to the stages of life, Stevens draws on the work of John Bowlby in order to corroborate Jung's insights into the nature of ontogenesis, otherwise known to Jungians by the shorthand term: the individuation process. A glance at the index under 'Bowlby' reveals numerous scattered references to Bowlby's work on attachment and separation, to his views (critical) on behaviourism, Cartesian dualism, to his concept of cybernetics as applied to the mother–baby interaction (the nursing couple as a self-regulating system) and to issues to do with feeling, instinctive behaviour, mating and monotropy (as evidenced by a child's preference for one caretaker above all others). Where Stevens takes issue with Bowlby, however, is with respect to the latter's failure to take sufficient account of the symbolic nature of the mother's role in the nurture of the child, and this, for me, proved to be the most interesting and relevant part of the book as far as the practice of psychotherapy is concerned.

As Stevens reiterates frequently, the role of parents is to activate the positive mother and father complexes in the developing child. So the 'good enough mother' enables the archetypal image of the 'great mother' to be constellated in the psyche of the child. This remains a resource for life, just as the archetypal image of the 'terrible mother', activated by the 'not good enough mother', or the image of the devouring father, activated by the 'not good enough father', remains a permanent countervailing negative image unless the child is later able to achieve a symbolic relationship with a new 'other', such as a psychotherapist, to enable the negative archetypal images to become eventually more humanized.

Part III, headed 'Synthesis and Integration', looks at the fact that we are permanently in two minds because of the brain's two hemispheres. He highlights the 'cerebral imperialism' promoted in western culture by the stress on the importance of rational, analytical processes which are the province of the left hemisphere. This has led to a 'somewhat condescending attitude to the right [brain]', an imbalance that he argues must be redressed in favour of the right brain, with its creative potential deriving from the activity of the unconscious. He also sees how research into the brain provides possible neurological bases for Jung's concepts. So the existence of more archaic areas of the brain links up with Jung's idea of the 'two million year old man that is in all of us'. Stevens' views tie up very interestingly with more recent research into neuropsychology and its bearing on psychotherapy.

In its original form this book is very passionate. Stevens has a mission to repudiate constructionist and deconstructionist views of the psyche, or self. These he sees as merely a working metaphor to describe the effect on human beings of purely cultural forces. He stands firmly on the side of the deep structures of the mind (archetypes) which account for fundamental differences between the sexes and for the necessity for institutions such as marriage and the family. To some, his views might seem reactionary. I found them, however, to be a valuable recall to first principles, or at least to a questioning of the current conventional postmodernist wisdom. Nevertheless, in the update he does try to establish more of a dialogue with post-Jungian thinkers such as Christopher Hauke. But dialogue is not what this book is largely about. It is more about conviction, backed up by impressive and well-substantiated research. Paradoxically, however, reading this book as a Jungian was a slightly cosy experience. I enjoyed being bathed in the all-embracing comprehensiveness of a Jungian psychology that includes all phenomena within its scheme of things. But I felt suspicious of my reaction as well. I would have appreciated more recognition of the difficulty that many non-Jungians (and even Jungians) have with what they see as Jung's mysticism – for example, Winnicott's problem with the term 'archetypal' and other Jungian jargon (Winnicott, 1965: 159).

But as a study of the biological basis of archetypal theory it is excellent and well deserves this reissue. Quite apart from anything else, it is a mine of useful information, much of which has remained with me since I first read it 20 years ago.

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GORDON HARRIS

Dilemmas in the Consulting Room
Edited by Helen Alfillé and Judy Cooper
London, Karnac, 2002, pp. 212, pbk £22.50

Most of the 13 chapters in this volume have been contributed by members of the Psychoanalytic Section of the British Association of Psychotherapists and are from the perspective of the Independent tradition, although in some of the papers Kleinian ideas have an important place.

The word 'dilemma' is widely interpreted by these contributors and I began to wonder whether the broader word 'questions' might have been more appropriate at times, especially in papers concerning issues of technique and theory, and where the author reveals thoughts and questions about therapeutic style and the therapeutic frame. Nevertheless, many of the papers invite the reader into an dialogic enquiry into the chosen topic, which is often freshly thought through and which represents an area of particular interest to the therapist, communicated in a personal way.

