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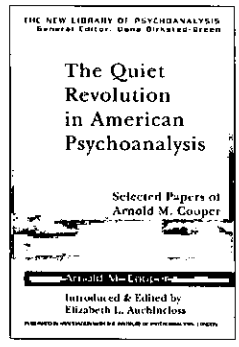

The Quiet Revolution in American Psychoanalysis

Selected Papers of Arnold M. Cooper

ARNOLD M. COOPER

Edited and Introduced by Elizabeth L. Auchincloss

This book brings together for the first time in one volume selected papers by one of the leading contemporary intellectual figures in the field of psychoanalysis, Arnold M. Cooper, M.D.

Cooper has addressed every aspect of American psychoanalytic life: theory, clinical work, education, research, the interface with neighboring disciplines, and the institutional life of the profession. In these papers, he both documents and critiques what he calls a 'Quiet Revolution' following the death of Freud, in the way psychoanalysis is conceived: as a science, as a theory of mental life, as a treatment, as a profession.

Throughout his professional life, the process of change has fascinated Cooper. His own contributions to psychoanalytic clinical theory have changed our understanding of work with patients to include a greater appreciation of narcissistic and pre-oedipal themes in development and of the human encounter embedded in the psychoanalytic situation. His progressive leadership in our educational and professional organizations has done much to promote change toward greater self-examination and tolerance of new ideas, and indeed, to create the conditions that make change possible.

Above all, Cooper's unique ability to observe and reflect upon the process of change, recorded here in papers selected from over 150 written in the years between 1947 and 2002, has helped make Cooper the guide to whom psychoanalysts repeatedly turn to understand not only where, but even what, psychoanalysis is.

Contents: **Cooper,** Foreword. **Auchincloss,** Introduction. The Impact on Clinical Work of the Analyst's Idealizations and Identifications (1998). Part I: *The Quiet Revolution in Psychoanalysis.* Psychoanalytic Inquiry and New Knowledge (1980 [1983]). Psychoanalysis at One Hundred: Beginnings of Maturity (1982 [1984]). Psychoanalysis Today: New Wine in Old Bottles (1986). Comments on Freud's 'Analysis Terminable and Interminable' (1987). Part II: *The Analyst at Work.* Some Limitations on Therapeutic Effectiveness: The 'Burnout Syndrome' in Psychoanalysis (1982 [1986]). Difficulties in Beginning the Candidate's First Analytic Case (1985). Changes in Psychoanalytic Ideas: Transference Interpretation (1985 [1987]). Some Thoughts on How Therapy Does and Doesn't Work (1989 [1991]). Formulations to the Patient: Explicit and Implicit (1995 [1994]). Part III: *Vicissitudes of Narcissism.* The Narcissistic-Masochistic Character (1973 [1988]). The Unusually Painful Analysis: A Group of Narcissistic-Masochistic Characters (1981 [1986]). What Men Fear: The Facade of Castration Anxiety (1985 [1986]) The Unconscious Core of Perversion (1989 [1991]). Paranoia: A Part of Most Analyses (1991 [1993]). Part IV: *Challenging the Boundaries of Psychoanalysis.* Will Neurobiology Influence Psychoanalysis? (1984 [1985]). Infant Research and Adult Psychoanalysis (1988 [1989]). Psychoanalysis and Psychotherapy: The Same or Different? (1990). Discussion on Empirical Research (1993).

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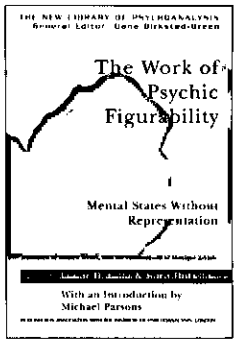

The Work of Psychic Figurability

Mental States Without Representation

CÉSAR BOTELLA
SÁRA BOTELLA

With an Introduction by Michael Parsons

The majority of psychoanalysts today agree that the analytic setting faces them daily with certain aspects of their work for which the answers provided by an analytic theory centred exclusively on the notion of representation prove insufficient.

On the basis of their experience of analytic practice and illustrated by fascinating clinical material, César and Sára Botella set out to address what they call the work of figurability as a way of outlining the passage from the unrepresentable to the representational. They develop a conception of psychic functioning, which is essentially grounded in the inseparability of the negative, trauma, and the emergence of intelligibility, and describe the analyst's work of figurability arising from the formal regression of his thinking during the session, which proves to be the best and perhaps the only means of access to this state beyond the mnemic trace which is memory without recollection.

The Work of Psychic Figurability argues that taking this work into consideration at the heart of the theory of practice is indispensable. Without this, the analytic process is too often in danger of slipping into interminable analyses, into negative therapeutic reactions, or indeed, into disappointing successive analyses.

Contents: **Parsons,** Introduction. Part I: *The Work of Figurability and the Negative.* The Limits of Thought: Paris-London Back and Forth. The Negative Duality of the Psyche. Non-representation. The Geometer and the Psychoanalyst. Figurability and the Work of Figurability. Part II: *The Dynamic of the Double.* On the Auto-erotic Deficiency of the Paranoiac. Working as a Double. 'Only Inside – Also Outside'. Community in the Regression of Thought. Part III: *The Hallucinatory.* The Negative of the Trauma. The Hallucinatory. Mysticism, Knowledge and Trauma. Part IV: *Outline for a Metapsychology of Perception.* A Psychoanalytic Approach to Perception. 'The Lost Object of Hallucinatory Satisfaction.'

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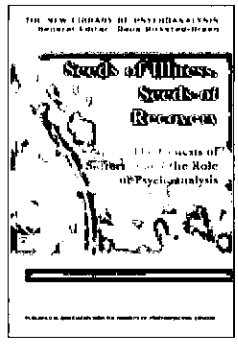

Seeds of Illness, Seeds of Recovery

The Genesis of Suffering and the Role of Psychoanalysis

ANTONINO FERRO

Foreword by Thomas Ogden

"What gives the book its special character is its skilful weaving together of a rigorous theoretical stance with the enjoyable, communicative skills displayed in his clinical work, and which one seems to witness in person, as though crouching in a corner of the analyst's mind. It is not easy to describe Ferro's writing skills, which are like those of a great musician who can allow himself the virtuosities while never for a moment forgetting, or lessening, the technical clarity of his performance." - Anna Ferruta,
International Journal of Psychoanalysis

Illustrated with richly detailed clinical vignettes, *Seeds of Illness, Seeds of Recovery* offers a fascinating investigation into the origins, modes and treatment of psychical suffering. Antonino Ferro provides a clear account of his conception of the way the mind works, his interpretation of the analytic understanding of psychopathology, his reconceptualization of the therapeutic process, and implications for analytic technique derived from his view of the therapeutic action of psychoanalysis. Drawing on and developing the ideas of Wilfred Bion, Ferro gives a unique perspective on subjects including:

- container Inadequacy and Violent Emotions
- the waking dream and narrations
- 'Evidence': starting again from Bion
- self-analysis and gradients of functioning in the analyst.

This highly original approach to the problem of therapeutic factors in psychoanalysis will be of interest to all practising and training psychoanalysts and psychotherapists.

Contents: **Ogden,** Foreword. Seeds of Illness and the Role of Defences. The Culture of Reverie and the Culture of Evacuation. Container Inadequacy and Violent Emotions. Nachträglichkeit and the Stork: The Analytic Field and Dream Thought Clinical Illustration. The Waking Dream and Narrations. 'Evidence': Starting Again from Bion. From the Tyranny of the Superego to the Democracy of Affects: The Transformational Passage Through the Analyst's Mind. Self-analysis and Gradients of Functioning in the Analyst. Pivotal-age Crises and Pivotal-event Crises. Psychoanalysis and Narration.

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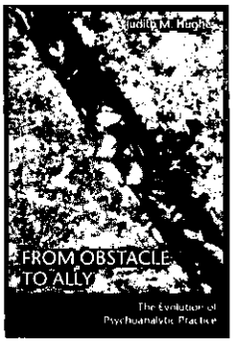

From Obstacle to Ally

The Evolution of Psychoanalytic Practice

JUDITH M. HUGHES
(University of California; San Diego Psychoanalytic Institute, USA)

From Obstacle to Ally explores the evolution of the theory and practice of psychoanalysis through an investigation of historical examples of clinical practice. Beginning with Freud's experience of the problem of transference, this book is shaped around a series of encounters in which psychoanalysts have managed effectively to negotiate such obstacles and, on occasion, convert them into allies.

Judith Hughes succeeds in bringing alive the ideas, clinical struggles and evolving practices of some of the most influential psychoanalysts of the last century including Sandor Ferenczi, Anna Freud, Melanie Klein, Wilfred Bion, Betty Joseph and Heinz Kohut. Through an examination of the specific obstacles posed by particular diagnostic categories, it becomes evident that it is often when treatment fails or encounters problems that major advances in psychoanalytic practice are prompted.

As well as providing an excellent introduction to the history of fundamental psychoanalytic concepts, *From Obstacle to Ally* offers an original approach to the study of the processes that have shaped psychoanalytic practice as we know it today and will fascinate practising psychoanalysts and psychotherapists.

Contents: Part I: *Hysteria: Transference.* Freud, Ferenczi, and Elma. Ferenczi's Experiments in Technique. Balint: Regressions, Malignant and Benign. Part II: *Obsessional Neurosis: Resistance.* Freud and His 'Grand Patient'. Anna Freud: The Analysis of Defense. Greenson: Forging a Working Alliance. Part III: *Depression: Negative Therapeutic Reaction.* Freud and His Translator. Klein: The Analysis of the Superego. Riviere, Klein, and Negative Therapeutic Reactions. Part IV: *Paranoia: Abnormal Changes in the Ego.* Freud, Brunswick, and the Wolf Man. Bion: Learning from Psychotics. Joseph: Countertransference and Its Uses. Part V: *Narcissism: Megalomania.* Kohut and Narcissistic Transferences. Kernberg and Pathological Narcissism. Rosenfeld and Narcissistic Object Relations.

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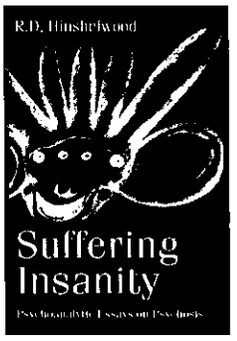

Suffering Insanity

Psychoanalytic Essays on Psychosis

R.D. HINSHELWOOD
(University of Essex, UK)

When madness is intolerable for sufferers, how do professional carers remain sane? Psychiatric institutions have always been places of fear and awe. Madness impacts on family, friends and relatives, but also those who provide a caring environment, whether in large institutions of the past, or community care in the present. This book explores the effects of the psychotic patient's suffering on carers and the culture of psychiatric services. *Suffering Insanity* is arranged as three essays. The first concerns staff stress in psychiatric services, exploring how the impact of madness demands a personal resilience as well as careful professional support, which may not be forthcoming. The second essay attempts a systematic review of the nature of psychosis and the intolerable psychotic experience, which the patient attempts to evade, and which the carer must confront in the course of daily work. The third essay returns to the impact of psychosis on the psychiatric services, which frequently configure in ways which can have serious and harmful effects on the provision of care. In particular, service may succumb to an unfortunate schismatic process resulting in sterile conflict, and to an assertively scientific culture, which leads to an unwitting depersonalisation of patients.

Suffering Insanity makes a powerful argument for considering care in the psychiatric services as a whole system that includes staff as well as patients; all need attention and understanding in order to deliver care in as humane a way as possible. All those working in the psychiatric services, both in large and small agencies and institutions, will appreciate that closer examination of the actual psychology and interrelations of staff, as well as patients, is essential and urgent.

Contents: Introduction. Essay One: Helping to Help: Address to Practical Carers. Essay Two: How can it be Thought: Psychoanalytic Theories of Schizophrenia. Essay Three: Suffering the Mad: Countertransference in the Institutional Culture. Epilogue: Being Psychotic, Being a Person.

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PETRŪSKA CLARKSON

JOURNAL OF THE BRITISH ASSOCIATION OF PSYCHOTHERAPISTS
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CAROLE ANGIER

author of

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Editorial

As a tribute to Donald Meltzer, who died last August, we begin this issue with Heather Tolliday's paper, 'A struggle to know', on her work with a type of patient whom Meltzer would describe as a 'claustrum dweller'. Describing the pseudo-mature – 'I can do it all myself' – transference of the claustrum state of mind, she focuses on the difficulty in helping the infantile transference, so fundamental to an analysis, to develop. She looks at the strategies the claustrum dweller employs to sabotage any emotional contact and the counter-transference feelings this evokes in the therapist.

Angela Bennett's paper, 'A view of the helplessness and violence contained in chronic fatigue syndrome', uses case material to illustrate how feelings of depression and rage that cannot be voiced may be expressed somatically in the illness of myalgic encephalopathy (ME). Given the tendency of our culture to look down on psychogenic illness, she sees restoring the self-esteem of the patient as depending on having the physiological nature of the illness accepted. The work of therapy is then to acknowledge and help release the patient's rage. She reviews recent research in this area.

Martin Kemp's paper, 'It ain't easy growing up in World War III', looks at difficulties in working with patients whose family life was dominated by violence between the parents as well as towards the patient. These difficulties are compounded when the abuse is ongoing and where, filled with a sense of powerlessness and outrage, the therapist is at risk of deviating from the analytic task of helping the patient to think about his or her actions and experience and colluding with ways the patient may act out. He discusses the value, as well as the ethical dilemmas, of taking a neutral stance with regard to a patient's appalling reality and how the external reality interacts with the internal world of both patient and therapist.

Our Classics Revisited section continues with a discussion by Sheila Spensley of Sydney Klein's 1980 paper, 'Autistic phenomena in neurotic states'. She assesses Klein's attempt to integrate autistic phenomena with his own psychoanalytic experience of impasse with patients who displayed a shell-like encapsulation of part of their personality as a defence against emotional contact. Through detailed discussion of a particular patient, and drawing on

Bion's work on the evolution of thinking, he looks at the nature of the transference and the implications for interpretation with such patients.

For our Art Review, Maggie Hammond explores Almodóvar's film, 'Talk to Her', which she describes as carefully choreographed 'like a dance, in which masculinity and femininity weave in and out, where men are identified with the feminine, and women with the masculine and where the unconscious is treated as if conscious'.

As well as an obituary of Donald Meltzer by Irene Freeden, we include an interview with Meltzer that was conducted by James Astor in 1988, in which we get a glimpse of Meltzer's early professional life, the development of his thinking and a brief insight into one aspect of psychoanalytic history.

The Editors

A struggle to know

HEATHER TOLLIDAY

> We shall not cease from exploration and the end of all our exploring will be to arrive where we started and know the place for the first time.
> T.S. Eliot*

ABSTRACT

The author uses Meltzer's discussion of technical issues involved in working with claustrum dwellers to think about her work with a patient who proved to be a claustrum dweller. In particular, she explores his manoeuvres to prevent the development of a transference relationship and the consequent failure of the work to get him to emerge from the claustrum so that an analysis could take place. She considers the factors in both the therapist and the patient which militate against, and facilitate, their making contact. Various elements, such as narcissism in patient and therapist, the strategies of the claustrum dweller to sabotage contact, the fear of catastrophic change and the difficulties for the therapist of holding on to countertransference experience when there appears to be no foothold in the patient's mind for such thoughts are explored in relation to the author's experience with her patient.

Key words catastrophic change, claustrum dweller, countertransference, narcissism, perversity, projective identification

Introduction

In *The Claustrum: An Investigation of Claustrophobic Phenomena* (1992) Donald Meltzer explores the nature of those personalities whose sense of identity is formed and established, not through continuous experience of projection and introjection with others, but through a quasi-relationship, effected through

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Little Gidding V (1969: 197).

Heather Tolliday is a psychotherapist in private practice.

intrusive projective identification, with internal, phantasized objects. In Chapter 6 of *The Claustrum* (Meltzer, 1992: 97–107) Meltzer considers the technical problems for psychoanalysts of trying to work with patients who prove to be claustrum dwellers. As he puts it, such work 'is really an attempt to make an analysis without the aid of a patient's need for transference objects' (Meltzer, 1992: 104).

In that chapter, Meltzer addresses the paradox of undertaking analyses with people who have no wish for a transference object but who seek analysis. How can there be psychoanalysis if there is no transference relationship between analyst and patient? His answer is that there cannot, but that it is possible to work with patients in a way that will allow them to emerge from the claustrum so that an analysis can then take place. In this paper I explore my experience of trying to draw a patient out of the claustrum into a transference relationship so that analytic work could be undertaken. We were never able to get to that because he chose not to emerge from the claustrum. He proved not to want a transference object. But what we did achieve was his recognition that he had a choice, and that he chose not to escape from the claustrum into the world of object relations and emotional links. I describe the strategies he used to deal with my impingements on him – the impingements which, had he been able to bear the pains of dependence and separation and become interested in himself through allowing an emotional relationship with me to form, could have strengthened his contact with external reality and enabled him to get into a normal infantile transference relationship with me, the relationship which is fundamental to analytic work. Through my persistence in pressing myself on his attention, I did affect him, but his response to any experience that I existed and existed independently of him was treated as an irritant to be obliterated by various perverse manoeuvres. What could have been the first shoots of a transference relationship were nipped in the bud.

I explore my experience in the light of technical issues considered by Meltzer in Chapter 6 (Meltzer, 1992: 97–107). These include the difficulties inherent in discovering that the therapist and patient are not in a relationship; the problems of relying on the countertransference; the dangers to the therapist of engaging with the patient in his claustrum, most particularly, the danger of being sucked in with him; and the difficulty of knowing whether a shift in atmosphere indicates the emergence of an ensconced bit of the personality out of the claustrum or just a shift in the location of the patient's sense of identity. I use this paper to think further about the pitfalls of working with this kind of patient. I focus on some of the factors in both the patient and the therapist which militate against knowing the truth or, in Bion's terms, thinking the thoughts (Bion, 1962: 82–88), and the factors that facilitate that process. As with John Steiner's 'psychic retreats', which he defines as 'areas of retreat from reality where no realistic development can take place' (Steiner, 1993: 41), Meltzer's claustrum is a deadly place for its inmate but, also, potentially, for the therapist too.

The patient in his hole

A story that this middle-aged man, married but childless, related very early on in our meetings, graphically delineated what I came to recognize as the basic structure of his mind and which, I think, also symbolically represents the structure of the claustrum generally. It was a story his grandfather, whom he described as a 'loner', told him when he was about eight or nine years of age. The grandfather, who had volunteered to fight in the First World War because he had believed that it was a war about principles (although he had been rapidly disillusioned), told how he and his fellow soldiers had been ordered by their commanding officer to advance from their trench the next day because the wire had been cut. However, a friend, called Scottie, had gone to look and had found that the wire was not cut. He reported this to the grandfather, saying: 'Taffy, there's no way we're going to get over that wire with loads of over 100 lbs. The only way we can survive is to find the biggest hole we can and hide until it's all over.' The grandfather had agreed to go along with his friend's plan and the plan had 'succeeded'. They had left the trench with the other men but had then slipped away and hidden. When my patient had asked his grandfather what would have happened had anyone found them, the grandfather had replied, 'Nobody would have dared; some things are best not noticed.' He had not wanted to accept this and had pestered his grandfather for an answer. The grandfather had then shut him up by saying that, when he was older, he would discover the answer for himself, which, indeed, two or three years later he did: it came to him that his grandfather meant that they would have killed anyone who exposed them in their hole.

As a description of a flight into the claustrum, this story struck me forcefully. In the face of disappointment with the object (the officer who lied about the wire), the subject adopts a fraudulent pose (pretending to go over the wire with the others) and hides himself away from the external world (the world of intimate relationships with others, of freedom of movement and of thought) in a hole in which the only relating is between the crudely split parts of the personality, the actively perverse Scottie bit and the passively, collusively obedient Taffy bit. The bit that knows the truth and stays outside the hole is intimidated into turning a blind eye to the truth by threats of violence.

Narcissism as an impediment to knowing

It is the therapist's job to notice that he is not in an emotional relationship with the patient because the patient has escaped from emotional relationships into a world of his own making – the hole that is occupied by his Scottie and Taffy bits, and which is cut off, although not completely, from genuine interaction with others. The claustrum dweller peoples his hole with what might be taken to be simulacrums of those who inhabit the same external world as he exists in physically but they are not the real thing, being products of intrusive projective identification. They have no independence of mind or of movement.

They conform to his wishes and needs, never frustrating or disappointing him.

An exchange at the beginning of only our second session gives a taste of how my patient aimed to use me:

> 'Is that fuschia by the door yours?'

and, without waiting for a response, continued,

> 'In the spring, if I'm still coming, I'll take a cutting. I wasn't going to tell you. But then I noticed you can see through the glass of the door. You could have the same trouble as people have who open their gardens to the public. They come armed with their plastic bags and scissors and secretly reduce a lovely plant to a stump.'
> 'So, even though you've realized I might notice you stealing from me, you'll still do it?'
> 'Well, nobody ever really wants to give anything to anybody so you have to take what you can get.'

Although, at this point, I was not certain that I was with a claustrum dweller, in retrospect, this announcement is a very good manifesto for the claustrum dweller. In secret, he will rip off any bits of me that he wants and use them as he wants. He has no respect for, or interest in, my integrity; only an instinct to use me as a part object to meet what he takes to be his needs.