Thus, the style of the papers varies considerably, from very subjective on the one hand, to very objective on the other. At one end of the spectrum is Dan Twomey's paper 'What identifies, sustains and preoccupies me as a psychoanalytic psychotherapist'. This paper seems to me to be the bravest both in being the most personal and revealing about the author's intimate feelings about his work, and also in discussing some rather unconventional decisions he has taken. For example, going to the funeral of a patient's relative; and, in another case, allowing his psychoanalytic work with an obsessive-compulsive patient to be carried out in tandem with a cognitive therapist. This decision seems to have been justified in that the patient improved considerably under this regime. The author spells out his deep considerations in both – and other – cases, and demonstrates that he is prepared to put the needs of the patient as he perceives them (for in these complex instances, it surely is always a matter of judgement) before the safety of orthodoxy. In so doing, I think this paper is truest to the real meaning of dilemma.

Another paper that has a very personal quality, reflecting the subject matter, is Judy Cooper's paper "I treat her like a human being": The role of naturalness in a boundaried relationship'. Drawing on the literature, especially the work of A.S. Couch, she argues quite passionately for naturalness in the relationship

with the patient, within the firm boundaries that allow a lively therapy to develop and flourish. She illustrates instances where she felt that a spontaneous feeling response to a patient's material was not helpful, making it clear that spontaneity is not the same as naturalness. She points out that Riviere said of Freud: 'He habitually reacted with simple spontaneous naturalness to whatever he met ...' and: 'He expressed concern and warmth towards his patients and quite freely communicated his reactions to their significant life events. He was able to reveal his personal feelings about realistic issues while always maintaining the benign detachment necessary for the analytic process.' The writer thus explodes the myth that sometimes holds sway that Freud's injunctions to neutrality and abstinence mean that he was also personally cold and unresponsive; the former commitment does not have to entail the latter. The author also vividly conveys the notion of personal choice involved in one's therapeutic style.

On one point, though, I would have to take issue with the writer. As the recipient myself of analyses with two well-respected Kleinian analysts, I do not recognize the picture she paints of the 'austere style of analytic exchange' she attributes to Kleinians, nor the 'anonymous', 'sterile' and 'insulated from reality' analytic style allegedly practised. This is not my experience, nor is it of the style and atmosphere of my own nor my Kleinian colleagues' work.

In a related area, Ruth Berkowitz offers a detailed and comprehensive discussion of the clinical meaning, helpfulness or potential problems of the therapist allowing the spontaneous response of laughter in the consulting room in '"I like it when you laugh"'. Again, the reader is allowed to participate in what feels like a personal thinking through of all the aspects of this question. One view is that laughter as such contravenes the injunction to abstinence. The discussion ranges fascinatingly over the implications of abstinence and of naturalness in this regard, including the essence, perhaps, of the question as posed by Bion: 'Why does the presence of a person matter? Why not just have a piece of machinery?' Acknowledging the potential for acting out in this context, which could express a narcissistic gratification for both patient and therapist, the writer concludes that, 'Sharing pleasure with a patient is important, but it is a diversion and the analyst must be up to analysing his own response.'

Leaving the papers concerned with therapeutic style, and on a different dimension of gravity is A.H. Brafman's paper 'The suicidal patient', where the reader is also allowed into the self-questioning of the analyst in connection with the life and death dilemmas posed by a patient who is suicidal or appearing to act in a suicidal manner. Dr Brafman discusses the meaning of death, stating that each person has his own notion of what it means, and his view that each person's concept of death and suicide is highly dependent on his own life experiences. He reviews the literature, highlighting the aspect where suicide is an attack on the body and where it is linked with and motivated by unconscious fantasy – which is different for different people – which indicates a loss of

contact with reality. He does not consider the converse, where I have a suspicion that suicidal wishes may be sparked by too sudden a confrontation with reality – the loss of a fantasy – where the fantasy of possession and control of the object may have defended a person against unbearable, traumatic experiences of disintegration and threatened annihilation. Dr Brafman discusses two distressing cases of suicide in his private practice, inevitably wondering whether an alteration in his technique might have prevented the tragedies. He also raises the interesting point as to whether a technique dominated by here-and-now transference interpretations – that is, the typical Kleinian technique – is vulnerable to the therapist's losing sight of, or not addressing adequately, a patient's potentially dangerous isolation, or indeed other current circumstances that could be life threatening. However, I think this would be to underestimate the Kleinian position and the possibilities of addressing these issues within normal Kleinian technique.