From the beginnings of his encounters with a patient who turns out to be a claustrum dweller, a major difficulty for the therapist is in actually recognizing that his patient is not in an emotional relationship with him. There is evidence that the patient has noticed the therapist because, at the least, my patient got to me at the appointed times and place – but it takes time for the therapist to realize how he is being used. Meltzer sees the problem of recognizing that the patient is a claustrum dweller as a source of serious technical difficulty. The instinct in the therapist to persist in trying to make an analysis where there is no transference relationship not only discredits psychoanalysis, but leaves the serious problems of the claustrum dweller unrecognized. This instinct to try to make an analysis where there can be no analysis is compounded by tendencies in the therapist which, together with the claustrum dweller's commitment to living inside his internal object, militate against the truth of the situation dawning on the therapist.

A primary obstacle to the therapist's facing the truth lies in his own narcissism. How can it be that his interest fails to stir the patient's feelings? He must be in the material somewhere and, of course, he can find himself there but not as an emotionally alive, independently minded object. Two years into our sessions my patient brought a dream which I interpreted hopefully in that I saw it as indicating that he had noticed me as separate and independent from him. In the dream he is standing in a check-in queue at an airport. He is dressed identically with others who are going on what he takes to be a package holiday. But behind him, just to the right of him, he is vaguely aware of someone whom he takes to be me who is not dressed like him and the others. The departure lounge has a roof and struts holding it up but no walls, so that it seems that it is

still under construction. Outside there is a big heap of rubble but, growing through the bits of debris, there are a number of ox-eye daisies, beautifully clear and distinct. My desperation to believe that we were beginning to make spontaneous emotional contact led me at the time to take the dream as hopeful. After two years of mind-deadening work, my capacity to remain stalwart was wearing a bit thin! I focused on the idea of a journey that he and I might take together and of an external world where, from out of dismantled bits, surprising, lovely, naturally growing things could be noticed. The possibility that I was being drawn into his packaged mentality, walled into his enclosed space with him, was, I think, too painful a thought for me to entertain seriously. I later came to realize this.

Counterfeiting and elusiveness as impediments to knowing

This strong temptation for the analyst to overlook the emotional deadness is readily reinforced by the patient's commitment to keeping interaction dead while giving an appearance of contact so as to maintain his omnipotence. And to this end he has developed to a fine art his capacity to deceive and counterfeit. As Meltzer puts it, 'such people have spent long years practising dissimulation . . . in order to hide from themselves and others their trespasser status' (Meltzer, 1992: 99). Entry into the claustrum was accomplished through stealth – Scottie and Taffy pretended to go over the top with others but slipped away unnoticed into their hole. The claustrum dweller's aim is to keep under cover of respectable activity what he is really up to. And so he is a past master at beguiling those whom he encounters with stories and behaviour whose purpose is to deceive, not to communicate what is true. My patient used words to create a screen to keep me out. He seduced me into the head/breast compartment of his claustrum with his stories of his Welsh mining childhood for far too long. Unlike Odysseus, I failed to lash myself sufficiently to the mast of my integrity to resist being drawn in. And, of course, one has to experience the patient in order for the thoughts to form that can tell you about him. But I know that I stayed too long. And I think that temptation is fed by what the claustrum dweller does to anyone who threatens to notice where he is. Like the outsider in the story who, if he sees the men in the hole, must not notice them, the therapist must not think his thought because, to do so, would blow apart the phantasy of omnipotence, making the patient vulnerable to awareness that the therapist is not under his control. When my patient felt that I had made a breach in his defences and impacted upon him, he resorted to devious tactics, becoming increasingly elusive, moving among the compartments of the claustrum, to try to draw me away from the question 'What is he doing to me?' to 'Where is he going?'.

Notes from a session in the first year with him give a flavour of this. He started with what might have been a hopeful sign – I had impinged on him:

'You know what you said about me last week, you know, about me being a moral and physical coward, well I haven't been able to get it out of my head ever since.' Shocked, I replied, 'I don't recognize this at all,' to which he responded, 'You know, you said I was terrified of knowing what was going on inside me. But you need to know that being a moral and physical coward has its good aspects – it can save your life.' I interjected, 'You seem to have found my noticing something about you as unbearable.' He interrupted, 'At infant school the rule was that you had to have a handkerchief. If you didn't, you had to stand on a chair in the class while the teacher used sarcasm and exposed you to the class as a nasty dirty boy.' I asked, 'Didn't your mother give you a handkerchief?' to direct his attention to my maternal function in an attempt to draw the maternal transference. He replied, 'I don't know. I would have been out playing. School was a quarter of a mile from home.' Here, the patient transformed my observation of the way he related to his mind into a mindless slogan, ('I'm a moral and physical coward') a counterfeit of my thought, which he happily beat himself up with. I had impinged on him but his response was to kill off the life of the thought, and use what might have become a perverse transference as fuel to maintain his incarceration. My attempt to develop a maternal transference was immediately cut off. The message to me was that I should neglect him, should not follow him because, if I did, I would humiliate him and stir his aggression and so he had to protect himself from contact by reducing my thought to a masturbatory chunter and by putting a distance between us.

Intimidation as an impediment to knowing

This threat of violence if the therapist persists in thinking his thought is a constant undercurrent in the experience of the therapist with the claustrum dweller. In the story, if Scottie and Taffy had allowed their occupancy of the hole to be noticed, they would have been tried as deserters, and possibly shot, and so my patient's adolescent response to what would have to be done if the incarceration were noticed was that the noticer would have to be shot. In other words, if I were to be successful in our work, and dared to get him to notice consciously where he was, and that I was there to help him out of his hole into the external world, a world of spontaneous emotional relationships with others, my reward would be death. The pervasive threat to me, that my professional life if not my actual life was under threat if I did not conform to how he wanted me to be, made it not only difficult for me to know what I knew but also to know how to get out of my predicament.

I was well aware from the evidence in his dreams that, for him, a third party existed only to be destructive, never facilitative, of coupling. He was very careful to let me know that he fed his wife with 'news' of our work. I had no confidence that what he told her, and how she was being groomed to use

what she was being fed, would have any integrity at all. I knew that if I despaired of being able to engage with him and evicted him from the therapy, got out from under his control, he would harm me. I do not think that physical damage was a real possibility most of the time but there were occasions when I did feel physically afraid of him. But what he certainly threatened me with was emotional harm. His capacity to frighten and intimidate me into doubting what I knew, and into trying to provoke me into acting out and abandoning him, was powerful and relentless for much of my experience with him. And so, even when I had decided that the work was going nowhere and that he was not going to revoke his adolescent answer to his own question of what would happen to the bit of him that could attend to the truth, it took me some time to get to a position where I could get him to choose to leave the work himself.

Countertransference as an aid to knowing

The major asset the therapist has in his fight to establish the reality of the patient's position is his countertransference. But it is difficult to trust and difficult to hold on to. Because of the patient's commitment to counterfeiting, at a superficial level he can make himself into a plausible patient, bringing material of the sort that seems to conform to the norm. Perhaps more importantly, the patient will try to intimidate the analyst into not noticing what he knows. The outsider must turn a blind eye to the occupants of the hole because not to do so will endanger his life. As Meltzer puts it, if the analyst is able to get behind the patient's self-construction, the idea of the patient's position that the analyst finds himself thinking in the early days of their experience of each other, 'is based so absolutely on the counter-transference that, except for exemplification in dreams, one would have to consider it entirely in the imagination of the therapist' (Meltzer, 1992: 98). The murderous perversity of the anal claustrum dweller is so removed from the respectable persona that the patient hides behind, the Taffy bit that takes cover behind the Scottie bit, that it is very hard for the therapist to hold on to what he knows, partly because of the intimidation – it will be the death of him to see what he notices – but partly because the therapist's view of the patient is often a result of what he can cull from allowing himself to be thrown back onto his spontaneous thought. Meltzer notes that there is a difficulty because it could be that the therapist's imagination is no more enlightened than the patient's. He refers to:

> the growing conviction in the patient, and a parallel suspicion in the analyst, that the analysis is all rubbish, that the analyst is just as ensconced in his psycho-analytical claustrum as the patient, that it isn't even the halt leading the blind but a couple of blind philosophers mistaking an elephant's legs for a forest. One's negative capability is put to the test indeed! (Meltzer, 1992: 104)

My patient told me of how his dog had disappeared into the night and had refused to return to his call. He had gone out with his torch into the fields behind his garden and had been very relieved when the dog returned. He had commented that it had not really been a problem because there were no domestic animals in the area, only rabbits and the like, and so it would not have mattered if the dog 'had come back with blood on the muzzle'. When I talked to him of his belief that no damage is caused by violence which is perpetrated secretly, he became angry, demanding to know what I was talking about, where I had got that thought from. And when I referred to his comment about the blood on the muzzle, he was outraged, adamant that he had never said such a thing. And so I began to doubt where the reference to violence had come from. It was an idea that, on exploration, I could find had no foothold in the patient's mind. Was there unconscious violence in me towards him that was contaminating my understanding of him? Thrown back as I was on my counter-transference, I had to struggle to keep disciplined, helped by the understanding of my supervisor and colleagues. With hindsight, whether my patient had said the words or not, the communication of covert violence was, I am sure, true. Inevitably when violence that was cloaked was uncloaked, his impulse was to disown it.

The nature of the claustrum as an aid to knowing

The position is not, however, entirely bleak. As Meltzer (1992: 103) points out, the claustrum is not a closed space. The claustrum dweller may have consciously forgotten the world of spontaneous emotional relationships, which he left so long ago, but the fact is that he did leave it to enter the claustrum and he must have entered it through a hole, however small. The bit of the personality which is left outside knows exactly what is happening and what is going on but is too intimidated by the threat of violence to notice it. But it is the bit that is left outside that helps the patient to know that he is in difficulty. These patients do hold the knowledge somewhere of how lonely, empty, ineffectual and hopeless they are because somewhere they know that there is a world, from which they have exiled themselves, where it is possible to be in lively relationships that are endowed with meaning and possibility. Meltzer (1992: 100) makes the point that the patient sees but does not notice the analyst and his setting. Evidence of this comes through in changes in the patient's dress and language that mimic those of the analyst; in the emergence in dreams of items of furniture in the consulting room. Whilst such evidence of the existence of that bit of the patient that is outside the hole is welcome, my patient's response to it was to pervert it to make the contact exciting. But at least a choice can be pointed out to the patient. In the third year of our sessions, my patient had a dream in which the chrome desk chair with its black wool seat in my consulting room became metamorphosed into a black leather and chrome lounger on which his wife voyeuristically tracked his

emotional state when welcomed by a surprise replacement for his dog, which had died a year earlier. He had noticed something of me, although at this point it was only a piece of my material world, not something of my character that he had experienced. He therefore had a choice: he could develop his dawning awareness of me to establish me as an external, independent object, available to help him out of his hole if only he could reach out to me or he could distort his awareness, wallowing in the perversity and seeking to draw me in with him. And it was the latter he chose. He transformed what he had noticed into a prop for a drama in which he engaged with a pimp and a prostitute. The technical question of how we might make contact without my risking losing my stability and becoming drawn into his perverse world was one that preoccupied me throughout my work with this patient.

Perverse excitement as an impediment to knowing

My patient's persistence in using his awareness of me, not to help him out of his hole but as a spur to his efforts to draw me into his perverse state of mind, was truly dispiriting. When he started a session in our second year with, 'I wrote in my diary last week that I felt you were itching your way closer and closer to something that I didn't want to encounter', I replied that, yet again, he was perverting my efforts to settle him with my understanding into something exciting – digging up secrets – that I was doing on my own and not with him. He replied, 'Have you ever watched hare coursing?' Shocked, I asked, 'What do you think?' to which he promptly replied 'No. Well, I haven't either. But I've seen films. It really excites me. All that blood and destruction. The speed. There's no stopping them.' He must have heard the shock in my voice but, as usual, instead of using experience of contact with my mind to deepen our relationship, he cut off contact, quickly changing his story. It is destruction that excites him and which he will pursue over anything else. I was shocked to notice, when I looked at him on the couch, that his eyes, behind his glasses, appeared to have skinned over until I realized that he had pushed the glasses up onto his forehead! He had the equipment to see. He just continued to refuse to do so.

Constancy and reliability as aids to knowing

Indeed, there did emerge some evidence in him of a wish to foster a tentative identification with his knowing and wanting to know bit – the outsider bit. For a short but lovely, because lively, period of our work, he brought some of his confusions and difficulties into the consulting room to be thought about with me. He allowed himself to receive my impingement on him, to use me rather than abuse me. It seemed then that all my heart-breaking and mind-numbing work had borne some fruit. The change in atmosphere, and what felt like genuine emotional contact, in the sessions were truly refreshing after so much

arid experience. Something sparkled in the sessions, and it was emotional contact, accepted and fostered. I think that my making a move that was unusual – I asked him if he could change a session, something I had never done in the three years that we had been meeting, helped to foster this. This untoward occurrence allowed something of my constancy and reliability, which had been seen but not noticed until it was disturbed, to hit him. He sat up, turned and looked at me as if seeing me for the first time and said, in surprised tones, 'It must cost you to keep my sessions so constant. The gasman never comes on the right day, but you do.' Most poignantly, he asked himself and me questions about his relationships with others and theirs with him, particularly those emanating from memories of his early childhood, relating to my mind and in particular my capacity to help him think about his confusion. 'You know, you never think of these things, do you? But when I think about it, I don't know why my dad didn't get his own house. It would have been a right of his employment. We didn't have to share with my grandparents. We could have lived separately. I could have had my own bedroom and not shared with my parents. But even if we'd had to share with my grandparents, why didn't my dad put up a partition? He could have done it as easily as he can breathe. It was well within his competence.' I felt for him in his bewilderment, a countertransference experience that was truly welcome after so much aridity. He seemed to be able to begin to take on board the possibility of allowing me my function as a regulatory penis in what began to have some of the characteristics of a potential paternal transference to me. His little-boy feelings frightened him, but he could allow himself to get into some emotional contact with me because he had some sense that I would be able to manage the boundaries of our relationship. It was quite clear to me that this shift had to do with a shift of attention away from the incarcerated Scottie and Taffy bits to the outsider bit and was, therefore, inevitably precarious. There was no evidence of any movement of the incarcerated bits of his personality out of the hole. Meltzer talks of the therapist's difficulty in knowing 'whether the ensconced part of the personality has emerged from the claustrum or whether the sense of identity and therefore control of consciousness and behaviour has been wrested from it' (Meltzer, 1992: 106) and develops this differentiation in the next chapter of *The Claustrum*, 'Emergence from the claustrum versus shift of consciousness' (Meltzer, 1992: 111–115).

The Christmas break at the beginning of the fourth year of our work, and the impact of his vulnerability if he allowed himself to know that I mattered to him, dispelled any mild hope I might have entertained that our change in contact was a result of my patient emerging from the claustrum, however tentatively. His hatred of the pain he was caused over the holiday break by having found and then lost me, pushed him into a savage attempt to shatter contact between us. He chose the one piece of furniture in the consulting rooms that belonged to me (the chair in the waiting room) – evidence of his minute

monitoring of me – on which to act this out. When I went to fetch him from the waiting room I was terrified by the violence with which he was twisting the back of the chair, trying to wrench it from its anchorage on the seat. His hands seemed unusually large and powerful, and his voice was full of venom as he hissed, 'One day this chair will let me down.' The Scottie bit of his character had taken over from the passive Taffy bit and the attentive, thinking, outsider bit had been completely annihilated. I had to brace myself to face him and get him to come into the consulting room so that we could think about what he was doing, and so that I could get the chair out of his grasp, and out of danger of any more damage. I had to fight with the bit of me that really wanted him to leave, but I was supported in my resolve to face him because I knew I was not alone in the house. I talked to him of how terrified he was of finding that he might have come to notice me as someone who might matter to him because that would mean that he would be vulnerable to being let down by me, and his response to that was to take charge of the breakdown by smashing the chair/the therapist's holding/thinking capacities. His response was to vehemently deny that he had done anything damaging. In the face of his anger, that I should not only witness his aggression but have the temerity to bring it to his attention, I had to hold on to my countertransference experience – I had been terrifyingly disturbed and I knew I had to stand firm in the face of his angry denial if there was to be any hope that we might recover contact. Meltzer's (1992: 104) suggestion that the therapist should try to hold in mind the lost child when what one is witnessing is a very perverse and intimidating adult is wise counsel but very difficult to carry out!

Contempt as an impediment to knowing

I felt disheartened, as the weeks went on, by his seeming determination to wreck any chance of getting back to where we had been before the Christmas break. He seemed to have no wish to struggle with anything difficult. The Taffy/rent boy bit of him became increasingly allied to the Scottie/Mafia godfather bit of him in his attempts to intimidate me either into silence and capitulation or into collusion with him and joining him in his hole.

A dream he had two months after the chair incident graphically delineated my fate: he was standing on the side of the road with his father when a stretch limousine drew up alongside the pavement. The boot and bonnet were both equally elongated and the driver was wearing dark glasses and had slicked-back, black hair. It was an open car and the driver was like a pilot, with cockpit-type controls. He was the only occupant of the car except that, out of holes in the top of the bonnet and boot, heads, of what he took to be the driver's minions, poked. The driver reversed the car into a parking space and my patient said to his father, 'This is no place for us', and led him into a dark basement bar. The driver and his minions then followed them in and the driver

kept on ruffling the father's hair in a humiliating way. He wanted to protest but my patient became quite anxious, telling him he must not react because he felt that the man was only doing it to get a reaction – he was spoiling for a fight that he and his father could not win. I talked to him of the bit that knows he is in the wrong place and tries to move out of it, but, instead of staying out in the open, chooses always to be drawn back, through masturbation, into an even worse place (the reversing car, into the dark underground place – the natural habitat of the sinister Mafia gang-type bits). I was left a talking head, with no freedom of movement or thought except in identification with the ineffective father, to warn that we needed to fight the bullying humiliating bits of his character. But he had no taste for a fight and shut me up. I felt hopeless. His contempt for me was overt and his perversity was triumphing. But I could not leave him as the intimidated, silenced father of the dream. I had to get to a stage where he could acknowledge that he was actively and knowingly choosing to stay in his claustrum and refusing to identify with the knowing outsider. The difficulties in doing so were huge. His skills in intimidation, blackmail and seduction had proved more than a match for my attempts to prove to him the delights of attending to the truth. I wanted to stop wasting, to use a phrase of Meltzer, 'the time of my life' on him.

I no longer had any hope that this man would want to come out of his hole. I felt that my only recourse was to concentrate on being attentive, which is difficult when you feel that you are either being threatened or seduced to compromise you. My stance had to be that I would not play his game but would notice the perversity and the desperation behind it because, if the patient acknowledges that the therapist is outside his hole, his envy will redouble his efforts to destroy or compromise him so that his integrity is thrown into doubt, thus making it easier for the patient to disregard what the therapist stands for.

Fear of catastrophic change as an impediment to knowing

Melanie Klein, in her essay, 'On the development of mental functioning' (Klein, 1958) addresses a further impediment to the therapist struggling to get behind the claustrum dweller's façade to discover the perversity that lies behind it. She talks of her recognition in observing small children of:

> the constant struggle in the young infant's mental processes between an irrepressible urge to destroy as well as to save himself, to attack his objects and to preserve them, that primordial forces struggling with each other were at work . . . The more the ego can integrate its destructive impulses and synthesize the different aspects of its objects, the richer it becomes; for the split-off parts of the self and of impulses which are rejected because they arouse anxiety and give pain also contain valuable aspects of the personality and of the phantasy life which is impoverished by splitting them off. Though the rejected aspects of the self and of internalised objects contribute to instability, they are also at the source of inspiration in artistic productions and various intellectual activities. (Klein, 1958: 245)

In other words, if the therapist can risk his own stability in exposing himself to experience which may activate primitive splits, he can become creative for the patient. But the risk is huge. His own stability is threatened and his own understanding of who he is put in the melting pot. Bion's notion of catastrophic change (Bion, 1970: 106–124) is often conceived as a disaster but the catastrophe is only a part of it. The catastrophe resides in the loss of the existing structure of the personality. The difficulty for the patient is to trust that, if he gives up what he has got, a leap of faith will produce a change that will discover something new – a place where he can learn from his emotional experience and develop new capacities. My patient's dream of walking along a riverbank carrying a suitcase of his parents' and his 'things', and of a huge wave rising up and whisking the suitcase out of his hands, seems to me to be a neat depiction of the difficulty. The sudden wave is the catastrophe, the flood of feeling that loosens our grip on our definition of ourself and, included in that, our understanding of significant others. In the second bit of the dream, he and his father were lying on their stomachs overlooking the edge of a cliff looking down at the suitcase, which was on the sand beneath, and my patient's father was telling him that he must not go down to retrieve it because there were quicksands below and he would get sucked into them and would never be able to get out. The dream ended with my patient stepping into the quicksands. This second bit depicts my patient's refusal to let go of what he has, to embrace change and abandon his hole. In my countertransference I responded to his projection, feeling his fear of the danger of change. I became identified with the outsider bit of his personality who felt hopeless to effect change, knowing that Scottie and Taffy were in a hole but powerless to do anything about it.

Conclusion

I failed to get my patient to bear the pain of relating to an external object so that I could gather his infantile transference needs. He withdrew from that possibility, back into his narcissistic world inside his object. Whether the obstacles he put in the way of my getting to know him would have been surmountable had I had no atavistic revulsion and fear of getting too close to the claustrum, for fear of being sucked in, I cannot know. Meltzer acknowledges the danger of being drawn in, referring to it as 'an all too common industrial hazard' (Meltzer, 1992: 105), which he has witnessed in the work of those whom he has supervised. There were times when I was reduced to being a talking head, and that compromised my integrity and made me vulnerable to my patient's instinct to destroy me through feeding libellous material to a third party, his wife. In an attempt to get me to throw him out, he told me that she had complained about me to her colleagues, saying that all I did was to charge fees for indulging him, but I knew I had to resist the temptation because to do so would have given him evidence, acted out, that he was right to identify with

the passive, hard-done-by Taffy bit of his character. If we were to end well, it was not that bit of him that I had to link to but with the bit that was outside, the bit that had been able to connect with me momentarily when he became alive to me as reliable, someone he could turn to. But he had turned away from that – I had tried for nearly four years to get him into an emotional relationship with me. For us to end the work with some benefit for him, he had to acknowledge that it was his choice to stay incarcerated, so that I was no longer implicated in his perverse manoeuvres. And, finally, he did so, after the summer break towards the end of our fourth year. He was able to tell me that he did not wish to continue; that it had been a relief over the summer to take refuge from the world behind the high walls of the house he had recently inherited. I accepted his want with relief but some sadness at the waste of his life and mine, but grateful for the developmental gain he had achieved in coming out into the open with a want in relation to me, even if that want was to cut off contact with me!

The encounters we had gave my patient an opportunity to review his adolescent decision that a blind eye should be turned to the parts of himself which were turned away from external reality to internal phantasy objects. I failed in our work to convince him that he should risk trusting the knowing bit of himself, engage in an open and honest way with what he knew, and use that knowledge as a basis for retrieving the Scottie and Taffy bits of himself that formed the bedrock of his character. Instead of coming out into the open with his capacities to fight, and using them to help him escape from what he came to know but, most of the time, refused to notice as his incarceration, he used them ingeniously and surreptitiously to resist and pervert my attempts to release him from it. Through the work I was able to bring to his notice the fact that he was turning a blind eye to his choice to believe that the only way to survive was to be in a hole. At least I think I can claim that, at the end of our work, we had achieved one shift in our knowledge. We had, to return to T. S. Eliot, managed 'to arrive where we started/and know the place for the first time'. The struggle to know had not been entirely futile. He knew he had a choice, he knew something of the nature of the choice, and he made the choice he made. It was not the one I wanted for him, but, after all, it was his decision, made this time as a mature man (at least chronologically) in the light of some – albeit reluctantly acknowledged – knowledge!

I know that writing this has been motivated by a wish to extract something valuable out of my experience with this patient. In thinking about the factors in both therapist and patient which militate against them knowing each other, I might be better prepared to stay with a clear mind in future encounters with patients in their holes. The problem of getting stuck with patients is as old as psychoanalysis itself; it is a problem that Freud (1937), and others since, have battled with. The challenge with claustrum dwellers is to encounter them willingly, as is our duty, but to keep clarity of mind and not to allow ourselves to

be emotionally contaminated and either to fall into the hole ourselves or to avert our gaze.

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A view of the helplessness and violence contained in chronic fatigue syndrome

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ABSTRACT

In this work, originally undertaken 10 years ago, the author asks whether there might be any one particular psychopathology likely to be linked specifically with the physical illness known as chronic fatigue syndrome (CFS) or myalgic encephalitis (ME), and whether CFS/ME aids and abets, and 'fits', an original mental state. She thinks the question cannot yet be answered, but hypothesizes that in some personality structures the onset of CFS/ME following a physical illness exacerbates negativity, and is an aspect of ordinary depression where there is a lowering of energy levels and a loss of zest for life, or it may reveal the pathological aspect of unresolved rage. Depending on the degree of pathological disturbance, working with and through the rage may or may not result in a resolution of the symptoms of ME. Some of the problems in the transference and countertransference relationship are considered, which make it extremely difficult to separate out reality from fantasy. There is then the further problem of the denial of the psyche by the patient as part of the violence inherent in the illness. The findings in this paper are corroborated by research undertaken over the last four years and these are incorporated into the paper. One case is presented, an example of ME in a borderline male patient in whom resolution could not be achieved.

Key words borderline states, chronic fatigue syndrome (CFS), depression, Jungian analytical psychotherapy, myalgic encephalitis (ME), pathological rage

Introduction

My interest in the problems presented by psychosomatic symptoms and conditions has continued over many years. Revisiting the particular problems posed

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by myalgic encephalitis (ME) led to further research, with the hope that public attitudes have changed. Ten years on, ME seems to be less talked about, but it is still a presenting problem in our consulting rooms. The Chief Medical Officer has reported twice on CFS/ME, in 1996/7 and 2002 (DoH, 2002). It has become recognized as an 'official illness' (Richardson, 2002: 32–35). The term 'chronic fatigue syndrome' (CFS) is, generally speaking, more recognized in the USA, and ME is more usually used in the UK. Patient advocate groups prefer the term 'myalgic encephalopathy' because fatigue is not always a feature (Clark et al., 2002: 97–98). The Government working party accepted both terms, CFS and ME, thus respecting different viewpoints whilst acknowledging the continuing lack of consensus on a universally acceptable name for this problem.

To put the current state of thinking in context it may be useful to consider the following. The Government report of 2002 shows that:

> . . . most cases occur sporadically, with a lifetime incidence rate in the region of 3–7% . . . with a peak rate in the 20–40 age group, and a preponderance of females. An association is made with social class, with professionals being more frequently affected than others. In the UK there were increases in the number of cases in the late 1980s and early 1990s, when it was followed by a small decline in the late 1990s. (Clark et al., 2002: 97–98)

Over the past 10 years I have worked with five patients presenting with a history of CFS/ME. One died of cancer. Three had ME in the past. I was under the impression that CFS was on the wane. It didn't seem to be talked about, although reports showed that in 1992 there were 100 000 patients with CFS (Shepherd, 1992: 28). Richardson (2002: 32–35) stated that more than 150 000 UK patients have ME. It was estimated that there is a prevalence in the UK population of between 0.4% and 2.6% (Hughes, 2002: 9–14). So, a general practice with 10 000 adult patients could have 30–40, or more, ME patients. As many as 25% of these are severely affected and may be house- or bed-bound. It is acknowledged that depression and anxiety can exacerbate the symptoms and impede recovery from the condition.

I asked originally whether any one particular psychopathology seemed likely to be linked with the cluster of physical symptoms known as myalgic encephalopathy, and whether ME aids and abets, and 'fits', an original mental state. It was, and still is, my hypothesis that, in some personality structures, the onset of ME after a physical illness exacerbates negativity and is an aspect of normal depression, where there is a lowering of energy levels and a loss of zest for life. It may reveal an unresolved rage, accompanied by a longing for health, freedom from fear and hatred, the rage having become locked in a somatic defence which takes on a borderline psychotic quality. Although ME has been thought to be a post-viral syndrome, it seems often specifically to follow glandular fever. In the patients I have treated, infections such as influenza have exacerbated the symptoms of ME.

Depending on the degree of disturbance in the patient, working with and through the rage may, or may not, result in a resolution of the symptoms of ME. The intensity of the rage may cloud the ability to differentiate between fantasy and reality, and, conversely, the difficulty of differentiating between fantasy and reality may lead to an intensification of the rage. In this paper I consider some of the problems in the transference and countertransference relationship which make it extremely difficult to separate out reality from fantasy in a borderline state. The title conveys the idea that the illness of ME acts both as a container for the unrecognized violent feelings of the sufferer and is also an expression of the harm he inflicts on himself by means of the illness, a harm that is perhaps inherent in all psychosomatic displacement. Furthermore, this harm is perpetuated both when the presence of the physical symptoms associated with ME is ignored, and, conversely, when the reality of a psychic component to the illness is denied. The denial of either component, the psychic or the somatic, is an aspect of the potential violence inherent in this illness. The experience of helplessness is palpable. The harm done by the denial of the physical reality exacerbates and plays into the patient's paranoid feelings: he knows that he is ill and he knows, at the same time, that he is not believed.

The patient may also fall into a paranoid state in relation to himself, whereby his body, now experienced as an external object or part self, is felt to be attacking and tormenting him (Schilder, cited in Rosenfeld, 1965: 182).

The illness of ME constitutes an extra loading that complicates any of the whole range of psychopathologies. In the case of the patient I describe, in whom the personality structure was very rigid, the element of paranoia made it doubly difficult to separate out reality from fantasy. Both the psyche and the soma have to be held in the analyst's mind. The denial of the psyche by the patient was, of course, also part of the violence.

Peter

I will discuss some of the aspects of the treatment as they appeared in the clinical work with the patient, Peter, recognizing that the variety and intensity of symptoms is very wide across the spectrum of ME, although at the same time there are certain important common factors. In working with this patient, I came to understand his condition in terms of the development of a highly sensitive and receptive infant whose maturation became distorted through a lack of appropriate holding by the mother, probably as a result of her own depression and physical illness. The mother–infant 'fit' seemed to have been doubly marred: at times her holding had failed as a result of her emotional absence; at others she seemed to have overwhelmed him with her intrusiveness. A defence developed by this patient against such extreme psychic dangers was concretization. His capacity to think creatively and imaginatively would

suddenly become obliterated in his need to hold on to a concrete certainty where there was no 'as if' quality. His exceptional intellectual talent was exercised to protect a delicate inner core Self from destruction. Thus there are indications that his disturbance had its precursors in infancy. In *Pathological Attachments and Therapeutic Action*, Fonagy (1999) corroborates much of my understanding about the processes involved in the development of reflective capacities and sense of self. However, this patient's emotional development seemed to be arrested at the onset of puberty, when his defences took a pathological course. The occurrence of glandular fever at the age of 22 precipitated the breakdown of his defences.

Peter, aged 27, presented himself as a highly intelligent man with a first-class degree. He identified with his professional father, whom he described as an 'overpowered, sweet man'. But he was at the same time furious with his father for being feeble, not standing up to women, in particular his wife (the patient's mother) and not supporting him. Peter's relationship with his mother was one of murderous attachment. He felt himself to be totally dependent on her and at the same time he hated everything about her – physically, in her aging body, and emotionally, in her manipulation of him. He reported the way in which she would play off the family against the father, who, she said ironically, would become ill if disturbed or distressed. Females dominated the family, and the patient found himself at the bottom of the emotional pile, furious and rebelling.

I am speculating that the damaging aspects of his relationships became intensified around the age of two, when Peter began to speak. At the age of one, his first sister was born, ousting him from his prime position. As the firstborn, Peter was the longed-for son, but he felt that his mother's enjoyment of him rested in her need for him to be the small, helpless, totally dependent infant who could not answer back. During the period of treatment, my experience in the countertransference was often one of the mother of the young child who was intent on answering back and making himself felt, and for whom his very existence and belief in himself depended on his being right and proving his mother wrong. Only antagonistic communication was experienced. Later, in a very regressed state, Peter would say he was actively switching the sound of my voice off, saying he could not hear me. He could not receive anything from me. Any thought had to be his own thought and his omnipotently, alone. He could not trust that he would be understood and not damaged. My interpretation of this was accepted by Peter as true, both as it related to his experience in the past and in his present experience in therapy.

Redfearn (1978: 219) discusses the way in which, at the schizoid level of mental life, the symbol does not exist, the metaphor is the experiential reality, there is no 'as if', no tolerance of ambivalence, and no sense of humour. I imagine that the mother's rage and frustration regarding Peter's challenge to her control of him might have led to an intensification in him of the ordinary

processes of splitting, where good and bad experience could not be held together in memory. This would have been intensified and followed by a further detachment and loss of relationship with the mother at the birth of his second sister. Kernberg (1984: 289) argues that

> significant superego developments (whether normal or pathological) take place from the second and third year of life on, preceding and crucially influencing the integration of the oedipal and post-oedipal superego.

Peter's repression of all conscious feeling except the need to be good and to please in order to survive, would, I think, have been paramount at about the age of seven or eight. At this age he would have already retreated to his room to work and read. He related stories of experiences at school where, in his desperation to find a sense of himself in relation to others, he would act the clown in his efforts to reach out, be noticed and approved of, and attract friends. He was totally unaware, he said, until his breakdown, of his own rage, which had been apparently so successfully repressed. Indeed, he reported that from a very young age all his energy was put into logical concrete thought whereby he could use logical argument as a weapon.

At 12, Peter became aware of his own great fear of death. His mother had become ill with pneumonia and had been hospitalized, and he had to confront his separation from her and the possibility of her death. At this time, too, he moved to a high-achieving secondary school, felt very alienated and disliked, but also made himself noticed by peculiar behaviour such as continually sniffing his tie and making animal noises. Peter was extremely lonely and was filled with obsessional fears and thoughts. His major preoccupation was to find a way of defeating death by becoming a spiritual god. Later, in his adolescence, this idea was gradually transformed into being determined to be the best at something more earthly. His researches into religion and philosophy all ended in disappointment, disbelief and cynicism as he found the flaws in the arguments. Peter's commitment to succeed in his chosen subject at all costs drove him to such intense behaviour that it amounted to self-inflicted torture. He described this battle with his own will in very physical terms of teeth-gritting and nerve-wracking, muscle-quivering concentration, which he would invoke alone in his room where he struggled with the work. The cost to his internal world was enormous. Peter's battle can be understood as a denial of the self, or as a closing off of his internal world, where his desperate efforts to reach out had failed and were now directed inside. The intensity of this experience was directed towards the self as object. Kernberg states that:

> . . . in borderline personality organisation such integration [that of the neurotic] fails, and both self and object representations remain multiple, contradictory, affective cognitive representations of self and others. This failure to integrate 'good' and 'bad' aspects of the reality of self and others is presumably due to the predominance of severe early aggression activated in these patients. Dissociation of 'good' and 'bad' self and object representations

> in effect protects love and goodness from contamination by overriding hate and badness. (Kernberg, 1984: 12)

Following his move to university, Peter again went through the phases of separation and loss. Again, he found relief in behaviour that drew attention to himself in his attempt to reach out to others, becoming the clown at a party or dancing on the tables, but these frantic efforts did not result in any friendships. His next university experience, where he took a further degree, was more positive. He began to feel himself to be less of a freak as his sense of loss and separation became less catastrophic. His idiosyncracies were tolerated and he, in turn, was more able to tolerate others. He was a long way from home and less contaminated by his family dynamics. Peter made one or two positive relationships and shared a flat with a male friend. However, while he was there his maternal grandfather had become very frail. As a child, Peter would visit him often and they would tell stories to one another. In Peter's internal world, grandfather was a relatively safe and benign figure, perhaps the only one. He knew intuitively that his grandfather was dying and decided to visit him, phoning just before he left. He did not know his grandfather had been asking for him. The grandfather then rallied and became stronger, saw his grandson and died the next day. This experience had a profound effect on Peter, who felt he had the spiritual power to help his grandfather from life into death.

The fragmented state of Peter's internal world was illustrated by the following: in the first two years of therapy one of Peter's habits was, at certain times, to continually rub his right eye under his glasses, often while gazing out of the window and making patterns, so he said, with the light and the leaves in his view. I interpreted how unbearable it must be in the room, facing his fractured feelings and his longing for comfort. I would feel then as if in some way I was being fractured and chopped into bits by him. Then he told me how, after the grandfather's death, he had suffered severe pain in his right eye, had continually needed fresh air and needed to go to bed to rest his head. He could not make any associations to these events in the present, in response to my observation, except telling me about how dreadfully ill he had felt then. I felt in the countertransference quite cut off from him and that this activity had a masturbatory, deflecting aspect; it seemed to be an attempt to hold himself together. It also felt as though he were blinding himself to any insight about his ambivalence, his fear and his rage. I was also rendered impotent.

Six months after the episode of his grandfather's death, as he was in the last phase of his research degree, Peter became ill with glandular fever. He appealed to his parents, who exhorted him at all costs to finish his research work. He did so but became very ill. His parents ignored him and went abroad for their planned holiday. This seemed to trigger the final collapse of hope he had in his close external objects, which in turn heralded the failure of trust he had in himself to withstand rejection. Peter abandoned himself.

He partially recovered and got a job, which failed almost from the beginning as he became progressively weaker. Nine months later he was at home, where he had been ever since, unable to work. His violent fantasies, and his fears of his feelings getting out of control and of imminent breakdown, brought him to seek psychotherapeutic help, much against the wishes of his mother.

Treatment and apparent progress

During the first 18 months some trust was established, and developing. Peter had begun by using the couch but he regressed very quickly, becoming dissociated and frightened of his own inner hostile world. The images of violence that confronted him, and his fear that he would get out of control, were very vivid. He fantasized that he would cut off my head with a cheese wire. He felt that, like all those other doctors, I was untrustable, manipulative, and twisted and turned to suit myself. He wanted to batter me into submission with a stick. In the seventh month I suggested he might feel safer if he used the chair, where he could see me and keep some hold on reality. This led to a greater sense of control, which became a central issue.

Peter gradually became physically and emotionally stronger, and became involved in social activities. After 18 months in therapy a situation arose in which he was asked to perform in public. The nine-month preparation time seemed significant symbolically as a period during which his potentialities might grow and blossom. However, the challenge put him into a great state of agitation. Many sessions were spent agonizing over whether he should, or could, take on this commitment. He wanted me to give him concrete advice. On the one hand, Peter felt the very high risk of the possibly disastrous emotional cost to himself, and, on the other, the social pressure to perform, which came from the family. He devised a brilliant speech and seemed full of hope and excited pleasure. My neutral position infuriated him and my interpretations, that he wanted me to take responsibility for the vulnerable part of him and that it was very frightening for him to take responsibility for, and use, the strong part of himself, were, as nearly always, rubbished. The day before the event he decided he could not go through with it and to run away. He finally found the courage to go to the organizers and tell them he could not do it. During the first two weeks following this 'disaster', he was in a numbed state of shock, part of him pleased that he had been able to assert and protect himself. Then gradually there was an increase of all his old symptoms. The level of hate in the transference was intense. He used his verbal and logical skills like swords. I became the target for the blame, as the one person, the idealized father, who could have stopped him from subjecting himself to such humiliation. Like all the others, family, acquaintances and professional helpers, I too, he said, had failed him. I suggested that he had shown great strength and courage in saying he could not perform, but the separation from his family that this involved was felt as an unbearable loss. These comments of

mine were met with derision. The failure and shame and fear were all-consuming.

I became acutely aware of his desperate and suicidal state. In one shocking session Peter asked me what I would do if he ran off up the road. In my counter-transferential state I was sure that this was to test whether I cared enough about him to prevent him from going under the nearest bus. I was cautious, in some way sensing danger, and I said, 'It would depend on what your intentions were.' He screamed at me, threw the cushion from his chair at me and stormed out of the room, out of the house, and up the road. He returned, minutes later and raged at me again, throwing insult after insult and ending in a frenzy of rage that had the quality of a minor fit. He said that the evidence that I did not understand him was quite clear, that I had not understood that, 'Of course I could not run up the road because I am incapable of running' – because he had ME. He had, in fact, just run up the road, despite his disability. But, clearly, I had not been able, as an idealized mother should, to enter into his state of mind. Perhaps my failure at this point consisted in my not recognizing that Peter also needed a 'paternal' response from me in the transference, one that would assess logically his idea of running up the road in the light of his health.

This incident made me acutely aware of the severity of Peter's disturbance. My concern that he might act out his violent fantasies in a very dangerous way led me to contact his GP. Peter was angry that I had taken this action, but he agreed that he felt out of control, even though he thought he would not act on his impulses. This shift marked a change in his attitude to himself and enabled him to confront the mad part, which was in danger of overwhelming him. A psychiatric assessment was the eventual outcome, which he welcomed, on the one hand, as a support and evidence of care, but, on the other, experienced as frightening and stigmatizing.

The work with me continued, with some new awareness in him of the dynamic in the space between us. For example, Peter had again been talking about his aspiration to make his mark on the world by doing at least one thing perfectly. He then lurched into an extreme position and said that really only one thing mattered – issues of life and death. I remained silent, confused by the grandiosity and idealization, thinking rather hard about the range of ways in which to comment or interpret. He said, 'You are not saying anything. You've gone to sleep, what is the point?', to which I replied, 'It's as though when I am not directly responding to you in an animated way I am dead, and then you feel as though you are dead. There is no belief that I can be thinking intensely about you and what it means to be you. The experience here and now is of the small child whose mother seems to have gone away and left you and you have to do something to animate her back into aliveness, otherwise you despair.' I think that, at some level, my interpretation made an impact and could be taken in, but his intense feeling of abandonment seemed to him like punishment and his only recourse was to lash out verbally and punish me in return. There were numerous repetitions of this experience, both in therapy and in his few outside

social contacts. He found it difficult to learn from them, needing to prove himself right and justify his rage. He found it hard to believe that he could be held in my mind, either when he was present or absent, although he would say that he held me in his. The concrete nature of his defences became highly intellectualized at the times when he was most distressed and disturbed.

Failure and giving up

In the first session following a break Peter said he found it hard to recognize me, both physically and mentally. 'Who are you really?' he asked. He had felt like this with a friend too. He was in a very dissociated state, and we were shadows through whom he could express the despair of his loss of us and of himself. Peter said he recognized there was a part of him that was afraid of getting better, and that some hope was being held out to him that he might. In his highly defended state a great philosophical idea had temporarily uplifted him: that life has to be accepted as it is.

In retrospect, it felt as though Peter might be settling for a new identity that could incorporate the gains of illness. However, in the next breath he returned to the old polarized position – 'If you saw a man on the street who had just killed your child, you couldn't just accept it.' Or, 'If I was drowning in the middle of the ocean, I couldn't just say, Oh silly me for not learning to swim.' Peter was again demonstrating his fear of abandonment. His extreme fear led to an active splintering in his mental processes, fracturing the light referred to earlier. Part of his defence in this state was to become grandiose to compensate for the risk of becoming scum, the ordinary dross of the world; Peter despaired in the feeling that he was dying already. The great terror of 'not being' gripped him. He also knew that it was the terror of the responsibility of succeeding that drove him into his deathly state. This primal psychic level, as Redfearn (1978: 227) points out, has much to do with archetypal aspects of union and separation, and with the immense energies involved, with the potential for either creation or destruction. He would say, 'I cannot separate, I cannot fend for myself, I must have someone to look after me.'