The discussion of issues surrounding suicide is useful and important in a way that two other papers in this volume are: we do not have the sense of questioning implied by the word dilemma, but the therapist may have to go outside the usual frame of confidentiality because of the seriousness of the conditions involved, and in this way the work may certainly involve difficult decisions. The papers on 'Psychosis as Jack in the box' by Dianne Campbell Lefevre, and that on 'Psychosomatic incidents in psychotherapy' by Peter Schoenberg are perhaps the most scholarly of the collection.

Dr Schoenberg details the many aspects that need to be considered when a patient complains of a physical condition. He says that even when the therapist can be sure that an emotional disturbance has significantly contributed to the condition, it represents complex diagnostic problems. 'Some psychosomatic symptoms may be the direct expression of anxiety or depression on the body. With others, more complex mental and psychophysiological mechanisms are involved.' He issues a salutary warning to those of us less experienced in psychosomatic problems: 'A therapist's desire to find symbolic meaning in all psychosomatic symptoms may limit the scope for true understanding of what is actually happening....' There is often a physical vulnerability that contributes when an incapacity to find words for important feelings gets expressed as a gross disturbance in the psychophysiology. It can of course be difficult for a therapist to decide whether a physical condition is psychosomatic, even when medical help is involved; and I imagine this is a familiar dilemma for every therapist – how or whether to interpret a physical symptom. Although he advocates active cooperation with the GP (I suspect this is easier for a medically qualified practitioner), Dr Schoenberg is alert to the dangers of splitting here. A scatter of helpers may represent the terror a patient has of becoming dependent on one person, and perhaps needs to be tolerated until this anxiety lessens. Dr Schoenberg goes on to discuss the effects of anxiety and depression on the body, and then focuses on cases of hysterical conversion, hypochondriasis, neuromuscular tension states,

migraine and skin conditions. He ends with sections on psychosomatic incidents as indicating regressive phenomena, and on the issue of secondary gain.

In the same way that a therapist may not see very gross psychosomatic disorders in their consulting room on a regular basis, yet may often be confronted with passing illnesses and symptoms that have to be thought about in this context, many therapists will not typically see grossly psychotic patients. However, we are all likely to have met some manifest psychosis, and certainly we have had to be alert to hidden psychotic functioning and the psychotic transference. Dr Lefevre suspects that an active, ongoing psychotic process is often missed because the sufferer feels tyrannized by the psychotic process and cannot reveal it. She describes the nameless dread that may drive a patient from therapy and that may be wrongly interpreted as anxiety. Following Bion, she assumes the distinction between psychotic and non-psychotic personalities. She advocates a comprehensive psychiatric assessment as well as a full psychodynamic assessment by someone experienced in psychosis. In teenagers and in adults there is evidence that adding psychological treatment to drug and milieu treatments at the first signs of schizophrenic illness may prevent ongoing florid illness. But psychoanalytic treatment may need to be adapted with these patients to be more flexible. Dr Lefevre reviews the models of psychosis, the relationship between phylogeny and ontogeny in a psychosis, and psychoanalytic models. Although there is evidence that appropriate psychological input can help, she stresses the difficulties involved in working with these patients: the tyranny, viciousness and hatred of reality – especially hatred of the need for the therapist – of the psychotic part of the personality. In the longest paper in the book, this chapter succeeds in distilling and elucidating many of the relevant aspects and issues surrounding the topic in a way that I found helpful.

A chapter by Lou Corner continues the focus on a particular group of patients, those who come to psychotherapy with a particular way of presenting a prominent person in their life – often a wife speaking of her husband – as 'the problem', in 'Difficulties when a patient presents by proxy'. (Here I have a slight difficulty with the title, as there could be an implication in the word proxy which sometimes creeps into the text which makes it possible to take the writer to be not making the distinction between the patient's internal object, say of her husband, that she is projecting into and presenting as the problem, and the actual real external husband.) The writer offers a clear and helpful overview of the history of the concept of projective identification, showing how a patient who presents in this way poses a difficult technical problem. The writer deftly illustrates how an interpretation based on the recognition of this mechanism, whereby the therapist is treated as the patient feels she herself is treated by the 'problem other', can have a resonance and helpfulness that a more obvious, possibly accurate, but more superficial transference interpretation can have. The writer places a useful emphasis on the dependency created by projective identification, highlighting that it is this dependency, linked with

internal depletion, that is the real problem, rather than the financial one that may masquerade as its reason in the patient's mind. She also stresses that the feared impoverishment consequent on separation is in reality an inner, psychic impoverishment rather than a financial one. With some case material in illustration, she discusses the technique used in the early treatment of such patients, contending that the early contact with the therapist will repeat the original problem where environmental failures in containment have led to the inability of the patient to withdraw their projections.

Anne Tyndale also addresses an important issue of technique. She makes an interesting parallel between a patient telling his or her story, and the writer of a novel, and her paper concerns the therapist's relationship to her patient's narrative in much the way a reader relates, or is made to relate, to the narrative of a novel. There may be a conscious or unconscious attempt to get the therapist/reader to see the story in a certain way. The writer is very conscious that the patient may also need us to see it from their point of view before the therapist tries to help the patient to disengage himself as narrator and to become a reflective author who stands back from his story. The dilemma here is how and when the therapist decides: 'Will you, won't you, will you, won't you, will you join the dance?' with the patient, as Lewis Carroll put it. Her clinical material illustrates the sensitivity with which the writer approaches this question with a patient who tells a story which she strongly suspects is not factually true, and how, rather than wading in prematurely with an interpretation, she waits until she can link the fantasized event with the underlying anxieties. She understood that his abandonment of his competent, reflective self had been in order to engage the therapist in as vivid a way as he could with situations in childhood when he had in reality feared for his life. The writer also develops the argument, with Bollas (and Freud), that the issue of how the patient's narrative is understood is particularly important with the hysteric, who does not want an independent listener. She offers thoughts on different countertransference reactions to the nature of the patient's narrative, and has a section also on issues about historical accuracy.

Although I was unsure, in this paper, about the ongoing parallel with the literary world of narration which, although useful initially, I feel could become a little cumbersome, I also found this paper to be original and substantial, developing its central theme in its diverse aspects in a way that made me think about the issue afresh. The same is true of Simon Archer's paper, 'Violence and hostility from a sense of shame: shame in the transference and countertransference'. What is particularly interesting here is the sustained analysis of shame in a client group that is not usually represented very often in a typical psychotherapy practice; that is, adults hovering, as Archer puts it, on the brink of criminal activity. Shame is an affect that has been rather neglected in the psychoanalytic literature, but with Archer, I have sometimes wondered about its importance in the origins of hostility and in the structure of allegedly psychopathic behaviour that is often present in criminals. The paper discusses

the distinction of shame from guilt, looks at its relationship with the ego-ideal and sexuality, reviews some of the biological aspects, and discusses its counter-transference aspects. There is some striking clinical material from a patient about his attempted murder of his wife.

The remaining papers (which are scattered throughout the book) deal with the universal issues of psychotherapy and analysis: the setting; money; breaks and their relation to separation anxiety; and the ending of psychotherapy. Each paper seems to me to give a helpful and competent review of the questions and difficulties that can arise, and each writer gives a flavour of their own thinking and ways of resolving certain questions. Sue Lipshitz Phillips in 'Some thoughts on the use of the setting in psychoanalytic psychotherapy' offers a thoughtful overview of some of the issues that arise in relation to the setting, with a brief look at some of the history of psychoanalysis – for example, the development of the experience of transference via Anna O and Dora. She emphasizes that the mental attitude of the therapist is a central part of the setting, but also draws attention to the recognition that there is always a psychotic aspect of the transference that takes advantage of the stability of the therapeutic setting and remains unnoticed unless and until unexpected breaches allow them to be exposed. The writer also importantly includes as a silent factor in the setting, the intense scrutiny the patient makes of the therapist in order to ascertain whether he or she is safe. In the spirit of the theme of dilemmas, she shows how the stability of the setting means that inevitable breaches, failures and slips can be used to generate new and productive work.