One effect of the progress Peter had made was to give him some insight into his condition and a greater recognition of his fragile state. His aggression was muted. The longing for the archetypal good parent, a benign God, was ever ready to spring into action to defend him against the pain of the absence of such a reality. The disillusion was unbearable. It often took the form of a desperate longing and search for a physical cure from ME, and when he was then faced with the inevitable disappointment, he would return to a state of equally desperate but triumphant rage. He had seen many consultants in every speciality and been advised to follow many different treatments, all in vain.

Peter's decision to end therapy came nine months after his critical outburst, another symbolic gestation period with an uncertain birth. During this period, after his psychiatric assessment, Peter was attending a psychiatric day hospital

on two days a week. Our work became diluted and more complex. A rivalrous situation was set up as different treatment approaches were suggested and tried out. Staff changed with extraordinary rapidity. Communication became more difficult as I tried to discover what was actually happening. What had seemed a potentially containing and positive alliance, where the hope for a gradual recovery could be maintained, slowly became an experience of frustration and failure. Peter announced that his mother had found him another therapist. It seemed he had given in meekly, thus re-enacting my having found him a psychiatrist whom he had agreed to see. I was left feeling outnumbered and overpowered by the hospital, Peter's mother and, finally, Peter himself. This was, of course, meant to feel like a failure, and it did. It was how Peter felt. But, I also hoped that some integration of the possibility of a positive maternal imago, which could allow him to explore, had taken place over the three years.

Discussion

McDougall's (1974) work on psychosomatic disorders illuminates the area of illusion and truth with which Peter had so much difficulty:

> Somatically ill patients may have to recreate their psychotic monsters and live with them in projected form for a while, until such time as they can be contained and integrated. (McDougall, 1974: 450)

For Peter, his psychotic monster was that he was a freak, untreatable, beyond anyone's ability to understand or help. Containment was a very fragile process and perhaps at this stage integration was not possible. In another paper, McDougall (1982) points out that:

> When patients face inner conflict and outer stress with no other mental mechanisms than psychic ejection of every affect-charged idea or perception . . . and when they produce continual psychosomatic maladies, the form of psychic equilibrium maintained in this way deserves the name of psychosomatosis. This kind of mental functioning in the psychotic psycho-somatic patient does not depend on either repression or denial. . . .In addition to psychosomatic phenomena, the other signs are therefore alexithymic manifestations [the inability to distinguish emotions and having no words for them], allied with concrete or pragmatic ways of thought and operational ways of relating to other people. . . .The person caught in this kind of dilemma has no other recourse, in the face of stressful situations, than to attack any perceptions that risk arousing emotion. (McDougall, 1982: 165)

Meaning is destroyed; commonly accepted meanings are arbitrarily distorted; other people's expectations or requests do not make sense. Peter would say he was 'exhausted but not tired', by which I understood him to mean the difference between his physical and mental state.

With this type of borderline patient with extreme narcissistic vulnerability, where the major defence is to fracture thought and meaning, there is very slow progress. One of the problems in treating Peter was always whether he would give himself time to work through any process without needing to destroy the meaning of his relationship with me.

Redfearn (1978) has also written on the problems of working with patients who are so heavily defended. In his article, 'The warring and combining opposites: problems for the psychotic patient and the therapist in achieving the symbolic situation', he discusses how, like the baby in the primal relationship with the mother, the patient, too, may need to unload pain or evil into the therapist in order to survive. Redfearn sees this as a physical and psychic necessity, in the sense of maintaining bodily health, and this was how I understood Peter's need. The psychotic nature of this unloading is extremely primitive and undifferentiated, and is a part of the splitting defence of the patient. Redfearn states that the defences are experienced as extremely offensive if they are to be at all effective. The therapist needs to be able to register the severity of the attack without retreating and this 'requires, in order of priority, survival, recognition, concern, and even love on the part of the therapist. Fortunately the patient often teaches the therapist how to provide these things in time' (Redfearn, 1978: 214–215).

It is to be hoped that this holding and containing function can gradually be integrated by the patient. In particular, the emphasis is on the archetypal constellation of the dual mother who symbolically represents both nurture, in all its positive forms, and also destruction, devouring and death. My difficulty in treating Peter was keeping a good enough balance between these aspects. To quote Redfearn again:

> The withdrawing loved person so easily becomes the evil one; the treasures of her insides so easily become poisonous, persecuting, or loathsome creatures or objects. The insides of the archetypal mother, the insides of the therapist and the phenomena of the world are experienced in some sense as one. (Redfearn, 1978: 227)

When Peter's fantasies became too terrifying he would retreat into a paralysed and rigid defence system. Omnipotent control and obsessional thought processes were his main defence. He assumed a grandiosity in order to ward off the horror of the ordinary and, as he saw it, of 'failure'. One of his persistent images was of being in the rarefied air on a very high mountain. His fantasy of horror was of having to come down into the valley, seething with human kind. This had become Peter's way of surviving, and his fracturing of attention and feeling, referred to earlier, had become a way of closing himself off from experience. There could be no whole experience. The valley in reality and fantasy was too full of a multitude of invasive and persecutory experiences and was unbearable.

Despite the fact that I was often used as the container for all Peter's violent and exasperated feelings, and was in turn exasperated by him, I equally often found myself full of hope for him and in some way admiring of his efforts to broaden and develop his internal world. I was often moved by him in his sadness, despair and locked-in state, and at other times charmed and impressed by some of the stories he had written or descriptions of some of his paintings. I was saddened by my inability to help him find an adequate or safe enough framework in which to disentangle and differentiate his feelings, although there was the beginning of a glimmer of a less defended self and a fleeting kindness about him that seemed to be less self-obsessed. Stolorow et al. (1987) show very clearly how the revivals in the transference of the patient's early history of developmental deprivation, need to be analysed from within the patient's subjective world:

> If we view the therapeutic situation as an intersubjective field, then we must see that the patient's manifest psychopathology is always codetermined by the patient's self disorder and the therapist's ability to understand it. . . .the idea of a borderline character structure rooted in the pathognomonic conflicts and defences is symptomatic of the difficulty therapists have had in comprehending the archaic intersubjective contexts in which borderline pathology arises. (Stolorow et al., 1987: 131)

This case highlights some of the problems in the transference and counter-transference which may demand to be confronted in working with severely ill patients. There is the very real difficulty of the clinical decision that may need to be made, in this case, my need to contact Peter's GP because of my fear for both his and my safety. Certainly, my doing so reactivated and reinforced his own tendency to concretization and splitting, and must have meant to him at a very internal level that I was unable to hold him or indeed that he could not be held.

Conclusion

The cluster of physical illnesses in ME cannot be seen as a single clinical entity whose aetiology can be understood in biological terms. ME is a descriptive term for a condition recognized by a variety of signs and symptoms, and is currently treated symptomatically. It is imperative that a diagnosis of ME tries to exclude the autoimmune, infectious and a variety of other diseasess, which can be fatal and which share some of the symptoms of ME, in order that sufferers can receive appropriate medical care. Glandular fever seems to be a common trigger to ME. The case presented illustrates one way, through the illness of ME, of dealing with depression and violent emotions that have not been able to be expressed in any other way. The psychosomatic system is circular, the psyche and the soma each affecting the other in unknown proportion. We do know that, in students under academic stress and in people who have been bereaved, there is a marked suppression and impairment of immune responses:

> In general, these findings concerning the interactions between the central nervous system, emotional states and the immune system make it easier to understand how life events could affect the onset and course of such autoimmune diseases. Equally it has been found that some illnesses, such as glandular fever and influenza, appear to have a particularly strong association with depression. (Wolff et al., 1990: 471–472)

For Peter it was impossible to know which affected what. For him, depression and low immunity to stress and anxiety were played out in his physical being. The depressive condition with which Peter presented was exacerbated by an inability to work through his fear and anger. The onset of glandular fever and the subsequent diagnosis of ME seemed to have released this anger and enabled Peter to be in touch with it. His ego was not strong enough to work with and through it. Developmentally, the amelioration of this condition must depend on the capacity to internalize the security of a good maternal object. There develops out of this internalization the capacity to symbolize and play, which relies on the development of trust, as does the capacity to know the difference between internal and external reality, and an ability to hold on to a relatively solid sense of self. Or, to look at it in another way, as Hubback (1983) so clearly describes:

> . . . via the transference/countertransference, there can be a carryover of the psychological possibility of coniunctio from the analyst to the patient. The theme can be worded in the fully Jungian form of granting coniunctio archetypal status, so that the constellation of that archetype can be postulated to activate in the patient the capacity to move from dissociation to internal harmony, or integration – the integration of the mother and father imagos. (Hubback, 1983: 39)

In this patient, the level of dissociation in his internal world was too great. The archetype of the coniunctio was not constellated. There was no conjunction between his split selves. The need to fracture his experience of being held was his major defence against his fear of abandonment or invasion.

In my researches covering the last three years, I discovered articles written from medical and neurological research into changes in the brain (Chaudhuri, Condon, Gow, Brennan, Hadley, 2003, 225–8), nursing practice and occupational therapy practice, but it has been very difficult to find anything written that had any psychological insight, let alone analysis, into this particular syndrome. By chance, I came across one single, excellent article by Shapiro (2002), 'Building bridges between body and mind: the analysis of an adolescent with paralysing chronic pain'. There was no allusion to either CFS or ME, but the paper is about debilitating fatigue. The author uses her case material to illustrate the many psychic mechanisms and determinants of psychosomatic processes and techniques in working with patients who initially define their distress as primarily or only physical. She points out that:

> A complicated confluence of historical, social and political factors has shaped practice patterns such that debilitating chronic pain and fatigue are typically defined by physicians,

> patients and the culture as purely or primarily biomedical conditions, rather than as problems that involve both mind and body. Whereas other typically psychosomatic problems, such as inflammatory bowel disease, dermatologic conditions and eating disorders, regularly come into the psychoanalytic sphere. (Shapiro, 2002: 547–548).

I was also put in touch with the research work of Dr Louiza Rangel. She and her colleagues are due to publish their fourth report. They have been working on CFS in adolescents since before 1999. Their first paper corroborates many of the facts as I understood them 10 years ago. The latest findings also support some of the conclusions I reached:

> CFS is commonly reported as being brought on by acute infections. Comorbid psychiatric (usually mood) disorders are present in at least a half. Personality problems and health attitudes have been described as possible predisposing and maintaining factors. . . . Clinicians commonly observe that a number of children become anxiously dependent on their parents, and mothers highly attentive to and emotionally involved with the child and CFS. . . .Many affected children are described as especially active and high achieving prior to illness onset, which may reflect difficulties in their ability to regulate activity/rest periods. (Garralda and Rangel, 2004: 543–552).

What is the reason for the increased psychopathology in CFS? Do CFS and emotional disorders share a common aetiological pathway? Is psychopathology a result of having a chronic physical illness? The latter seems unlikely, since adolescents with CFS display more psychological distress and depressive symptoms than those with medical diseases such as cystic fibrosis, juvenile idiopathic arthritis or cancer. However, psychopathology, especially anxiety disorders, may be even more common after than before recovery: increased rates of personality disorder and difficulty in children with CFS than in healthy control subjects; and more enduring traits in them signalling conscientiousness, vulnerability, worthlessness and emotional lability. When excessive, these traits may reduce children's ability to cope with the usual and common life changes and stresses. Iatrogenic factors must be relevant (Walford et al., 1993; Pelcovitz et al., 1995; Carter et al., 1999).

Summary

The level of the pathological defence may determine the outcome where the patient presents with the symptom of ME. I suggest that the cluster of physical illnesses exacerbates, and is exacerbated by, depression and negativity; an unresolved rage may be revealed, which may be an aspect of 'natural depression' or it may be psychotic in nature. The aspect of the illness in which the psyche is denied is part of the internal violation of the self. This violence is projected out through the body and acted out in the world. I then make the hypothesis that any improvement in the illness of CFS or ME will depend on the capacities of the therapist and the patient to achieve a coniunctio in the therapeutic

relationship, and this will depend on the capacity of the therapist and patient to hold and work with the rage that will inevitably be released.

The overriding problem, it seems to me, both in patients and professionals, remains in the psychesoma split. Those patients already demoralized by their physical state cannot, at an unconscious level, allow a further battering of their already low level of self-esteem; their defence is absolute. They live in a culture that still looks down on psychogenic illness, that does not recognize or respect its reality, and they are very frightened of something they cannot see. In many families there is no language in which profoundly deep and difficult emotional responses, such as shame, guilt, helplessness, fear, anger and destructiveness, can be described or expressed verbally. The self-esteem of the patient depends, therefore, on having the physiological nature of the illness accepted. This is inevitable. We are human beings who will convert feelings into symptoms when we are unable to speak.

Part of the assessment of an ME patient recommended for psychotherapeutic treatment must include, as in any patient, their capacity for psychological thinking, however small or intuitive this may be. Clearly, many patients will be unsuitable for treatment because of their cultural attitude or internal unavailability.

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'It ain't easy growing up in World War III': countertransference complications in work with young people who have experienced domestic violence

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ABSTRACT

Work that involves close engagement with severely damaged young people will provoke powerful and sometimes counterproductive emotional reactions in professionals. A number of therapeutic encounters with young patients who have experienced violence in family life are described to highlight some of the experiential and technical aspects involved and the varied ways in which the theme of domestic violence may, or may not, resonate in the transference. In some instances therapy takes place against a background of continuing abuse; in others the therapist's reaction is complicated by emotions generated in the political and social domain.

Key words adolescents, countertransference, defences, domestic violence young people

This paper explores the manner in which therapeutic engagement with young people who have experienced violence within the family can impact emotionally on the clinician. The examples cited took place in an institutional setting, where patients are seen on an open-ended, once-weekly basis. The focus of the paper is on the experiential, and perhaps technical, rather than theoretical aspects of this work. There have been many overviews of the history and meanings of the term 'countertransference'. Anastasopoulos and Tsiantis (1996) have written a review of particular relevance to this paper, exploring the ways in which the developmental tasks and characteristic defences employed in adolescence impact upon the therapist's equanimity. These authors suggest that

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developmental instability and associated switches in mood 'in conjunction with the massive use of projective identification, creates unusually powerful feelings of countertransference, and the therapist's therapeutic role and neutrality are tested' (Anastasopoulos and Tsiantis, 1996: 18). Hoxter (1983) published a useful paper that relates the countertransference to the nature of the child's deprivation, though without explicitly considering domestic violence.

The non-analytic literature on domestic violence suggests that there has been little research undertaken into its effect on young people, but there are indications that countertransference difficulties can influence the approach of social workers and other professionals (Imam, 1994; Mills, 1998; Singh, 1999; Bell, 2000). For example, there can be a tendency to minimize the impact of violence 'except when the risk of direct physical injury to a child was identified' (Ashworth and Erouga, 1999: 75). The danger to children of a mother's behaviour – either her own violence or her response to that of men – can be missed in a focus on the role of the abusing male. Splitting is cited as a response to feelings of guilt, disgust and powerlessness. Everything bad might be located in the abuser, and everything good in the professional's own nurturing capacity. One consequence might be to overlook, or be disposed to deny, any possibility of positive parenting capacity in the perpetrator, or in the victim's relationship with him (or her). There are particular problems encountered in dealing with the issue cross-culturally: there can be a tendency either to pathologize or idealize family structures in particular cultures, or to jump to readily available stereotypical explanations rather than learn the details of a specific case.

Versions of all these difficulties could easily arise within the context of psychotherapy, suggesting that a useful prophylactic might be wondering how violence, as a factor in the patient's family background, affects the transference and countertransference. This must be particularly important for a treatment which is, in large measure, concerned with utilizing these aspects of the therapeutic encounter. It is fundamental to a psychoanalytic approach that critical elements of formative interpersonal relationships are recreated in the transference, and the analytic clinician is alert to wondering which aspect of internalized object relationships might at any particular time be metabolized within the person of the therapist. There is controversy as to how this occurs, but this is not the present concern. All will concur in the contention that where a patient has undergone traumatic experiences these mechanisms of displacement and re-enactment will be especially anticipated, whether we are thinking of singular experiences which have cut across a person's otherwise healthy development, or the cumulative impact of abusive patterns of relating that have characterized a patient's family culture. We would anticipate particular consequences for the handling of aggressive impulses, and be alert to the potential for elements of 'acting in' to appear in the work of the therapist.

Violence affects the processes that lead to the internalization of self-object representations, representations of the self and the maturation of ego functions. It disrupts reality testing and can result in defensive developmental delay. Some of the damage may be fairly easily perceived, but some may confuse and distract the therapist, as is suggested in the following example.

A 15-year-old girl was referred for depression. At the time, she and her mother were living in a refuge, a place to which they had fled from the last of a succession of violent men. She belonged to a family where relationships had, for generations, been characterized by violence perpetrated mainly (though not exclusively) by men against women. The girl presented in all observable respects as a latency child – open, charming and without any sign of having engaged with adolescence proper. She demonstrated a surprising resilience that faltered only when she approached the subject of the tenuous and one-sided relationship she maintained with her distant birth father. I warmed to her: she was the kind of child you find yourself daydreaming about adopting, rescuing. She used the sessions well; I felt good about the work. In relation to her I remembered the idea that to use an object constructively a patient must have had some good experience of a nurturing object in their early years. This was reassuring too; after all, I had no reason to doubt that she would have made the most of what loving parenting had been available to her. One recurrent theme in her material, however, among the indications of a determination to make the best of things, was that of despair, and, in particular, despair at ever knowing love or safety with a man. 'You can't trust men,' she said, because all the men who had beaten her mother and herself had started off seeming so nice.

Whilst in the consulting room I hardly noted the irony of this, so comfortable did I feel in the sense that I was providing her with an opportunity to experience a different kind of object. After all, I *was* different to those brutal and frightening men. It was sometime later, and with a prickling feeling down my back, that I suddenly realized that her openness to me might reflect not her appreciation of the relative safety of the therapeutic relationship, but rather reveal the way she might idealize, and make herself vulnerable to, any man who 'took her up'.

In the case cited above there was a paternal aspect to the countertransference: she made me feel strong and important, and there was a sense that we were both safe from the men who had hurt her, who were far away in another part of the country. The therapist is, I have found, subject to a decidedly less ego-syntonic experience where the patient is herself living in fear. Where a younger child is being hurt some of the burden is shared with a multidisciplinary network, and lifted through the operation of clear procedures that have to be followed and which are designed to ensure the child's protection. The situation is more complex where, as in Marie's case, a young woman in her early twenties is the patient.

At our first meeting, Marie described a life of drudgery and abuse, where she was still subject to sexualized verbal assault and physical attack from the males in her family. I was unprepared for the force of my reaction to having to bear witness to ongoing humiliation and hurt. I was outraged, and enraged with everyone involved; I was shattered at my own impotence. The patient appeared to be at one and the same time a cauldron of seething resentment and hatred, and a pool of hopeless resignation. She found relief from the unmanageable combination in a range of secret self-destructive behaviours. Bearing witness meant a great deal to her – 50 minutes a week where she sought some confirmation that it was not she who was mad.

The patient was isolated: her mother, the only other female in her life, advocated submission and patience. Simply by coming to therapy there was a strong sense that she was subverting a family culture in which she seemed to be perceived by those in control as a degraded belonging. I found myself feeling anxious lest the brothers should realize how subversive the therapy might be, wondering what retribution they might take in order to retain control of their sister. I could not be clear whether I was simply picking up on her fear or whether there was a realistic possibility of being targeted.

Sensing my own vulnerability, or confusing mine and hers, was not the only intrusion of family dynamics into our relationship. Passivity and fatalism were a potent mix, which regularly exacerbated the already terrible situation in which she found herself. My response to her apparent determination to make the worst of things and see only others' responsibility for her difficulties infuriated me beyond measure. There were definitely times I had to contend with impulses towards her that, I am sure, were akin to those to which her father and brothers gave uninhibited vent. In one particular session, where she described having almost connived in being robbed, I know these feelings were reflected in the tone and abruptness with which I addressed her.

My initial horror at the violence in Marie's life was, in time, aggravated by another fear: that I was somehow enabling her to perpetuate a life of terror, insults and exploitation. In the event Marie seemed interested in finding a way out of her situation, and as I was keen to support her efforts to move, it became – I think in both our minds – a primary goal of our work to enable her to begin a life apart from her family.

With her agreement I supported her application for housing, and her contacts with Social Services. Very slowly and in great secrecy the possibilities were explored. After many months and a number of setbacks (in which Marie's need to find people in authority to punish and frustrate seemed to play a part), this approach seemed to bear fruit. She was offered a flat, viewed it, and was about to accept it when a letter sent by the Housing Department was opened by her mother. I received a phone call from a distraught patient saying that she would not be able to attend any longer as she had been forbidden to do so. Her father had arranged for her to live with an uncle and aunt several hundred

miles away, and she would be leaving imminently. My approach had been an attempt to resolve a dilemma, but the outcome had been to deprive her of the one relationship that had served as a witness of her physical abuse, a place she had begun to use to talk of experiences of sexual intrusion, which had confirmed her fragile sense that what was happening to her was wrong and that had held out hope of some alternative future.

With hindsight I consider that a sense of competitiveness with the men in her family – to prove that I was potent in some constructive way and to shove feelings of powerlessness back onto them by levering her away from her dependence on the family – might have been an active element in my approach. Reflection on this piece of work has gone through various phases, in which I have realized a tendency to think of the patient as more passive than she was, as if I were doing things to her rather than working alongside her. Somehow, the interplay of aggression and victimization is inseparable from my memory of attempting to provide a therapeutic space to this young woman.