In 'Money – symbol and reality', Denise Taylor addresses the many issues surrounding money in the therapeutic situation. She states her belief that there is an inherent paradox in the practice of psychotherapy: that it comes from the healing tradition, and yet we ask to be paid. While, probably with some others, I would think of the issue of payment rather as one of the harsh realities to be faced by a patient, this is a paper whose liveliness and comprehensiveness I enjoyed very much. Money is one of those issues that hardly gets a mention in a training, and yet can be a very important part of the transaction between therapist and patient. It is a subject that it can be tempting to avoid on both sides, and the author gives a number of clinical examples to illustrate some of the pitfalls and complications that can arise. The author's engagement with her patients in relation to this practical issue is manifest, and some engaging clinical examples are given. Some of the theoretical issues are also addressed: the meaning of money, its anal character, and also its connection with sexual fantasy, and its 'famously chameleon-like ability to infiltrate relationships', including the therapeutic one.

Helen Alfillé gives a clear and thoughtful exposition on the subject of breaks in therapy and how they allow us to be in touch with and work with the fundamental issue of separation. Referring to Freud, Klein and Mahler, she offers a lucid account of the vicissitudes of the different defences and actings-

out that can be brought to bear by a patient to avoid the full implications of the reality of psychic separation. She addresses the familiar situation when anger about a break in therapy gets manifested as withdrawal, when interpretations, although accurate, can become lifeless. Most therapists will also resonate with the dilemma – not unusual but sometimes complex to handle – posed by the author when a patient starts a relationship which one suspects is to do with anxieties about the therapy, and especially linked with breaks. Usually there will be no obstacle to a fairly straightforward interpretation; but in certain circumstances we may particularly wish a good relationship for the patient outside the therapy, and fail to interpret the defensive aspect. Such a situation needs sensitive interpretation especially in the case of a patient whose fantasy is that the therapist needs the patient to give the therapist everything. The essence of therapy consists in helping a patient to move 'from a narcissistic way of relating, to an object relating way; from responses that deny the importance of the therapist to responses acknowledging the attachment, negative and positive, to the therapist ... thereby tolerating the ambivalence.'

The final chapter in the book is appropriately about 'Termination and the resolution of the transference', and to this topic Mary Twyman brings to bear a steadfast hold on the recognition of the power of the unconscious. While the conscious recognition of a forthcoming ending 'brings a particular atmosphere' to the treatment, the author reminds us that one characteristic of the unconscious is its timelessness. So that even in the optimum situation, a consciously mature ego can be seriously at odds with the unconscious. The working-out of this primary reality forms an important part of this paper, and gives it a salutary character whereby the difficult implications are not avoided. Thus it may be that there are elements that are aroused and that remain, that can never be fully addressed, and that may result in enactments after therapy has ended. The writer reminds us that Freud was not particularly optimistic about analysis, and that important issues for the patient to be worked through are those to do with the limitations of therapy or analysis, including the personal limitations of the therapist or analyst. Some of the phenomena associated with ending are illustrated with clinical material, and these include both the calm, 'on-track' responses, and the turbulent events that sometimes occur during the ending phase. There is the curious paradox that after a period of intensive engagement, it is not possible to totally anticipate the actual experience of loss of the analysis in the patient's mind, and the essence of this experience is for the patient to bear alone. The paper includes some thoughts about the importance that the patient may have had for the therapist or analyst. As we all must recognize, patients help us to crystallize our own thoughts, they may stimulate new thinking by posing new problems, and allow us to develop ourselves as human beings through the intimacy of the relationship, so that the therapist may also have to mourn his or her patients, although this is not comparable to the mourning a patient, optimally, will have to do.

As described earlier, an overall assessment of the book has to include the fact that its title, for many of the papers, is a bit of a misnomer. Although these are substantial and helpful papers, they do not really exemplify situations that could rightly be termed 'dilemmas', and to that extent perhaps an opportunity has been lost. It is probably safer to write a paper that is about a well-thought-out aspect of theory or technique, than it is to describe the sorts of hot-under-the-collar situations that can arise in a session, or an unconventional decision that probably most of us will have agonized over in our time. However, to make that point is in no way to detract from the quality of the papers per se, and I think all exemplify high-quality thinking and creativity.