There is also something in this example about the therapist being idealized but impotent. This might be seen as a form of attack on the therapy or therapist, and certainly I believe that these patients teach us a great deal about passive aggression. But a more significant aspect might be the actual recreation of a situation of seeking help from somebody who is too weak, or frightened, or neglectful to be protective or containing. If a once-weekly, 50-minute dose is inadequate to the task, through the therapeutic alliance, of enabling patients to regain a sense of agency, it might be said that they have found an object which is, objectively, impotent and neglectful. Patients, then, are left to perpetuate abusive and destructive relationship patterns in the external world, and therapists find themselves in the intolerable position of having to watch, powerless, as their patients continue to suffer degradation.

In a similar case, I tried to cope with this by crushing any concern I had for the patient. In this attempt not to be affected by the assaults to which her body and mind were routinely subject I was striving, consciously and in vain, to disassociate, a defence that the patient used unconsciously and to great effect.

Although we might anticipate that a violent upbringing will be reflected as an aspect of the therapeutic encounter, it will do so in varied and unpredictable ways. Repeatedly, I have been surprised at the force of my own feelings of irritation and impatience, sometimes resulting in their finding an outlet in the nature and manner of the interpretations that I have offered to these patients. The patients themselves, on the other hand, have all appeared compliant or quiescent, never overtly hostile or particularly 'difficult'. Through my work elsewhere I know that this is not always the case; perhaps too powerful an identification with the aggressor diminishes a motivation for change, and renders the subject unable to make use of a traditional therapeutic treatment.

They can be thrown back on the need to dramatize in the external world the terror and violence of their lives, requiring a different kind of holding environment. For the young people described here, however, it seemed that they had grown up not only terrified of other people's violence, but also unduly afraid of their own aggression. One isolated young man who had been bullied at home and school, and who had resorted to substance misuse and self-mutilation, would smash mirrors and thump brick walls; but in 18 months of work he never once looked me in the eyes. Again, this left me with a sense of power, but we came to see that it was in fact his way of protecting me from a violent anger that he was convinced would destroy me or our relationship were it ever expressed.

A more complicated transference emerged in the relationship with a young man, David, which mirrored something of the contradictory nature of his experience of parental care, as well as his defences against it. He valued his parents and felt loved by them, and was grateful that they had nurtured and encouraged his creative talents. His mother, however, suffered from chronic depression, and his father had been prone to sadistic and unpredictable bouts of violence against his son from an extremely young age.

In his social life, David described a number of long-standing friends who regularly responded to him as if he were a lost and needy child requiring their love and protection. My initial feelings towards him were equally warm: there was something innocent and charming about him. He did not appear to identify at all with the battered child, even when telling me of his history: he seemed more inclined to joke about it, and to invite me to share a profound bafflement that such things could have taken place at all. I was confused, almost taken in by his sense that he had come through it all pretty well and that he need not dwell too much on a past that did not seem clearly linked to his present predicaments.

Some months into the treatment, David began a period of sustained promiscuity, taking a passive role in anal intercourse with a succession of strangers. Condoms were used only if his partners insisted. This had been a recurrent pattern, and over the years there had been scores of unsafe encounters. Week after week he would recount (without any apparent erotizing of the transference) a series of deathly, anonymous sexual encounters. This was the first indication of how he might have dealt with living in a near-death situation at home. It emerged that his primary fantasy was of being raped and abused: he knew that his body language towards his sexual partners was such as to communicate that he could be used as they liked. Here was violence, but so incorporated into erotic self-expression as to have been rendered wholly ego-syntonic.

My sense of being useful, and of wanting to nurture David, gave way to frustration. Interpreting what I took to be the murderous and suicidal meaning

of his behaviour had little impact. Perhaps we should think of these repetitive reports as a form of assault, from which I needed to protect myself, or push back at him. In any case, in my frustration I found myself becoming bullying, forcing the reality of what he was doing to himself down his throat – perhaps shafting him with it would be a more appropriate metaphor. At times I experienced an overweening potency, freed from restraints to trounce the patient with my responses to his material. Clearly, re-enactments were taking place both within and beyond the transference. I had noticed how each time he entered the consulting room he would first give me a frightened or surprised look that I had thought of as a rather dramatized expression of his anxiety at our re-encountering one another. But I came to view it as displaying his anticipation – his unconscious hope – that I might beat him up. There was a definite sense that when something of that quality entered the relationship he was more satisfied than when it was absent. He ended one session in which I felt I had been more than usually muscular by commenting, 'Now it feel as if the work has begun,' and, 'This is what I thought therapy would be like.'

For months we continued in this way. David became more regularly safe, although when he wasn't it was my anticipated reaction that worried him, not his or his partners' health. Eventually, however, there were signs that significant changes were taking place. He began a session saying that he had been buggered the night before in a pub toilet, without using condoms. David said this in a tone that allowed me – for the first time – to comment on how appalled he felt at his own behaviour. In this sense, a shift had already occurred. In some attempt, it seemed, to expiate his sin (his guilt in having to confess this to me) David assured me that the idea that he might catch HIV had occurred to him prior to penetration, but, as the other man was only about 18, he thought it was unlikely and he had put the thought out of his mind. This was the point that induced a profound reaction in me. Utterly incensed and, I think, strongly identified with the other young man's parents, I said, 'You were able to think that he might kill you, but you couldn't let yourself think that you might be killing him.' David reeled as if I had struck him. His demeanour and expression became pathetic and bewildered. I pressed home, 'It is unlikely, of course, that it would ever be your own son who would be at risk here, but I suppose it could one day be the son of one of your female friends.' As well as this – rather irrelevant – broadside we more calmly explored what had been so vividly illustrated in this encounter: the sociopathy inherent in the behaviour, the way that each of these men and the culture of which they were a part had somehow blinded them to an element of reality that was essential if either of them were to be safe. The perversion of the act of love into one of destructiveness could not have been more apparent.

The following week David had his first HIV test. On being told that he was negative he had a panic attack, and in the next session described how he had 'known' that he had been positive for the last three years and that he did not

know how to cope with being healthy. (The negative result was confirmed three months later.) But David was determined not to put himself at risk again, and he knew now that he needed help for something other than facing the fact that he had an incurable disease, although he did not yet know what it was that he needed this help for.

The work had entered a new phase. Sensations of fear now pervaded other settings – at work, in relation to the people with whom he shared a house, and in the transference. But none of them was sexualized, or ego-syntonic. Some months further on David began remembering and re-attaching memories with their affect, allowing an identification with himself as a child.

Is there any difference in quality between transferential and countertransferential experiences, where the problems with aggression are taken to be internally generated, and where they seem to result from specific external relationships that involve assault, of whatever kind? I am sure that there is a difference, although what part the therapist's own emotional reaction to the knowledge that the patient has been or is still subject to violence is itself unclear. Psychoanalytic literature abounds with quite extreme terms for emotional pain – 'nameless dread', 'fear of annihilation' – when referring to internal states of mind: it is difficult to imagine how the presence of an external danger could make matters much worse. Yet, we see these internal states as being made tolerable ordinarily by the consistent presence of a containing attachment object, whose behaviour belies the paranoid fantasy and whose survival allows the internalization of a secure good object. A different order of isolation and desperation would be expected to follow where those on whom the child is absolutely dependent actually hate, and prove themselves unable to contain their own violence, let alone that of the child in their care. So, this difference in the quality of the countertransference might relate to this; namely, that we now do not find ourselves participating in a regression to a state of dependence upon a benign object, something which normally accords with our conscious and unconscious representation of our role, and which can reinforce our confidence in our own internal goodness. We find ourselves, rather, in the face of something altogether more malignant and naturally feel a desperate need to avoid the horror, to keep hold of an idea of hope – something other than the real isolation and hopelessness that underlies the patient's primary experience. Undertaking clinical work with people still undergoing violence, as described in the two examples above, poses further challenges for those trained to focus, to the exclusion of other extraneous 'noises', on the inner workings of the transference.

As reported in the Introduction, the social work literature highlights the way in which workers' defensiveness can hinder effective work with this patient group. Bell (2000) comments that research with social workers 'revealed a preoccupation with procedures for interagency co-operation which left little capacity . . . to work with the families' distress' (Bell, 2000: 270). She says

further that 'professionals split defensively into factions', and perhaps my attitude towards the Home Office, in the final vignette described below, contains something of this about it. It was salutary to read Hoxter (1983) on the defences employed by therapists not to feel the pain of deprived children, particularly her comments on anger as an evasion (Hoxter, 1983: 127). To be confronted with impotence (and perhaps the real limitations of therapeutic work) can be intolerable, and might induce a compelling need to act outside the normal boundaries of therapeutic work, perhaps to become involved in attempts to change the patient's external circumstances.

But are there other ways in which we employ professional or organizational defences – as opposed to personal ones – against knowing about domestic violence? It has been suggested that 'agencies working with violent people reflect this violence in managerial and work cultures which are oppressive and patriarchal' (Bell, 2000: 270). There are occasional examples of abusive responses (like 'pindown' and children's homes that become networks of abuse), and I have experience of staff in residential settings on occasion adopting rejecting and vengeful attitudes in the course of their engagement with young people in their care. This does not seem an element of the culture of psychotherapy, or of psychotherapy services with which I am familiar: but perhaps it is worth wondering what defences we might employ in the face of these awful realities.

For psychoanalysis, traumatization is an internal process. We – in effect – traumatize ourselves through our responses to what happens externally. Writing about trauma highlights many different aspects, but generally focuses not so much on the external event as on the way the subject experienced and understood it. There can be an emphasis on whatever pre-existing constellation of internal object relationships might have predisposed a subject to experience a particular situation as traumatic. Or we might highlight the patient's disturbed emotional response to trauma, and the damage that has been done to psychic functioning and the capacity to think. I wonder if, at times, our approaches might allow us to follow a theoretically sound and even clinically valid aspect of the patient's internal world while selecting those insights that allow us to keep a distance from these experiences as unsymbolized and impossible to assimilate. It may be that to insist on retaining a confidence of being oneself a good object in this way could involve abandoning the patient to the horror, and, as ever, there is that paradox that somehow feeling hopeless and useless may be a necessary prelude for patients to be able to feel something other than despair. Rosenfeld (1987) refers to this when he describes how traumatized patients, who have had to cope on their own and had to adopt 'severe defensive reactions as denial, splitting and depersonalization', when they seek analytic help expect the clinician 'to share the terrifying experiences which are quite unbearable for him' (Rosenfeld, 1987: 36). Unconsciously, patients often try to

involve their analyst in their experiences by very forceful projections, sometimes so violent that they appear to be attacks on the analyst and his or her work. This is a painful and difficult situation for analysts to bear, and one which might induce them either to seek to evade the experience by interpreting their patient's aggression or by offering not analysis but a corrective emotional experience.

In the collection of papers *Countertransference in Psychoanalytic Psychotherapy with Children and Adolescents* (Tsiantis et al., 1996), there is an interesting contrast between the majority of articles based on individual analytic treatments and the one by Tsiantis about work in an inpatient unit. In an article by Anne-Marie Sandler, for example, about individual work, aggression in the child is viewed as a reflection of the strength of internal aggressive objects whose power reflects 'identification with an *internal* aggressor' (Tsiantis et al., 1996: 77; emphasis in original). The parents' passivity and helplessness, and their inability to set boundaries, are seen as the external pathogenic factor, leaving the child with internal persecutory feelings and fearful about his own aggression. In the article about a therapeutic inpatient unit, on the other hand, there is an assumption that violence of one kind or another was a central part of the young people's *external* experience. Tsiantis (1996: 138) recognizes the role of unconscious fantasy and the way that external events seem to validate and reinforce fears that were previously contained. However, the reality of the external is also given much greater therapeutic importance: there is a real aggressor with whom to identify; actual parents' defences to internalize; a situation that undermines trust and makes much more dangerous the question of how the child is perceived by the parents; and actual interpersonal experiences to re-enact. One consequence, then, is the expectation that direct and real abuse is likely to result in more acted-out violence, sometimes to the extent that a young person will need a containing environment to open up again a space for thought between feeling and action.

If a defining characteristic of domestic violence is the curtailing of space between feeling and action, the simple experience of being with a therapist who sits, listens and does nothing has perhaps a significance that we might not automatically appreciate. As Hoxter (1983) writes, warning against the temptation to indulge one's hatred and anger towards the family or other professionals involved in a child's care: 'It may even be harmful if the child comes to realise that the adult is not containing anger but is passing it on to hurt others and is perhaps repeating a pattern of quarrelling parents and family breakdown' (Hoxter, 1983: 127).

So, tolerating these particularly trying countertransference reactions would in itself, perhaps, be highly significant for the patient, in terms of finding an attachment object upon whom the patient depends who does manage to contain his or her own impulses to act in the face of aggression, frustration or

any kind of psychic pain. Most of the patients described here had extreme difficulty tolerating any depressive feeling or any situation that made them experience their vulnerability. Some went through periods when they would leave the session if staying threatened their steely but brittle emotional indifference to themselves.

Another point that has been repeatedly confirmed over the course of time is that the experience of domestic violence cruelly burdens victims with deep anxiety in relation to their own aggression. Each of these young people lived in fear of their own violence, as well as that of anyone else's, and they have insoluble dilemmas about what to do with their own rage.

I have recently been working with a young woman whose solution was to provoke her boyfriend to attack her, a situation that she describes with a placidity which completely disappears when she describes her own impulses to attack those around her. From the frequency with which patients worry about finding an acceptable method of dealing with their rage and aggression, I can only suppose it must be present as a problem within the transference, even when it is not readily apparent, and that enormous energy is then used up controlling it. I suspect that I have missed this on many occasions, so careful are such patients to disguise the negative transference. This can cause serious problems during termination, where the rage at the experience of loss and abandonment can result in an intensification or return to self-destructive patterns in the patient's external world, and which did cause two of the patients mentioned in this paper to break off prior to a planned ending.

Although deeply personal and private – even in institutional settings – our work constitutes a part of society's response to problems that arise in a social context. There is a question of the degree to which we need to know about that context, a question that comes up with particular force when we are working with refugees and victims of abuse from cultures other than our own. As well as this issue of contextualizing patients' interpersonal experience, there is perhaps a need for us to think about the social construction of the countertransference. As already suggested, the presence of concurrent and ongoing violence impacts upon the countertransference in a terrible way: the therapist trained to deal with the most vicious internal defences can still be rocked by encountering external realities which might be just as vicious, and outside the control of either of the therapeutic couple. A particular complication arises, I think, when the context of the work becomes intertwined with the aspects of the social identity, if this is the right term, of the therapist.

Anna grew up in the shadow of the violence perpetrated by her alcoholic father on her mother and herself. As she entered adolescence, war provided further terrifying experiences, leading eventually to the family's seeking refuge in the UK. Over many months, a picture was built up of a young woman with severe problems relating to her own feelings, with an intense fear of intimacy, burdened with a bleak and despairing outlook on her future. However, the

primary obstacles to her making fuller use of the therapy were the constraints imposed upon her as an 'asylum-seeker': she could not separate from her parents, earn money or begin her education. A childhood of domestic terror and an adolescence wasted in the bleakness and fear of war had been followed by a void in which she was being prevented from establishing any effective basis for a meaningful adulthood.

Many of our sessions took place in silence; Anna could not cry, and could only laugh when in a cynical and detached frame of mind. It was difficult to see what she might be gaining from our meetings. I felt threatened by intense feelings of helplessness, but also of anger at the unnecessary waste that resulted from the restrictions under which she lived. With hindsight, I can think that my helplessness probably had various sources: an identification with her situation, perhaps also a response to her passive aggression, expressed in her refusal to engage in a therapy that might have been useful to her. I also think that it may have been important for her to be with a man who did not respond to his helplessness, and who contained his rage, without resorting to physical violence. But a significant and unusual aspect here, delivering something of a shock to the therapist's equanimity, was to be identified with the perpetrator, not in the mind of the patient but in his own mind. There is a parallel, perhaps, to the shame one might feel passively watching 'one's country' go to war, again. The slogan 'not in our name' is, I suppose, an attempt to distance ourselves from guilt, rage and impotence. So successfully have I been socialized into an identification with this society and its institutions that I find it difficult to face the human consequences of its asylum policy without feeling directly responsible. One could say that the therapist is in the position of having a patient mirror back something horrible about himself. The rage I felt was not hers, but the consequence of what I experienced as an internal conflict of my own, between my implication in her abuse and my having placed myself, through working as a psychotherapist, in the position of having some awareness of its consequences. Yet this is more appropriate to form the basis of a statement of solidarity or an admission of shame, rather than a transference interpretation. It is a good example of an 'idiosyncratic countertransference' (Giovacchini; cited in Anastsopoulos and Tsiantis, 1996: 4), from an orthodox viewpoint deriving from an inadequately analysed therapist whose own conflicts are interfering with the work.

I desperately wanted Anna to come in feeling hopeful, reporting something positive that 'we' had provided for her. Instead I had to witness her demolition of herself as a person, while finding no basis on which to establish that there were any other options open to her. Hope, expectation and self-regard were simply too expensive to be considered. Significantly, a court decision to grant her asylum (though subsequently challenged by a Home Office appeal) led to a rapid development of the work, including the first eruption of anger at my incompetence and insensitivity. Much more difficult for me was a session in

which, during a rather stilted interaction, she let drop the word 'torture'. I reeled as the possible implications – my fantasies of what this young woman might have been through – deluged my mind. I struggled not to reveal just how upset and shaken I felt; that I was upset and shaken was evident. Many months later – by now in many respects in more secure circumstances – she revealed that she had lied to her boyfriend, having told him that she had been raped. She could not understand why she had said it, except that it provided an excuse when she did not want to be intimate with him, and a rationale for the instability and hostility to which she exposed him. Tentatively, I wondered if her mention of the word 'torture' was of a similar order and with deep shame she admitted that it was. The only sense we could make of these 'lies' was that there was no direct way in which she could engender in those she was close to any sense of the impact of her father's violence: what had been a secret nightmare could only be conveyed by transforming it into a public, acknowledged crime.

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CLASSICS REVISITED
Sydney Klein, 'Autistic phenomena in neurotic states'*

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Introduction

Sydney Klein's paper was included in the memorial to Wilfred Bion, *Do I Dare Disturb the Universe*, edited by James Grotstein and published in 1981. Many of the contributors to this substantial volume had had close and personal experience of Bion's thinking, either as analysands, supervisees or friends. Whilst all felt indebted to and inspired by him and his work, the range and variety of the papers offered revealed an influence that encouraged diversity and individuality. To use Grotstein's words, Bion's approach to psychoanalytic understanding was an injunction 'to go one's own way, with Truth as one's North Star, Honesty as one's navigator and Imagination as one's rocket fuel' (Grotstein, 1981: 35). Grotstein's exhortations are fully realized in this paper by Sydney Klein.

Klein's paper appeared in the *International Journal of Psycho-Analysis* a year before its publication in Grotstein's volume, at a time when psychoanalytic interest in autism was being stirred by the developments in thinking, and working, with autistic children occurring in this country and in the USA (Kanner, 1943; Bettleheim, 1967; Mahler, 1968; Tustin, 1972, Meltzer et al., 1975). His interest in autism would, doubtless, have been augmented during his time as a consultant at the West Middlesex Hospital, where he held medical responsibility for the patients of child psychotherapists, among whom was Frances Tustin, who worked there for a time. They had in common a deep appreciation of Bion and his work: he, influenced by the latter's teaching and writing; she as one of Bion's analysands. It is this link with the work of Bion that it is important to preserve, and to which I would like to return in this review.

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Klein's paper was a serious attempt to integrate the phenomena of autism with his own psychoanalytic experience of impasse with particular patients whom he otherwise considered to be only mildly neurotic. He also saw the relevance of theories which imply disruption of the sensory apparatus, the prerequisite of thinking.

The patients Klein refers to were well-functioning, often successful and highly intelligent adults who, at the same time, disclosed areas of their personalities that were almost impenetrable to emotional contact. He found them particularly resistant to change, largely because of their failure to take in interpretations. Klein was the first to propose a link between these manifestations of cut-off areas of emotional encapsulation and the states being described in the treatment of autism. Whilst exploring the possibility of such a link, he did so in full recognition of the intrinsic technical problem involved, which called for close attention to the precise nature of the transference, that is, how to make contact with 'an almost impenetrable encapsulation of part of the personality, a mute and implacable resistance to change, and a lack of real emotional contact either with themselves or the analyst'.

Unfortunately, Klein's paper has been cited more in relation to its title than its important content, and his reflections on the relationship between autistic phenomena and Bion's concept of alpha and beta functioning, have rarely been developed in further exploration of the interface between psychotic and autistic phenomena. For the last two decades, Klein's concept has been widely borrowed (sometimes stretched to breaking point!) in a loose application to a variety of clinical observations. Autistic 'objects' and phenomena have been presented as explanations for a gamut of clinical problems in a way that seems to dismiss the inherent contradictions associated with the impermeable character of such phenomena. Frances Tustin was impressed by Klein's paper, and she added momentum to his notion of autistic enclaves in neurotic patients by adopting most of his title for her third book, *Autistic Barriers in Neurotic Patients* (Tustin, 1986).

In this work, Tustin gave prominent support to Klein's concept in a reconsideration of the dynamics underlying conditions such as anorexia and psychosomatic and phobic disorders. However, the substitution of the notion of a barrier for 'impenetrable encapsulation' has led prematurely to ideas of removal of an obstacle and consequent restoration of functioning; attention to the depth and intractability of the characteristics identified by Klein now tend to be glossed over, if not disregarded.

In a science deriving directly from the philosopher, Kant, who declared that all knowledge of the world begins from experience, which rests on the evidence of the senses, Freud and Bion taught us that development of the capacity to think precedes its expression in language. In Bion's theory, thoughts evolve from the transformation of sense impressions and intuition, and require the institution of a mind as an organ for thinking the 'thoughts without a thinker'. Linking the phenomena of autism with what Bion had to say about the

evolution of human thinking processes, the essence of Klein's thesis lay in the evidence he saw for Bion's theory of fragmentation and projection of the sensory apparatus (the prerequisite of thinking) and the destruction, therefore, of thinking, *in statu nascendi*. Klein was careful to differentiate these impenetrable states from others, described as 'psychotic islands' (Rosenfeld, 1987) or 'false self'(Winnicott, 1958), as he attempted to open new ground.

The attendant difficulties of adopting a new paradigm in relation to interpretation and the transference are also apparent in this paper as Klein struggles to understand the sessional material in new ways. Time and again, he continues to use (Melanie) Kleinian interpretations, directed at subject–object fantasy content, despite his thesis that inability to take in interpretations is the crucial problem! Klein's detailed presentation of the case material, however, gives us an opportunity to observe the outcome in relation to different interpretive approaches; we are offered evidence of clinical effect in the patient's own responses.

From the beginning, Klein set his contribution in the context of Bion's discovery of a psychotic kernel lying concealed in every neurosis (Bion, 1957). In his opinion, every psychoanalysis needed to engage with this psychotic aspect of the personality underlying neurotic patients (and probably so-called 'normal' patients, too) for real understanding and integration of the self to take place. In 1980, Sydney Klein felt that the full significance of Bion's writing had still not been fully recognized by the psychoanalytic community, and, with this paper, he offered his own clinical experience as evidence in support of Bion's theory. As already observed, Klein's argument is made less easy to follow because he, too, is beset by the problems involved in relinquishing old paradigms in order to adopt the rigours of Bion's new psychoanalytic technique. Twenty years on, the significance of Bion's contribution to thinking about human thinking has yet to be widely comprehended in relation to its transference implications.

Autistic phenomena in neurotic states

Reviewing his psychoanalytic practice, Klein introduces patients in whom he has identified a cluster of features which he linked with the phenomena found in the treatment of children with autism. These were patients whom he considered to be well endowed, successful and hard working. They were clinically co-operative, regularly relating dream material and reporting improvements in their lives and relationships. Despite such an impression of psychoanalytic progress, he was left, he said, with a feeling of being out of touch with the patient, and with a suspicion that 'no real fundamental changes were taking place'. Klein began to have the feeling that there was an 'impenetrable cystic encapsulation of part of the self which seemed to be cutting the patient off from the rest of her own personality and from the analyst'. The most common manifestations of this encapsulation were conveyed by a thin, flat

quality of feeling, coupled to a desperate and tenacious clinging to the analyst as 'a source of life'. As if in contradiction, there was also a pervasive mistrust of, and a constant expectation of hostility from, the analyst, who was idealized as powerful and omniscient. As a result, the analyst was closely monitored for any hint of irritation or disapproval of the patient, which might be detected in facial expression or tone of voice. The patient's material was interesting and relevant, but, although topics were pursued relentlessly, they were never worked through and Klein attributed this to failure to take in interpretations. He compared the rigidity of his patients in this respect with the compulsive, repetitive play of autistic children, who resist all attempts to intervene. At other times, Klein found that these patients could also drift away from the dialogue in a manner reminiscent of the autistic baby, who slips out of the maternal orbit.

In the preamble, Klein also adds some interesting remarks about the dreams of these patients. His comments are brief and generalized, but there is a suggestion that he observed changes in the dream content after he began to draw attention to these 'autistic' encapsulations. Patients began to dream of being inside walled towns, stone buildings or fortifications. Images of crustaceous creatures, such as cockroaches, armadillos or lobsters were more frequent, and Klein likens this to Tustin's (1972, 1981) 'shell-type' child, seeing identification with such creatures as an advance on projection either into the body as psychosomatic symptoms or into other people.

Case material: 'a hard nut to crack'

A detailed illustration of Klein's argument is presented in an account of his understanding of a patient with a history of cystic inflammation. Klein continues his main thesis and offers some convincing evidence of the aptness of the notion of impenetrability. Sometimes, however, the strength of his argument gets lost in a welter of [Melanie] 'Kleinian' interpretations, more relevant to object-relatedness than impenetrability, and this will often confuse the reader. Nevertheless, it is in the honesty and fullness of the process recording that we are treated to verifications of Klein's (and Bion's) hypotheses, which come straight from the mouth of the patient.

The patient is a rather detached woman, who consistently claims that she has no feelings about breaks or weekend separations. After the second holiday break, she suddenly developed acute abdominal pain and had to be rushed into hospital. An inflamed ovarian cyst was discovered, and this had to be removed. Before the second holiday break, the patient developed an acute swelling in her breast, which was operated on and diagnosed as an acute cystic inflammation. Despite the operation, the patient continued to experience pain and swelling in both breasts. Following the clinical material, Klein understands these swellings as omnipotent appropriation of mother's creativity, by projective and introjective identification of her mother's creativity, and he supports this with dream

material in which the patient describes having two swellings on either side of her body. She associates the dream imagery with having been sitting between two pregnant women at a dinner party. This was followed (we are not told how) with fantasies of attacks on 'the goose that lays the golden eggs'.

At other times, the patient's fears of losing her self-confidence were represented in her mind by the collapse of a brick structure, and Klein ascertains that this is primarily due to fantasized attacks on the binding cement, which the patient associates with semen. From all this material, Klein perceives fantasized attacks on the creativity of the couple, who are not allowed to come together in her mind. Even though the patient might accept such interpretations, Klein found no overt evidence of hostility, nor, indeed, of any emotionally toned response, in the consulting room. This led, inevitably, to comments and interpretations about the lack of real emotional contact in the analysis, and Klein describes two dreams that were reported after his remarks.

The dreams were presented in a Monday session. In the first, the patient is driving up a hill in a red car. Her association to this is that when she is without the analysis at the weekend, she stops going forwards and feels like a child. In the second dream, the patient is lying in a hospital bed in a room with her mother there. There are cockroaches in the room and her mother is very angry with the nurse, whereas she, the patient, is quite calm. Her association to this dream was of a similar real experience in adolescence when she was hospitalized for the removal of a dermoid cyst. When her mother visited, she (mother) had been very angry with the nurse because she could not tolerate anything dirty in the room.

Klein continues to interpret with reference to the patient's feelings about him but the patient continues with associations to another experience of cockroaches involving a girlfriend. Klein then uses previous information given about this girl – that she has recently started an analysis – to introduce more interpretations about his patient's feelings of jealously and rivalry in relation to fantasized analytic siblings. This, to a patient whom he sees primarily as (a) out of touch with feelings and (b) unable to take in interpretations. The patient's response finally brings illumination.

The patient complains that her analyst has said as much before, but that she cannot see it: 'I must be blind,' she says, turning the blame on herself. The patient then goes on to describe how furious her husband gets with her for not taking things in, and adds, 'I must be a hard nut to crack!' Klein's mind is on adhesive identification, projection into cockroaches or into the dermoid cyst, where the whole process can be cut out, but, in the following session, the patient offers another image – the hedgehog. The patient says that when she feels under attack – and there can be little doubt that she experiences the analysis as an attack – she feels she can protect herself, either by shooting out her quills or by collapsing inside herself. This is the patient's defence, and it largely explains the cut-off impenetrability that Klein has particularly identified. Nonetheless, we see him, at this point, still tied to the old paradigm,

and he interprets her 'protection' as a projection of hostility. The patient responds by referring to a father who didn't give her enough attention and who 'kept battering her with lectures'. She recalls how he always kept passing her over to mother when she telephoned home. We may be tempted to suggest that on several occasions we are witnessing Klein handing the patient over to the constructs of Melanie Klein when he loses sight of his own.

Resolution arrives when Klein is touched by the patient's account of the hurt and disappointment she suffered at the hands of a rather insensitive father, and he interprets her disappointment in him. This, she vehemently denies, clinging to an idealized image of her analyst as always kind and attentive. It is when Klein finally interprets the central dilemma – the hedgehog reaction – that she cannot receive anything from him without also feeling persecuted and deeply fearful that contact is reached. The analyst is suspected of being a cruel and treacherous Stalin, pretending to be genial, but, in reality, murderous.

This then led to material that began to cast more light, not only on the patient's problem of how to take in understanding but also on the interpretation and where it needed to be directed to facilitate the process of taking in. There are two dreams to be explored. In the first, the patient's husband is talking on the telephone to a young girl who is staying with them and she, the patient, cuts the wire. Once again, Klein's first interpretation is a traditional Kleinian one, taking up jealousy and, in the transference, analytic sibling rivalry. When the patient replies that she does not understand this, Klein adds the vital link, which not only sparks life in the patient but brings Klein's own thesis to life. He shifts the perspective from a subject–object paradigm to the intra-subjective field, explaining that the patient cannot understand because she is also cutting an internal link between a dependent needy part of herself and her intellect. 'I do understand that,' she says. To illustrate this, the patient says it is like being in a boat and cutting the ropes that are pulling her ashore; in other words 'biting the hand that feeds', or 'killing the goose that lays the golden eggs'.

Klein ends his presentation of this treatment history by returning to a discussion of the concomitants of experiences of non-containment, which he sees as underlying the developmental experience of patients with these autistic-like enclaves. The body becomes a container for feelings that are experienced as sensory rather than emotional. Decision-making opens up a terror of engulfment by paralysing doubt because alpha elements and, therefore, thinking are unavailable. This patient revealed how she used the analyst's mind to avoid what she termed her 'doubt monsters'. Being faced with doubt would plunge her into what she described as 'constant hysterical action', and, although the patient could cleverly disguise this by referring to her 'pseudo-bravery', it was clear that what she experienced was a high-speed, out-of-control, flight from terror. The fear of becoming engulfed by these explosive terrors was further intensified by the counter fear of the alternative, an implosive collapse. The dilemma is spelt out by the patient when she describes her feeling of non-containment: 'I feel worse than an unborn baby,

more like a mindless dog' that can only settle when the master returns.

Klein compares the avoidance of fear of death and disintegration, which is a characteristic of the autistic defence, with the behaviour of this patient. Fragmentation of the sensory apparatus insures against awareness of the self, since alpha function is precluded. It is an attack on thinking *in statu nascendi*, since feelings are expelled before awareness of them, the more completely to defend against fear. In this case, the patient relies on the analyst's awareness and thinking, and feels mindless when she cannot cling to his mind. With fragmentation there often comes hypersensitivity of parts of the personality, and Klein mentions hypertrophy of speech as an example in this paper. Speech can also be used as a defence against underlying feelings of emptiness or, worse, non-existence. In such patients speech is used as a way to avoid a link, or to maintain a pseudo-link, with the analyst, rather than as a communication, and this is where the analyst may first become aware of the lack of emotional contact, which Klein has identified. Nonetheless, it is also an effective disguise for fear, and many analysts and psychotherapists may be led up the garden path before becoming aware of the hidden void that is being disguised. Klein finds real communication with these patients to be exceptionally difficult, and he warns that a great deal of anxiety may have to be lived through if penetrability is to be reached. At the same time, he is in no doubt that working to reach this goal will avoid many hours of 'lengthy intellectual dialogue' that will otherwise remain meaningless.

Discussion

What continues to hold interest in this paper is not so much the introduction of a new approach to the understanding of neurotic patients, as the painstaking re-evaluation and gradual relinquishing of old techniques that we are privileged to witness. The author is poised between two paradigms for exploring the analytic material and the transference. The understanding often assumed and appropriated from the title of the paper is by no means complete in the text. It is a paper that allows for new learning because we can revisit, with the benefit of hindsight, material that was breaking new ground in its time.

Klein's thesis is as important to clinical practice today as it was 20 years ago, and possibly more so, as clinicians find themselves faced with ever-deepening levels of mental disturbance, in particular among children. Klein was the first to make an important theoretical and clinical link between the behaviour manifested in the treatment of autistic children and certain features of the transference behaviour that he observed in his adult psychoanalytic patients. Areas of emotional encapsulation in the patient, which Klein found almost impenetrable to psychoanalytic interpretation, reminded him of Tustin's (1972) descriptions of children who seemed to live a shell-like existence, remote from emotional contact with others. Enclaves of inaccessibility are also well-recognized in the psychoanalytic literature, but are understood in terms of psychotic functioning. Rosenfeld (1987) described 'psychotic islands' in the personality,

whereas Steiner's (1993) ideas, developed around the concept of a 'psychic retreat', have found an established place in the literature, as have Britton's (1998) contributions on psychic development and the critical experience of a 'third position'.

All these authors write about areas of impenetrability in the personality and focus on the considerable technical difficulties experienced in the analysis of such patients. None has found a place in their thinking for enclaves of shell-like autism, but draw instead on the potential for psychotic splitting and projection to explain the encapsulation of 'psychic retreat'. Klein's patient puts it aptly when she describes herself as a 'hard nut'. When alpha function is precluded, the patient is stuck with concretization, unable to abstract. Absorption in sensory excitations per se, does not afford the autistic child emotional experience from which to learn so that development moves, according to Bion, 'in the direction of inanition'. In such cases, there is no distinction between a thing-in-itself and its mental representation, so that conscious and unconscious are undifferentiated and constitute the brick wall of incomprehension and impenetrability – the 'hard nut'. No longer is the task one of bringing conscious and unconscious awareness into focus to reach a sense of truth. The 'hard nut' of incomprehension has first to be cracked for that distinction to be recognized. While Bion recognized the existence of patients incapable of abstraction, his focus was on those with some, if inadequate, capacities for alpha function. He did not address the question of autism, but we can assume that such patients would be included in the category 'inability to abstract'.

Tustin (1972) described the child with autism as 'stuck in a sensation-dominated, over-concretised mode of functioning'. It means that psychical activity has not been sparked off by attaching consciousness to the sensory impressions in the way that Freud conjectured (Freud, 1911); the senses do not talk to one another to produce common sense. The patient remains in an untransformed, beta element world of undigested sensory facts. Alpha function is deficient, if not absent (Bion, 1962a), and this is why communication and comprehension become a primary issue in treatment. Mitrani (1992, 1993) has explored deficiencies in alpha function as a factor in psychosomatic disorder. In her 1993 paper, she reminds us of the distinction Freud drew between psychosomatic symptoms as a representation of repressed wishes (hysterical conversions) and organic symptoms, which he thought suggested unmentalized experience resulting from 'psychical insufficiency' (Freud, 1895). Klein's work has also been relevant to child psychotherapy in relation to psychosomatic conditions and the 'psychical insufficiency' experienced with psychotic children (Rustin et al., 1997; Rustin, 2001).

'Psychical insufficiency' has been graphically portrayed by Tustin to draw attention to the very different quality when lack of containment and alpha function prevails. Rather than fear of something, or someone, there is fear of

spilling out, floating away or falling into a black hole. Bion (1962a) calls this 'nameless dread' and Ogden (1989) uses the term 'organismic anxiety', conveying its existential nature and biological roots. It was enclaves of 'psychical insufficiency' that Klein noted in his patients' lack of emotional contact and inability to take in interpretation. This means that there are real implications in how to address the patient's problem. Difficulties are compounded by the fact that these patients are by no means mute or tongue-tied, and this is why Klein found that many hours could be wasted talking 'beside the point', as it were; that is, talking 'as if' the patient were taking in the conversation. This is rendered all too easy, in the way that evacuative speech, employed to fill the session, can seriously mislead the listener. As usual, Bion has had some helpful things to say about how to respond in such circumstances. The primary requirement is to become sensitive to the patient's state of mind rather than to be led by his narrative. Eschewal of memory and desire is the paradigm Bion advocated for all analyses, but in cases where there is felt to be 'an almost impenetrable encapsulation of part of the personality, a mute and implacable resistance to change, and a lack of real emotional contact either with themselves or the analyst' it is a lifeline for the therapeutic alliance. In cases where the analyst's interpretations begin to feel redundant, it is useful to remember Bion's advice that we can only give 'a second opinion'; a second opinion about the relationship the patient thinks he is making with the analyst. This may or may not be accepted or valued by the patient, but it is the fate of the second opinion that is of interest. As Bion (1987) once remarked in relation to a patient whom he found so boring he could scarcely stay awake, 'I began to wonder how he did it!' That is, the obstacle has to become a focus of curiosity. The task is no less daunting when, for example, a patient's experience is presented concretely, as both hopeless and immutable; a millstone to sink the most redoubtable psychotherapist. Just like the problem of evoking some spark of interest in the autistic child, the task becomes one of prising open some space in the patient's concretization to generate attention and the possibility of alpha function.

It is also easy to forget that psychoanalysis is still in its infancy and that therapeutic impasses such as Klein has tried to describe may also have to await developments in theory and technique. This paper is one of very few to examine the developmental origins of a clinical impasse by linking Bion's work on the evolution of thinking with autism and features comparable to autism in neurotic patients. The study of developmental psychopathology, as Klein has found, is as important as a contribution to understanding the course of normal development as it is to finding ways of alleviating or curing these early disorders. Both Freud and Bion were baffled by the question, 'How do psychical qualities come into existence?', and the nature of consciousness continues to occupy the minds of philosophers today. It was the states of apparent mindlessness and the lack of psychical awareness in this patient that alerted Klein to consider the

phenomena of autism, and it was her mindless states that the patient herself feared so much.

Modern research has identified the absence of a concept of mind, 'mindblindness', as a primary characteristic of autism (Baron-Cohen, 1995) although sensory factors in this have not yet been examined. Tustin's emphasis on the role of sensory dysfunction placed the disruption of autism at *primary* process level, putting her thinking on a continuum with Freud's first thoughts about the sensory roots of consciousness, and with Bion's idea of the chronological priority of sensory experience contained in his theory of the evolution of the mental functions (Bion, 1962b). Although she did not relate this specifically to the long-standing question about the origins of psychic activity raised by both Freud and Bion, Tustin's work suggests that autistic aloneness may be associated with a bifurcation at the very point of primordial sensory consciousness, which Freud (1911) identified as critical to the setting up of the reality principle. Sydney Klein was attracted by these ideas but he saw too that there were major implications for technique if we are to communicate with patients at this level. Will it become possible to engender attention and abstraction in those with autism and, in less extreme cases like that described in Klein's paper, can we safely reanimate enclaves of inanition?

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ARTS REVIEW
Talk to her: gender and changing states in a film by Almodóvar

MAGGIE HAMMOND

> A woman's brain is a mystery – even more in this state [when in a coma]. You have to pay attention to women, talk to them, caress them, remember they're alive and important to us.

These are the words of Benigno, the main character in the film *Talk to Her*, directed by the Spanish film-maker, Pedro Almodóvar, and released in 2002. For Benigno, the unconscious is a more comfortable state than the conscious. The feminine is a quality he could identify with, although himself a man. The film is carefully choreographed, like a dance in which masculinity and femininity weave in and out, where men are identified with the feminine and women with the masculine, and where the unconscious is treated as if conscious. One poignant illustration of this duality is perhaps the aggressive destructive dance of the bullfight, with its inevitable sacrifice, juxtaposed with the motif of 'Sleeping Beauty', turned in on herself, awaiting rescue and awakening.

Pedro Almodóvar has an interest in what defines feminine and masculine, with an acceptance of fluid gender and relational boundaries, which he explores in his many films. In his paper, 'Gay sensibility, the hermaphrodite, and Pedro Almodóvar's films', Wyly (2001) says of masculinity and femininity in the films, 'They appear to be rather elastic, and to have little – if anything – to do with the anatomised topography with which humans are born' (Wyly, 2001: 229). Wyly (2001) explores how the other is never foreign, never really 'other', but more a third state of being, perhaps like the hermaphrodite. He links this with Jung's conception of the hermaphroditic state in the child, contained in the concept of Child Archetype (Jung, 1959a), and there is certainly a sense of the child in the character of Benigno. Wyly (2001) further suggests that there is more than this in Almovódar's work, what he calls a 'post-

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adult' hermaphroditism, evolved from polarized adult sexuality, which then comes together. The film *Talk to Her* explores the progression from the hermaphrodite position of the child to that of the adult, with all the consequences this brings.

Talk to Her can perhaps be understood as the story of two love affairs. On the one hand, there is Lydia, the lady bullfighter, with two suitors. One suitor is the bullfighter, El Niño, (translated as 'The Child'), the other is Marco, a journalist and travel writer. Then there is Benigno the 'hermaphrodite' nurse, and Alicia, the young dancer in his care, who is in a persistent vegetative state. Lydia is both very feminine with her long black hair and flashing eyes, but also masculine, as a bullfighter. The audience learns that she took this up at the wish of her father, who was only a banderillo. There is perhaps an identification with her father, her animus (Jung, 1959b), which drives her. The journalist appears as masculine, seemingly in touch with his emotions, as we see him crying early in the film, but at the same time unable to articulate them freely. El Niño is full of machismo, but also emotional and expressive with, perhaps more than a touch of the child.

Benigno, the nurse, appears at first as if he is sexless, the carer, although the scenes between him and Alicia are also very erotic. We learn in time that he was a fatherless boy who spent 20 years caring for his mother, who, it is suggested, was either very narcissistic or depressed. Benigno developed his feminine side, perhaps in identification with his mother. He trained as a hairdresser, a beautician and then a nurse, so he could care for her. Alicia was a motherless girl, perhaps herself inadequately nurtured by her psychiatrist father who sought surrogate carers for her. Her ballet teacher appears as a possessive but devouring mother figure, similar to the mother of Benigno.