Finally, I suppose the question has to be asked, for whom is this book intended? I think it can be helpful for the experienced therapist to think or rethink through those perennial questions that occur in the daily practice of the work, and there is much that is original and thought provoking. I think also it will be particularly useful for the beginning therapist, because it raises questions and addresses issues that are not necessarily addressed during a training. It brings home the reality of the therapeutic relationship being between two individuals, and the responsibility of the therapist to conduct the therapy ethically and meaningfully. These are fundamental issues that every therapist has to think through for themselves, and the capacity to question issues afresh, which is so essential to the work, is well conveyed.

JESSICA SACRET

Short-term Psychotherapy. A Psychodynamic Approach
By Alex Coren
London, Palgrave, 2001, pp. 225, pbk £16.99

Short-term Psychodynamic Psychotherapy. An Analysis of the Key Principles
By Penny Rawson
London, Karnac, 2002, pp. 299, pbk £22.50

These books are like chalk and cheese. Alex Coren's book, the shorter of the two, is generalized and wide ranging. It is one in a series of basic texts covering a wide range of topics and seems to be written to a format. It is aimed at 'anyone wishing to use counselling and psychotherapeutic skills and will be particularly relevant to workers in health, education, social work and related settings'. Penny Rawson's book is particular in its format and its style. It aims to make explicit how she works as a short-term psychodynamic psychotherapist through examination of case studies. She writes: 'The main task was to tease out in detail what is meant by short-term psychodynamic therapy as revealed through

the selected cases, the key proponents and the literature. It is 'written with the professional therapist in mind although it may also interest the layman'.

Coren's book is educational and he writes authoritatively. Under each chapter heading, an array of ideas is introduced and there is an impressive bibliography. Following an introduction there are four chapters that give a thorough sweep of theoreticians and approaches that contribute to short-term psychotherapy. This is comprehensive and succinct.

In Chapter 5 Coren draws out the common themes of the previous chapters and from here on he frequently writes as if he is referring to one particular model which he thinks we share. I think it would be helpful to make this model explicit at this point. As it is, the book continues referring to a generalized non-specified short-term model.

In Chapters 5 and 6 Coren links short-term psychotherapy to contemporary notions of the idiom, the therapeutic triangle, usage of transference and countertransference and ideas from narrative and attachment theory. A necessary simplification occurs to help the reader understand these concepts and relate them to short-term work.

Chapter 8 is called 'Differences in therapeutic technique between open-ended and time-limited therapies'. In this chapter Coren repeatedly refers to the difficulties that psychodynamic counsellors trained in open-ended work have in working short-term. I think he overplays this issue here and at other points in the book. It is hard to see what this chapter offers other professionals hoping to develop their counselling and psychotherapy skills and it seems to digress from the aims of the book.

The chapters about assessment, training and supervision are limited by talking generally and trying to cover all options. In the chapter on assessment a comprehensive range of ideas about assessment is given but it is not easy to relate these to different short-term approaches.

In the chapter on 'Therapeutic outcome and the effect of managed care of time-limited therapy and its practitioners' Coren spells out how outcome research and financial constraints can conspire to suggest that short-term therapy is *the* treatment. He argues well and strongly that this diminishes the place of clinical acumen and threatens to undermine the therapist and the profession.

Chapter 11 is called 'Time-limited therapy in different contexts'. It covers very briefly aspects of practice in primary care, in business and industrial contexts, in education, in bereavement, with elderly people, and in mental health settings. This is a short chapter and I felt that opportunities were missed. First, the dynamics of different settings could have been explored more fully, especially the impact of the hopes and expectations of the setting on the counsellor, the client and the counselling process. Second, this chapter seems an appropriate place to explore the contexts in which short-term therapy might be offered to people who

would not usually embrace counselling and psychotherapy. Finally, there are many settings where short-term approaches are necessary because of the temporary nature of the client group – for example, prisoners, asylum seekers, and so on, and the specific dynamics of working under such consideration could have been elaborated.