The film is structured as if it were a dance on a stage. It both begins and ends with stage curtains and a dance. The opening dance is of two tragic, emaciated sleepwalking women, while the closing dance shows couples moving across the stage, suggestively moving their hips. There is a chorus of nurses, who behave like the male stereotype, smoking, swearing and swapping sexual comments. We are given a sense of an 'as-if' life, which is perhaps the experience of all the main characters, hoping for a transformation in the end. The action develops in a similar manner, as we learn about first one set of characters and then another, until they come together, and intermingle, initiating change. In this article, I will follow the structure of the film, bringing out the themes around gender, but also attempting to allow the process created by Almodóvar to tell its own story.

In the opening scene we meet Marco and Benigno, who are in the audience watching the dance of the two trance-like women, who fall to the ground while being protected by two men. Marco is in tears, while Benigno, apparently emotionless, is watching Marco's reaction to the dance. The symbolic picture of the unconscious woman has been introduced, along with the man who responds, and the man who seems to feed off the feelings of another. The next

scene follows Benigno, talking to 'Sleeping Beauty', the lovely young Alicia, asleep in her comatose state. Benigno is recounting the story of the dance to her, but this time with more feeling, as if the presence of the unconscious girl unlocks the life in him. Whilst talking he is manicuring her nails, exactly as if she were awake and responding. He is then depicted with a female nurse, washing Alicia, including her genitals, at the same time discussing her period, as if he were a woman, or a sexless being. Alicia is finally tied into a white garment, perhaps to represent purity, but it also resembles a shroud. Although Benigno's sexuality seems to be denied, this denial communicates the eroticism of the scene even more powerfully.

The action then moves to Lydia, the bullfighter, engaged in an aggressive interview with a female television chat-show host. Here, the interviewer is full of bullish aggression, pursuing Lydia to talk about the break-up of her relationship with El Niño, the male bullfighter, with whom she used to share the arena, as well as her bed. The audience then sees Lydia in an actual bullfight, another erotic dance, connected and dangerous, perhaps dedicated to El Niño, who is in the audience, and Lydia's flamboyant display to him of her skill and recklessness. At this point we learn of her identification with her father who never himself became a matador, and who had died the previous year. We sense her need to outperform her father and her ex-lover, even if it puts her in mortal danger. However, she isn't a man, she doesn't have a penis, and she is phobic of snakes. This emerges very powerfully when Marco the journalist, having seen the television interview, is intrigued enough to try and get an interview with her. She may have fought him off too, if she hadn't encountered a snake in her kitchen. Marco kills the snake, and his relationship with Lydia begins. The presence of the snake suggests to me that Lydia has a justifiable terror of the masculine in her, something she fears is truly endangering her and which Marco had managed to take care of by killing the snake. Her femininity is now more emphasized.

In the way of the dance, the spotlight now moves briefly to the complementary couple, Benigno and Alicia. The camera leaves Lydia in her bright orange hotel bed, her place of refuge from the snake, and focuses on Benigno's bed which is a less glamorous affair. However, above this bed is a photograph of Alicia in her trance, giving a sense of a shrine, in which Benigno is surrounding himself with his beloved. On his bed is a catalogue with a picture of the luxurious bedroom he is planning, leaving the viewer to wonder – for whom? Again we see Benigno cutting Alicia's hair, while chatting to the other nurses about deodorants.

Meanwhile, another bullfight is imminent. Lydia's relationship with Marco has developed, but all is not well, and on the eve of the fight she makes it clear that she wants to talk to him about something when the bullfight is over. The discomfort in the viewer builds as Lydia's sister, fearful and religious, talks of her horror over a story of nuns raped by missionaries in Africa, because they were

the only women free from Aids. We are perhaps told that defenceless women have been abused and exploited by those who should be sexless. We are then launched into one of the most powerful scenes of the film, depicting Lydia being dressed for the bullfight. It is as if she is being covered in a second skin, as a male dresser helps her into her red matador tights. She is then squeezed into bejewelled armour, as the buttons on her jacket are carefully fastened with a button hook. The costume is finished with her matador's hat, her flowing black hair tightly scraped back out of sight. She is putting on her masculine array, which, we sense, she has discarded since the incident of the snake. We also learn, ominously, that the bulls are heavy. In the bullring, our anxiety is justified. Lydia stands as if petrified, without putting up a fight. She is gored by the first bull, and lies in the sand, like one of the dancers in the beginning of the film. A male fighter draws the bull off her and she is carried out. Lydia too, is now in a persistent vegetative state. Perhaps her relationship with Marco had loosened her identification with the masculine, her 'animus' so she could no longer fight, or was this collapse connected with the matter she needed to discuss? The questions are left hanging in the air, but meanwhile she is taken to the same hospital as Alicia, where Marco and Benigno meet.

Almodóvar explores the meaning of Lydia's fall through a song called 'Cucurrucu'. We see Lydia and Marco, in a bar on a hot summer's night on what turns out to be the evening before the bullfight. A man is singing a traditional Mexican song about a woman who died for love. Her soul entered the dove, who cried 'Cucurrucu'. Tears are rolling down Lydia's cheeks as she listens to the song. There is a suggestion that Lydia's fall represented a sacrifice for love. In a scene in the hospital, Marco takes on the guilt for Lydia's fate. He feared that his talking about a previous love, for whom he had also killed a snake, had prevented Lydia from talking to him that night. But El Niño too, has guilt, a part to play. Was she dying for love of him, as a powerless, rejected woman?

In the dance, we now have the three men in the centre, Marco, Benigno, and a little apart, El Niño. The scene seems to suggest that some changes are about to begin. Benigno is now in touch with the masculine, in the shape of Marco, and appears aware of the erotic aspect of Alicia's naked breasts, which he covers in the presence of Marco. He is massaging the thighs of the unconscious girl when her father the psychiatrist appears, who expresses some concern about Benigno's motivation. The father appears too easily reassured by Benigno's statement that he is 'into men', and that he is 'no longer alone'. This is what Alicia's father wants to hear, otherwise he has been putting his daughter at risk all this time, as she has now been in a coma for four years. However, we hear Benigno recounting the incident to his female colleague in sexually derisive terms. He no longer seems such an innocent child.

The theme of separation is taken up by the ballet teacher. She is planning a ballet about soldiers in the trenches, perhaps representing the male in the vagina, in mother earth. She describes how, when a soldier dies, his soul

emerges, the female from the male, the ethereal from the earth. This is very reminiscent of the idea of 'coniunctio' described by Jung in *The Psychology of the Transference* (1954), where the king and queen, 'sol et luna', the opposites, come together. The 'coniunctio' then enables a greater separation and purification, through the soul emerging from the body. Benigno appears to begin to separate out his fused sexual polarities. However, he doesn't understand the difference between the conscious and the unconscious. He is still planning the bedroom he wishes to share with the unconscious Alicia, holding the picture of the bed in front of her closed eyes.

At this point, we learn more of the history of Benigno and Alicia. Four years previously, Benigno had been living with his domineering mother in a house opposite the ballet school, where Alicia was a favoured pupil. He was voyeuristically obsessed with her, spending every available moment at the window. One day, shortly after his mother died, he seized his opportunity when Alicia dropped her wallet. He rushed to return it, and walked beside a reluctant Alicia, learning where she lived and that her mother was long dead. He also found out that her father was a psychiatrist. He made an appointment with the father for a consultation, allegedly to gain entrance to her world, but perhaps at some level too, recognizing that he needed help. Through the subsequent session, the audience gets further inside Benigno's world, learning that he had looked after his mother for 15 years, after his father left when he was five years old. Benigno tried to give her a life, thereby perhaps sacrificing his own. Benigno appears stuck inside the mother, like Jonah in the whale (Neumann, 1954), and the development of his sense of himself was severely arrested. He was left with no capacity to relate to an alive and separate woman, all he seemed able to do was to mother and nurture. However, some consciousness or thinking attitude began to develop when the psychiatrist invited him back, telling Benigno that he had had a 'special' adolescence. This was a new idea for Benigno. Perhaps Alicia's father represented the third, someone who could think about Benigno and maybe facilitate some separation from the mother. However, the same week Alicia was knocked over by a car and arrived at the hospital in a coma. Her father demanded 24-hour nursing care, with the best nurses. Benigno was held in high esteem in the hospital, so after initial misgivings the father stopped thinking, and handed his daughter's bodily care into the hands of this young man with the 'special' adolescence, and his ambivalent sexuality.

With both women in a vegetative state, the difference between Marco and Benigno is emphasized. Benigno talks about his time caring for Alicia as the four richest years of his life, taking over her life, and in a sense living it for her. Marco, on the other hand, can't talk to Lydia, or even touch her. For him, she is switched off and brain dead. He is moved by Benigno's exhortation to 'talk to her' with this affirmation of the power of the unconscious mind, but he is also deeply uncomfortable with it. In a passage reminiscent of Christ and Peter in the Bible, he asks Benigno three times 'How much experience have you had

with women?' Finally, Benigno can avoid the question no longer, and replies 'Lots. Twenty years with mother and four years with Alicia'. Clearly, his mother was not very conscious either and Benigno's experience has all been with his internal woman, whom he could make into what he needed.

As with the bull fight, the ballet and the song, Almodóvar now seems to suggest the situation through a set piece, a silent film. The viewer is left unsure whether this is an actual film or Benigno's fantasy. What we see is Benigno describing to Alicia this disturbing film, while sensuously undressing and massaging her inner thighs. The film is about a character called Alfredo and his partner Ampora, who discover a shrinking potion. Alfredo drinks it and shrinks irretrievably. After 10 years living with his impossible mother, he seeks out Ampora, who greets him like a lover. While she is asleep Alfredo travels down her body to her genitals and crawls inside her vagina. Ampora's face displays sexual pleasure and Alfredo can stay inside her for ever. Perhaps he has symbolically re-entered the mother, but this was combined with a sense of adult sexuality. It was this combination that so disturbed Benigno. On the screen, when we have seen the black and white silent film, we see the colour red, in the shape of a penis, combining with a corresponding shape from the other direction. There has been a 'coniunctio'.

The action now moves to the hospital terrace, with the two comatose women. Benigno appears upbeat, while Marco seems despairing. The viewer is shown a sequence of the wedding of Marco's former lover, which also took place just before the bullfight. The service emphasized the importance of the spoken consent of two people coming together in marriage. Lydia was crying for El Niño, and perhaps also for Marco, shortly to be rejected. Marco only talked about himself and seemed unable to listen to Lydia. Once back in the hospital after the fight, he meets El Niño, who confirms the reconciliation between himself and Lydia a month before the fight. Marco now decides to leave the country but first he seeks out Benigno, who quickly covers up Alicia's breasts and speaks to Marco as if he himself were an experienced partner: 'There was something in your relationship that didn't work,' he declares to Marco.

We then hear concerns about Alicia's missed period and of Benigno falsifying the medical records. The situation deteriorates and Benigno is excluded from Alicia's care. Outside in the car park he reveals to Marco that he hopes to marry Alicia, because for him, coma is no impediment. Marco is alarmed and furious. He shouts out: 'Alicia is practically dead!' Benigno is unmoved and states: 'I thought you were different'. Marco now carries out his intention to leave the country. At the same time, at a hospital case conference, it is confirmed that Alicia is pregnant, with Benigno as the obvious suspect. There is consternation and guilt as the team gradually realizes how blind they have been in accepting Benigno's 'sexless' presentation. Benigno himself seems confused and is perhaps in denial, as he is described as 'that retard' by the hospital staff. The paradox is, through his

caring for a young woman (not a mother), and, perhaps, his relationship with Marco, a part of him has grown up.

In the narrative of the film, Almovódar allows Alicia to live while Lydia dies. Meanwhile, Marco, who is abroad, reads about Lydia's death in the newspaper. He returns to Spain to seek out her grave, and Benigno. He discovers that Benigno is in jail accused of rape. Benigno, in jail, appears changed and he is desperate to have news of Alicia and the baby. He had been patient until the baby was due, but now the state of not knowing is unbearable. Perhaps he wants to know whether he actually can be creative and father a baby, like a man. What he is not allowed to know is that in giving birth, Alicia woke from her coma, and although the baby died, she is now alive. Perhaps Benigno had found a way to awaken the 'Sleeping Beauty', like the prince of the fairy tale, the kiss symbolizing intercourse and the coming together of male and female, the opposites. The viewer has a sense that this event has to some extent released Benigno too. He has been forced to separate from Alicia, and, in the process, to internalize her to some extent, as he worries what has happened to her in her life apart from him. But, if Benigno has transformed he is not permitted to live it. In the belief that Alicia is still in a coma, and unable to bear life without her, he takes an overdose, hoping to put himself in a coma. Before he does this, he has opened out to Marco, finally crying and craving physical holding of himself. For a moment it seems Benigno has found himself. Lastly, in a poignant scene, Marco is seen to visit Benigno's grave, where perhaps he finally learns to talk to the dead.

The film ends with Marco moving into Benigno's flat, apparently moving into his life. It is here that he sees Alicia, who has returned to her dance school, and finally they meet. It seems that a relationship might start between them, and that Alicia might now escape from a negligent father and a possessive stepmother and be free to meet her prince. In the final dance, we again see couples gliding across the stage, the women suggestively moving their hips.

Perhaps what we have been watching after all is the story of the relationship between Marco and Alicia. For it to flower, there have been two sacrifices: two people have died for love. Lydia died after the bullfight when she relinquished her identification with the masculine, but she did not withdraw from the fight, to which she was committed. Benigno died because the masculine awoke in him, but he remained in thrall to the unconscious world. When society incarcerated him in an external prison it proved unbearable. Lydia and Benigno both underwent a partial transformation, but were unable to complete the process. In a sense, both died by their own hand, although that may not have been their conscious intention. Through knowing Benigno, Marco learnt to listen as well as talk, and perhaps to leave his nomadic existence. Through Benigno's care, Alicia stayed alive, with her body in a good condition, in spite of the years in coma. Through his entering her and awakening a creative process, finally she, herself, awoke. The dance goes on.

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Books reviewed

Bad Feelings
By Roy Schafer
London: Karnac Books, 2003, 164 pp, £19.99, pbk

Bad Therapy: Master Therapists Share Their Worst Failures
Edited by Jeffrey A Kottler and Jon Carlson
New York and Hove: Brunner-Routledge, 2003, 201 pp, £16.50, pbk

Roy Schafer's thesis is that bad feelings are part of being alive, and disappointment is a feature of normal development (for example, oedipal frustration) and of subsequent everyday life. In this book, Schafer deals with both ordinary disappointment and that problematic category of patients who suffer from chronic disappointment. They have a totally joyless attitude to life and are 'injustice collectors', due to severe deprivation and pain in their early object relationships. They enter analysis expecting disappointment and use resignation and despair as their armour. In the transference, the analyst becomes the source of disappointment, so they are constantly complaining and the analyst always fails them. Treatment with this type of patient is slow and arduous, and psychoanalysis can never rid them of their bad feelings. What it can do, Schafer feels, is to 'reduce the painfulness of unavoidable bad feelings and increase the tolerance for psychical pain'. It can help the patient's capacity to love by 'reshaping the hurts and humiliations of the remembered past and expanding the range of safe, gratifying and possible futures'.

Using both a contemporary Kleinian approach and insights from the contemporary Freudians, Schafer shows how negative feelings – disappointment, anger, guilt, envy, humiliation, shame, despair – invade the consulting room for both patient and analyst. One feature of maturity is, of course, to develop satisfactory, adaptive defences against painful ('bad') feelings. For Freud, there was a subordination of the pre-genital drives and the focus of libidinal investment was at the phallic, oedipal level. From early in life, the child accommodates to chronic disappointment and painful feelings which become invested with a libidinal charge. This disappointment is based on a diet of humiliation, which is perceived by the child as such, but this sadomasochism (which has some

pleasurable aspects) is kept going because otherwise the child would live in an affective desert. This results in a dramatic impingement on the child's resources and leads to the aforesaid joyless attitude, which becomes hardened and embedded because the libidinal investment began so early. All this is very much in keeping with Masud Khan's concept of 'cumulative trauma', with repeated environmental impingements leading to a marked depletion of the ego. It will come as no surprise that these patients are extremely difficult to change in therapy. For Klein, the pre-oedipal experience is of utmost importance, and Schafer explains how the child learns to use sadomasochism, being unable to see any good in the other and only experiencing the bad. This is due to projective identification with its assaults on the other's goodness and a projection of the patient's bad feelings with the perception of the object as invariably destructive.

Schafer has an interesting way of looking at negative therapeutic reaction. Freud regarded the reverting to previous maladaptive modes of behaviour in the face of analytic progress as the result of unconscious guilt associated with oedipal advancement or triumph with the associated fear of castration. Klein emphasized the central role of envious transference in the negative therapeutic reaction. More recently, analysts have ascribed a wider variety of painful feelings to this reaction. In addition to guilt and envy, they mention fears of loss, rejection or abandonment, envious and persecutory attitudes and attempts to retain total control over the grandiose tendencies stimulated by their worldly and analytic advances. Patients may then pursue destructive behaviour, leading to mediocrity, failure and humiliation. Schafer considers seeing things in terms of 'negative therapeutic reaction' as a shift away from a neutral psychoanalytic position and as expressing a 'negative countertransference'. He sees it as the analyst's disappointment that the patient is not meeting his expectations rather than as a point of resistance and part of the inevitable shifts in the transference in every treatment. If the analyst can maintain his analytic attitude of neutrality he might see that the patient may be trying to regulate the kind and pace of change that is occurring:

> Sometimes analysands believe it necessary to back away from what they unconsciously experience as too risky for them at that moment. Too much of their psychic equilibrium is at stake. When they do back away, they show the analyst that something more remains to be analyzed or that more time is required before an insight can be consolidated or a change in mental organization can be implemented and stabilized. I ask, what is negative about that? (p. xv)

This sounds as if it could have come from Winnicott himself.

Schafer explores many aspects of negative feelings, including the analyst's altruism, which can be a defence involving using the other to solve his own unresolved conflicts. Also, the problems of 'false goodness', which must be differentiated from genuine goodness, either of which may appear at the

prospect of termination. The book is useful for all psychoanalytically orientated therapists as it is full of clinical illustrations which confirm that a hardened attitude of despair, which can present as depression, mistrust, frustration and masochism, originates in early life and stems from a profound disappointment with the early object. Schafer stresses the need for the analyst to maintain his analytic stance in the maturity of the depressive position and to remember that the work with these patients is bound to demand the utmost patience and dedication from us for, as Anne Alvarez has said, 'Those who have been damaged at dawn cannot forget or forgive' or at best find it very difficult to do so.

In *Bad Therapy* therapists come from various theoretical orientations and the book is written in a popular, lively style which, at times, seems quite sensationalist. The chapters look at when therapy (be it individual, couple, family or group) fails to succeed. The authors describe this clinical breakdown in terms of 'worst failures' and 'stunning failures'. It is a pity that there is no index and the papers are short. Whilst this, on the whole, makes for easy, undemanding reading, it feels somewhat unsatisfactory for such a serious subject, and may have led to some conclusions which seemed rather superficial. For example, John Gray, originally a family therapist but now a writer on relationship issues and famous for his book *Men are from Mars, Women are from Venus*, concludes his chapter entitled 'Being in bad therapy' by taking exception to the Freudian prohibition on any self-disclosure from the therapist. He feels that disclosure is not only permissible but can be extremely helpful if the therapist has resolved the conflict confronting the patient. He then takes this one step further, saying that we can only be an effective therapist if we have faced a particular problem ourselves. Consequently, he states he is proficient at dealing with anxiety and relationship issues, and that he would never be a good therapist for an alcoholic because he has never been an alcoholic. But what about empathy? And is not any addiction a desperate attempt to try and control need which, at core, must be about anxiety and our relationship with our internal and/or external objects? Furthermore, as the psychiatrist the late Max Glatt, who specialized in treating addiction said, 'We all have the seeds of addiction in us' whether this is focused on work, food, drink, drugs, sex, shopping, books, exercise, money, possessions, etc., and, as clinicians, we bear witness to this constantly in our consulting rooms.

It is important to note that the editors were aware of the shortcomings of their project and say how disappointed they felt that their questions did not help the contributors go deeper. However, this is a useful book in that it opens up an important topic for further exploration, and, by identifying the areas of danger for us as therapists, it highlights the need for constant supervision and a constructive and honest sharing of our work, rather than living with our errors in a climate of 'secrecy and shame' or 'hiding them in coded notes or recurrent nightmares of discovery'.

The overall findings of the book were useful in stripping away any grandiosity or fantasies of therapeutic omnipotence, particularly the humbling insight that

'we can never meet our own unrealistic expectations for perfection. We can rarely, if ever, exert the kind of influence that we would prefer. We can never cure all the suffering we see.' Bad therapy, the editors conclude, occurs 'when either the client or the therapist is not satisfied with the result, and when the outcome can be traced to the therapist's repeated miscalculations, misjudgements, or mistakes'. They found the therapist's main pitfalls leading to clinical failure were the following:

- following their own agenda without listening to the client;
- making the same mistakes over and over again;
- inflexibility and reluctance to make needed adjustments;
- not knowing where they are going;
- arrogance, overconfidence, therapist's narcissism;
- an internal feeling of ineptitude;
- failure to create a solid alliance;
- using obsolete methods;
- negative outcomes for the client;
- losing control of self or countertransference issues;
- making invalid assumptions.