The final chapter shows us how Coren uses the ideas of idiom, the therapeutic triangle, transference and countertransference and the narrative to find a focus and direct the work. Here he gives a concise statement about his approach:

> I would contend that the central paradigm of time-limited therapy is the use and understanding of the therapeutic relationship. The awareness of unconscious processes in the transference and countertransference and how these can be identified and used in the use of symbols, metaphors, and personal idioms with the treatment relationship, together with knowledge of developmental theory, all make these brief encounters possible and productive (p. 207).

The book ends: 'In this it [time-limited therapy] may realise Freud's wish that psychoanalytically informed therapy can become a therapy for the people.' Penny Rawson has a similar hope for short-term therapy, as she makes clear in Chapter 1:

> Many more people would approach counselling/therapy if they had confidence that they could be helped in a few (2–10) sessions. These they could afford – whereas the idea of ongoing therapy for six months or years may prevent them even considering therapy. Many more could be helped in this way if they were aware of the focal and short-term method.

Rawson's book is a research analysis of 11 case studies of short-term psychodynamic psychotherapy, mostly her own. She uses Feltham and Dryden's terms of psychodynamic counselling as a method 'that draws on the psychoanalytic tradition and expects to employ "concepts of the unconscious" such as "resistance and transference" and uses techniques such as "free association" dreams and "interpretation"'. In addition to these psychoanalytic concepts she draws on other therapies.

Rawson takes us systematically through how she undertook the analysis and its results. As she does so she gives plenty of case material and illustrations of the kind of interactions that actually took place in the consulting room, giving the reader the opportunity to relate his or her own practice to Rawson's. Her approach is underpinned by her trainings at the Dympna Centre with Louis Marteau, who described his approach as 'psychodynamic using newer therapies', and at the Westminster Pastoral Foundation where the full-time training was in a long-term analytic approach with a Jungian framework. From this she developed her short-term approach and is currently the Director of FASTPACE,

a consultancy specializing in brief psychodynamic therapy, training and supervision. Her motivation for undertaking the study and writing the book was to respond to the question: What is short-term psychodynamic therapy?

The first three chapters introduce the book and its methodology. These would be stimulating to anyone undertaking research using case studies and can be skipped by those just interested in the results. The book then divides into two parts. Part 1 is the 'Analysis of the emergent key themes: findings from the in-depth cycle of analysis' and Part 2 is 'Summary of the findings from the in-depth analysis of the key themes and provisional conclusions'. These descriptions may be off-putting but contained within them is the real detail of Rawson's approach. Other psychodynamic theories and approaches to short-term work are interwoven as she progresses. Thus the reader learns how Rawson fuses a psychodynamic approach with ideas from new therapies through their relevance to her thinking and practice.

In the concluding chapter Rawson gives the key principles that contribute to the process of short-term therapy as undertaken by her and her colleagues. These provide a useful synopsis of her approach. They are:

1. Understanding of psychodynamic principles
2. Importance of the first session
3. Therapy as short as the client's need allows
4. Early establishment of the therapeutic alliance
5. Therapist attitude
6. Teaching
7. Enabling the client to become their own therapist
8. Activity
9. Focus
10. Flexibility and fusion
11. Incisiveness
12. The sensitivity of the therapist in order to be in tune with the client.

Short-term psychodynamic counselling and psychotherapy is flourishing in GP surgeries, education and the workplace and, whether as practitioners or supervisors, it is something many psychotherapists are encountering. Both these books give the reader a sense of those short-term approaches that draw on psychoanalytic thinking. Coren's book is not aimed at psychoanalytic psychotherapists and I think it is most suitable for its target audience or as a teaching tool. Rawson's book is unusual but presents a lively and different look at short-term psychodynamic psychotherapy. I think it would appeal to psychoanalytic psychotherapists who have knowledge of what Rawson calls newer therapies and who want to see how these can be integrated with psychoanalytic ideas into a short-term approach.

ROSE STOCKWELL

Therapeutic Care for Refugees: No Place Like Home
Edited by Renos K. Papadopoulos
London, Karnac, 2002, pp. 319, pbk £16.99

The usefulness of psychotherapy in the political arena has been raised of late. By focusing on some of the most vulnerable and desperate people in our society – refugees, used here as a global term to include asylum seekers – this book poses that question in an irresistible way. The title of the book is carefully chosen. It emphasizes 'therapeutic care'. Context is all important here because psychotherapeutic methods may have to be modified in the light of the needs of clients and changing day-to-day events.

The subtitle of the book is *No Place Like Home*. Home is the operative word. In the opening paper Renos Papadopoulos discusses its significance to refugees; how their understanding of it is often different from the assumptions made in their host country. A Chilean, although now safe in affluent California, remarks that his life now 'is both a dream and a nightmare at the same time'.

The real pain is to do with loss of home, however welcome refugees are made to feel in their new surroundings. Hitherto much has been made of the trauma they have suffered (as in Bosnia or Kosovo, for example). Yet, in their experience, the longing for home may override this. Home is not yet a psychological concept and this book does much to address that deficiency.

For refugees home means the place itself, bricks and mortar, their familiar surroundings. Robert Frost is quoted by Renos Papadopoulos to illustrate this:

> Home is the place where, when you have to go there,
> They have to take you in.
>
> I should have called it
> Something somehow you don't have to deserve.

The awkwardness of the second sentence fully makes the point. Home is like that; not always easy to explain, but there as of right.

Dislocation and resettlement are central to the refugee experience. Renos Papadopoulos takes us back to Homer's *The Odyssey* and the saga of his 13-year homecoming. But, as Renos reminds us (he calls it 'Homer's magnificent irony'), Odysseus gets home to Ithaca in the 13th of the 24 books in *The Odyssey*. The last 11 books are to do with resettlement. Home needs mutual recognition. Odysseus has all along been longing for the sight of smoke rising in his own land, yet at first neither he recognizes it, nor does anyone else recognize him. There is much work to be done. Odysseus's struggle is to reconnect himself to his surroundings and to re-establish his identity. Getting home is only part of the story. Integration involves hard work and sacrifice, on both sides.

The book points up the multi-level challenge to the practitioner of dealing with refugees. The paper by Valerie Sinason is an outstanding example of this. She was asked to see a couple from Rwanda, a mother and 13-year-old daughter, who had witnessed horrific events, had been raped singly and together, had

seen their husband/father killed in front of them and then seen his body parts thrown into the lorry alongside them, and then later been forced to eat these. Sinason prepares for this meeting with exemplary professionalism and conducts it likewise, taking care to explain to the couple what she can offer and for how long she can see them. She listens to their story with due attention and interprets whenever she sees fit. The one-and-a-half hours are soon up and she reminds them, gently, as we do, that 'It is time'. At this point the daughter explodes:

> 'No!' shouted the child. She looked at me with absolute horror and fury on her face. She remained seated mute with despair. 'You stopping. You. Not me. Not time.... Easy say stop. Easy say dead. Easy say-now-kill. Say it is time. Orders. British fixed appointments. Refugee. Home office. Queue. Passport. Easy easy words. Goodbye Killer.'

Sinason goes on: 'With her pale-faced mother smiling nervously at me the thirteen-year-old left the room, leaving me humble and shocked.' Sinason's comfort zone, the traditional framework of psychotherapy, had been brutally challenged, a raw challenge too to her humanity, to her acknowledgement of her shared place on the planet with these desperate refugees. Here psychotherapy has been pushed to new limits. Sinason states: 'As a result of that thirteen-year-old, I have rethought my language in all kinds of settings.'

This is an important book, forcing us to think about things we may prefer not to think about. It rightly brings out the complexities of the refugee situation and how imaginative responses are often called for. Psychotherapy, especially the sort of work carried out by the authors of these 14 papers, can in this way have a bearing on present-day politics. Psychotherapy takes note of the 'other', at what else might be the case, at what is hidden, the shadow in us. Other interesting and valuable papers in the book deal with group work with refugees and how the use of 'social capital' (family relationships, kinship, local support and so on) can enlarge their perspectives, moving them on from their inevitable self-centredness. The book is part of the Tavistock Clinical Series, and also charts the work done by Tavistock members recently with refugees in Kosovo, how 'listening in depth' and awareness of the long-term destabilizing effects of war can shape individual lives for years to come, a lesson needing to be heeded now in Afghanistan and Iraq. As I say, this is both a valuable and powerfully written book, right at the cutting edge of the social upheavals now going on, and it deserves to be read, and reflected about, for that very reason.

JOHN CLAY

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