Ours has been a discipline that has had some difficulty in self-criticism. When discussing our work we always seem to come down on the side of optimism and self-righteousness, so it is good to have these two books, which explore the more negative side of the psychoanalytic profession. Previously, gross therapeutic misconduct and failure has mostly reached the public domain via the media. These books may be the start of looking at these issues from within the professional domain.

JUDY COOPER

Learning from our Mistakes – Beyond Dogma in Psychoanalysis and Psychotherapy
By Patrick Casement
East Sussex: Brunner-Routledge, 2002, 150 pp, £15.99, pbk

Patrick Casement is a distinguished training and supervising analyst of the Independent Group of the British Psychoanalytic Society. Like his previous books, *On Learning from the Patient* (1985) and *Further Learning from the Patient* (1990), the author shares with the reader his extensive experience in working with different types of patients, as well his own particular way of conceptualizing the analytic encounter.

Casement explores technically and clinically the methods that the analyst's observing ego has to develop in order to achieve a capacity for reverie necessary

to understand the patient. This includes foremost the capacity to sense the ideographic, the non-verbal and the pre-conceptual. He encourages the creation of an analytic space that permits the unconscious to emerge. Central to this endeavour is the analyst's need to self-analyse and examine his own part in the analytic interaction.

The nine chapters evolve from the re-examination of the curative factors in psychoanalytic therapy to the detailed discussion of the fine-tuning of techniques that maximize the attainment of such goals. These include mainly methods of self-supervision, such as trial identification with the patient and the therapeutic use of re-enactment in the sessions.

Chapter 1, entitled 'Getting there: the unfolding potential of psychoanalysis', demonstrates how some treatments can foster a pseudo-progress due to the imposition, by the analyst, of a set of values which produce compliance in the patients instead of transformation. Often, the patient's need to identify with the analyst leads him to comply rigidly to a model that does not really meet his needs. Casement shows how even Freud's original rule of free association can sometimes become an impingement on the patient. He criticizes analysts who interpret as resistance every time patients do not associate, because they do not admit that they themselves might be wrong. They fail to examine their own countertransference. In effect, patients who do not freely associate are often using a defence that requires countertransference examination for elucidation of non-verbal or pre-verbal material. Casement reminds us that the analyst's role is an interactive one and that the patient not only acts according to his inner world, but also in response to the analyst's tone and intention. He gives an interesting example of an analyst's 'blindness', when faced with a patient's transference feelings. The analyst kept interpreting her separation anxiety, whereas the patient needed instead to separate from a psychotic mother in order to be free. The patient had no option but to leave the analyst.

The author feels that the manner and proper timing when an insight is offered to the patient is quite crucial for its acceptance. He compares this to Winnicott's discovery of a period of hesitation (Winnicott, 1958) in which the baby plays with the external object, in order to negotiate its incorporation. The effective interpretation is the result of a creative development between patient and analyst. The author firmly believes that interpretation outside the ripeness of the material can be intrusive.

Chapter 2, 'Mistakes in psychoanalysis, and trying to avoid them', deals with common mistakes made by practitioners, and offers advice as to how to deal with them. Casement distinguishes between 'useful' from 'not useful' mistakes. In the first instance, the author aptly reminds us that there are mistakes that can be used for furthering the analytic process, in particular those mistakes which stem from the analyst re-enacting an unconscious striving in the patient's inner world. In these cases, unconscious role responsiveness emanating usually from the patient, either in the form of projective identification or projection,

can be used in order to understand the transference. In order to achieve this, Casement advises the development of an inner dialogue in the analyst. The latter permits the analyst to both be able to be immersed in the linear relationship with the patient while being able to observe and give meaning to the experience.

In contrast to this type of 'useful mistake', Casement warns against the graver errors made due to the insufficiently analysed countertransference in the analyst, which deprive the patient of the opportunity to understand his transference. Patients unconsciously search for a recipient of their projections, hoping they will be able to bear and manage unwanted material. The patient needs the analyst to unconsciously play out the patient's unconscious script without altering it through the introduction of the analyst's own rules into the space provided.

Chapter 3, 'The experience of a session: trying to communicate it', describes a case in progress to show the process of internal supervision. The author's rendition of the session is quite touching, and illustrates the choices for interpretation that have to be made by the analyst. He clearly shows how a careful trial identification and self-monitoring by the analyst permitted to differentiate pre-oedipal material from oedipal material. In addition to the case presented, the author shares with the readers his own thoughts as to how to present a session to an audience of colleagues and how to write about it. Casement shows how the process of presentation in itself involves self-analysis through the careful processing of the material. He shows how the analyst needs to take into account what Heinrich Racker (1957) called 'indirect countertransference', a term used to describe the outside inferences, such as supervision or group colleagues or readers, which may affect the analyst's work in the session and even the rendition of the session.

Chapter Four, 'Towards autonomy: some thoughts on psychoanalytic supervision', deals with examples and problems in supervision. In this interesting chapter, Casement discusses how to work in order to stay closest to the actual process and to the unconscious needs of the patient. He focuses on three aspects of supervision:

- the overall psychodynamic picture and process of the patient;
- the interaction between supervisee and patient;
- the creation of a model that can be internalized by the supervisee.

The creation of an internal supervisor within the psyche of the supervisee evolves from the student's own analysis, supervisions, clinical seminars and clinical work. This development culminates in an increase in the student's ego capacity to observe whilst under the emotional bombardment stemming from the patient in the sessions. Casement reminds us of his previously mentioned technique of trial identification, whereby the analyst monitors the patient's responses to the analyst's interventions as a useful tool in promoting this capacity.

The author gives examples of how the student sometimes jumps ahead of the patient's communication, thus distorting it. Casement introduces the original idea of unconscious supervision by the patient. In effect, the patient unconsciously searches to re-enact with the analyst aspects of his internal world, which effect countertransference reactions in the analyst. Thus, previously unthinkable phenomena become amenable to thought and understanding. The re-enactment of these psychic contents, and their containment and processing by the analyst, allows the latter to reach what Bion calls 'the selected fact' in a moment of analysis (Bion, 1977).

Chapter 5, entitled 'Some hazards in being helpful in psychotherapy', shows how mistakes in an analysis can be used to elucidate unconscious material and to interpret the transference. This relatively small and simple chapter, written originally for counsellors and trainee therapists, stresses the point that, often, the best recommendation is to stick to the analytic task, which includes both the bearing of uncertainty and the discovery of that which is difficult and as yet not understood. A very well-described summary of a case shows how the analyst's attempt to be 'too helpful' evokes early anxieties in the patient related to a mother who is unable to cope with abandonment. The reliving of this in the transference was crucial. The reader will surely recognize those particular situations whereby the analyst feels pressurized to receive painful, difficult material. The purpose often is for the analyst to bear the material as it is and not to interpret because the patient experiences this as deflection of pain by the analyst. The baby part of the patient hopes to have a mother who can receive the painful projections from the baby sufficiently up to the point when they can be made meaningful and only then translated into language.

Chapter 6, 'Re-enactment and resolution', illustrates through case studies how re-enactment in analysis results in the reliving and changing of previous trauma. The author reminds us of an important axiom in psychoanalytic practice: how we often succeed when we are failing. Casement describes the case of a man with whom the analyst unconsciously repeats the mistake of thinking of someone else instead of the patient. In due course, through using the analyst to represent a key figure experienced in childhood, the patient was able to become aware of previously disavowed and split-off material. Casement puts it like this:

> Mr T needed me to be 'there' for that anger, and that upset, and for me not to be protecting myself with any transference interpretations. Only then could we also attend to his transference use of me, as he had come to experience me during that sequence. (p. 85)

He continues:

> Yet again, it is not by being a 'better parent' that we are able to deal with the deepest effects of early trauma. It is by being there for a patient's most difficult feelings, often associated with trauma and seeming to have been more than others could bear, that a patient can eventually find experience that is better and that is healing. (p. 85)

In Chapter 7, 'To hold or not to hold a patient's hand: further reflections', Casement discusses a previously published paper (1982) to discuss important issues concerning the handling of severely traumatized patients. (The original paper is an appendix in this volume.) He reveals further material in order to clarify the confusion and criticism that arose after he wrote the original paper. He shows how the most important technical element in such difficult situations is to follow the patient's unconscious communication, and not just to follow, rigidly, a set of proscribed rules. His struggle in this analysis was not whether to hold or not hold the patient's hand, as requested by the patient, but how to understand the tranferential communication. He now reveals that the patient's mother did not hold her when she was a baby because the mother had a severe infectious disease. The re-enactment in the analysis and the proper handling of this very painful experience permitted this discovery. Readers will find themselves identifying with the pressures caused by the intensity of the transference, which is often concrete and in search of a psychic container. Casement states: 'My struggle was not "how to stay true to the rule" but "how to remain true to my patient" ' (p. 95).

In Chapter 8, 'Impingement and space: issues of technique', Casement presents his ideas about how to provide real space in the analytic situation in order to maximize the attainment of unconscious striving in the patient. Basing his thoughts on Winnicott's experience with children, Casement re-emphasizes his main point, that to manage the analytic process the analyst needs to steer and contain rather than control. Often, the analyst becomes annoyed or anxious with a patient, and, as a result, tends to exert his authority over the patient, thus encouraging compliance in the patient. Thus, the patient's ego is reinforced in the actuation of his false self rather than the development of a real self.

Chapter 9, 'The unknown beyond the known', elaborates on the author's central premiss that the analyst ought to be free of dogma in order to respect the process of discovery of the unknown. He warns against the tendency to opt for that which is mostly familiar, instead of waiting patiently until the unknown is converted into something that can be thought about. The problem of relying too much on theory, which happens often with inexperienced analysts, is that 'the result for the analyst is an illusion of familiarity and of pseudo-understanding, that may give the analyst a sense of security but may not give the patient a secure sense of being understood' (p. 113). To demonstrate this point, he offers an example of the analysis of a blind man. Every interpretation made by the analyst was experienced by the patient as if the analyst wanted to deflect the patient from his own inner world. Words that were commonly used belonged to the 'seeing' world and therefore were devoid of meaning. Eventually, the patient needed to be helped to develop his own vocabulary that had meaning to him.

Readers following other theoretical models (Klein, Bion, et al.) will find themselves in disagreement with some of the author's working hypothesis that

lies behind his interpretive work. Specifically, Casement does not accept the role played by the death instinct and its derivatives. There is no discussion of the serious negative reactions motivated by destructive or envious elements that can create a vicious circle in the analytic process, leading to impasses. Although Casement refers to the delusional madness of the psychotic part of the personality, he tends to attribute these almost solely to the symbiotic entanglement and confusion caused by a non-facilitating environment.

His criticism of the classic Kleinian approach, which attributes everything to the inner world and does not allow for a space to develop between the outer and inner worlds, does not appear to take into account post-Kleinian developments, influenced predominantly by Bion's work on the theory of thinking. These developments are exemplified by authors such as John Steiner, Edna O'Shaughnessy and Ronald Britton, among others, who tend to emphasize the importance of the container-contained function as central in the analysis of a patient's anxieties. In fact, nowadays, the Kleinian model would pay great attention to the failure of the container prior to the analysis of the persecutory forces acting within the patient.

It appears to me that Casement's view of the effect of the analyst on the internal world of the patient, (what he calls 'impingement/intrusion'), is somewhat over-exaggerated. Casement maintains that interpretation outside the ripeness of the material can be intrusive because it is perceived as a super-ego being thrusted by the analyst into the patient. However, in my experience, we also need to take into account that often it is the non-contained projection of the patient's persecutory system that returns as an outsider, thus creating a greater defensive posture in the patient with its concomitant defences. If we do not interpret these unreturned projections, the patient's persecutory inner world will only escalate further and create an internal toxic environment, necessitating in turn even more sophisticated defences, which can then become intractable.

His way of explaining complex phenomena in simple terms reflects the author's style of interpretation, which aims to communicate both with the child and the adult in the patient. In effect, however, the simplicity of the language is perhaps to prove his main tenet: that it is essential not to impinge upon the patient's space with any preconceived dogma. At times, therefore, the book reads very simplistically. When compared to his previous books, this one is not as seminal. Although it can certainly be read on its own, I suggest that *Learning from Our Mistakes* would be more appreciated if read as part of a trilogy.

The book's strengths lie in its clinical acumen and in providing the reader with a wealth of case examples. The author's candid sharing of his clinical experiences acts as a form of supervision for the reader. It offers a master class in object relations that includes fine tuning of techniques that we commonly use to analyse the transference. Casement is very convincing in his effort to convey

to the reader that it is permissible to make mistakes as long as one acknowledges them and learns from the experience.

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RICARDO STRAMER

A conversation with Dr Donald Meltzer*

JAMES ASTOR

The conversation took place on 29 December 1988, at Simsbury. I went down to visit Don after Christmas. We had a meal together and most of the conversation took place at the table in his kitchen where he conducted some of his supervisions, particularly the evening ones. The atmosphere of the interview was friendly: I had known Don for some time and he was happy to talk to me about his work. He spoke, as he often did, with his eyes closed when giving a long answer – only looking at me when I asked a question. Reading his replies again, I can hear his evocative and fluent delivery and see his fist, holding the thin, white cigarette he smoked throughout the interview; he sipped wine as he talked. I did not challenge the evasions. Later, I typed up the recording, and he made some corrections, as he knew this was going to be published.

My last meeting with Don was when he was in the nursing home in north Oxford, shortly before he died. I asked him about his fear of death, and what he thought his legacy would be. He spoke of the death, by drowning, of his son in childhood and how this was an irrecoverable-from event. He thought his best book was *The Psycho-Analytical Process*. I asked him about *The Apprehension of Beauty* and *The Claustrum*, and he acknowledged them after a long, long silence, when I thought he had gone to sleep. I left feeling profoundly sad that this extraordinary, gifted and complicated man, who had inspired so many people, should have alienated as many, and increasingly isolated himself in his last years.

The interview

How did you become interested in working with children?

The route is very direct. As a medical student, I had done medicine in order to become a psychoanalyst. During medical school I did an elective in Bellevue Hospital, on Loretta Bender's ward where the original work with schizophrenic

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children was done, and it just grabbed me. Of course, it was there that I first heard of Melanie Klein; Loretta Bender gave me *The Psychoanalysis of Children* and that also grabbed me, particularly in that context, in which I was seeing terribly psychotic children, both heartbreaking and fascinating. Nothing was being done therapeutically, they were being given electric shock treatment.

Did you have to give these children ECTs?

No, they didn't ask medical students to do this work. Then, when I went to do my psychiatric training in St Louis, I specialized in child psychiatry. It was there that I finally arranged, through the Air Force, to come to England and study with Mrs Klein. This was in 1954.

What were you doing in the Air Force?

Oh, that was the Korean War, they couldn't get doctors for the services, so they drafted the doctors. Then, having done my mandatory two years of service, I could make a deal with them to extend my service in order to be posted to a particular place.

You say you were grabbed by this book of Mrs Klein's, but prior to this experience had you been trying to treat children by other methods?

One of the reasons that I chose St Louis, other than the fact that it was halfway between my family and my wife's family, was that there was a study group from the Chicago Institute and there was a big Department of Child Psychiatry, which was very psychoanalytically orientated. My training in child psychiatry was very much from the point of view of analytic therapy. During my six years in St Louis I had analysis and training seminars, and it was there that I started working with autistic children. I did some research on autistic children and on strabismus in children.

What is strabismus?

Cross-eyed. I had been cross-eyed myself and it was of great interest to me. Actually, I was wall-eyed. It is all right now, except when I am tired.

You speak of having analysis in St Louis but not presumably Kleinian analysis?

No, no one had beard of Melanie Klein in St Louis until I introduced her work into the Department. The service that I ran there was, however, inspired by my limited understanding of her ideas.

In 1954 you came to England. Did you start analysis right away with Mrs Klein?

I started my analysis the day I arrived. I had been over the year before and had arranged it all. I received some interesting letters from Dr Winnicott, saying that I mustn't expect to be treated as someone special just because I was in analysis with Mrs Klein. I was, however, treated very nicely actually.

Was all of this within the framework of doing the Institute training?

Yes. When I first came over as an officer in the Air Force I could only be confident of having four years here. They were very kind to me at the Institute and let me start the training immediately, instead of having to wait a year. They took into consideration my training in the States. So, Dr Winnicott was in fact very nice to me.

Was he chairman of the Professional Committee then?

I don't remember. I had my training at the Institute and had supervision with Hanna Segal, Herbert Rosenfeld, and my child cases with Betty Joseph, Esther Bick and Hanna Segal.

Which of those supervisors do you recall having the most influence on you?

It was Mrs Bick who understood most about children and was most experienced with children. At that time in the Klein group there were very few people who were deeply experienced with children. Mrs Bick had done research with children (her doctorate was with children), had started the Tavistock training and understood most about the interplay of the depressive and the paranoid-schizoid in the lives of children. Other people tended to have a sort of sequential idea that once you had reached the depressive position it was clear sailing. She was more aware of these as positions of value and not just structural positions relating to splitting processes. Her work leads directly on to Bion's formula Ps–Dp and the concept of the continual interplay between paranoid-schizoid and depressive states of mind. It was she I continued to work with up until the time of her retirement and through her to begin lecturing at the Tavistock Centre.

Where were you working at this period?

All private. I had had a little difficulty getting my citizenship, so I had two years of just teaching and training cases. The authorities thought I was an escapee from McCarthy's America, a communist. But, once that got cleared up I started my practice. Of course, during that time in the Klein group, not only were they doing the training but also having their children analysed. Mrs Klein was a great believer in the prophylactic analysis of children. So, almost all my child cases were the children of colleagues or relatives of colleagues, which was in many ways very co-operative and one could carry on the analyses pretty well as long as you felt it was necessary. It wasn't a great way of making and keeping friends, but that's another story.

In comparison with today, your experience of child analysis was in a very different climate from that in which most of us now work.

Well, today, child analysis is almost entirely in the clinics and the health service, whereas psychoanalysis is almost entirely outside the health service. It's a very anomalous position. The situation I had come from in child psychiatry in the States was one where there had been a tremendous mushrooming of child guidance clinics, with tremendous therapeutic expectations that were soon disappointed because the huge skills were not there. It was dependant on the concept of the team, the psychologist, social worker, psychiatrist, and the results were really pretty poor and the reputation of child psychiatry, which was dynamic and psychoanalytically inspired, suffered quite a lot.

But, here in England you found yourself in a small analytically minded group of skilled practitioners. Was it all muddled up – the teaching and the treating, the supervising and analysing?

No, I wasn't in teaching groups with Mrs Klein. The child training at the Institute was fairly nominal except for the cases and the supervision. The literature seminars were skimpy. This was before the child department was built there – by the time it was built, child analysis had faded away. After Mrs Klein's death, the fashion of Kleinian training with children seemed to wane. The child training fell into abeyance until around 1967 when they tried to revive it and Mattie [Mrs Martha Harris] was asked to reorganize the training. But it never recovered, partly because of the development of the child psychotherapy trainings. The Tavistock Centre and the Hampstead Clinic really just drained off all the people who were interested. It was also because the Institute had always followed this, rather, I think, foolish, policy of insisting that people trained with adults before they trained with children, which meant they couldn't take people until they were well into their thirties.

What was the reasoning behind this?

A mystery. I really do not know. It is part of treating child analysis as a kind of stepchild of adult analysis. It's a denying of the tremendous amount of research value that has come out of work with children. They were inclined, really, to give more credit to work with psychotic patients, which was, in amount, much less than the work that was being done with children and the ideas that were coming out of it. Bion's work with schizophrenic children and Rosenfeld's with schizophrenic adults – those papers were startling but their actual contribution to our understanding of development and the workings of the mind has been absolutely minimal really. It was partly a misunderstanding that went along with calling it the paranoid-schizoid position that it was thought that schizophrenia was an evolution of a particular stage of development. It has turned out to be something entirely different from any stage of normal development. Therefore the findings about schizophrenia contributed to our understanding of how the mind can go utterly wrong in its functioning but it contributed little or nothing to how it can go right. And therefore it hasn't contributed to the

concept of child development or really to the concept of the structure of the mental apparatus. It was a period of enthusiasm in the 1950s and early 1960s – enthusiasm for the treatment of schizophrenics. Of course, too, the therapeutic results were so disappointing and the research harvest did not make a constructive link with the work that had already been done and the concepts that had already been established. It was a bit of a blind alley really. Fascinating. It was followed by a dead period when the analysts who had stayed in the health service to do this work left to work privately. It has been revived recently, not so much here as in Scandinavia where they have a mental hospital system that enables them actually to work for long periods with schizophrenic patients and have the facilities for prolonged, 10, 15 years, of hospital treatment. In Italy too there has been some very valuable work with schizophrenic adolescents.

Would you say the shift has been away from pathology to interest in development?

Yes.

And is Mrs Klein's idea of the prophylactic analysis part of this shift?

Mrs Klein's ideas of a prophylactic analysis were psychologically sound, they were only sociologically unrealizable. First of all, it became clear that the treatment of disturbed children requires not only training but also talent. It also became clear, certainly in this country, that the sacrifice in time and money that was required of parents was not going to be forthcoming. The culture wasn't favourable to that. The prophylactic value of analysis has manifested itself in other directions rather than therapy – in child rearing, and the educational system.

Do you think Mrs Klein's model is more orientated towards development than pathology?

Well, the difference from the therapist's point of view between an interest in pathology and an interest in development is primarily a matter of direction. whether one's interest in the material is following its forward movement and the development of the personality, or its regressive movement and its revelation of fixation points, of infantile conflicts and the repetition of the infantile neurosis. It is largely a matter of one's point of view, whether you are looking backward to try to understand and reconstruct the past or whether you are looking forward with the point of view of facilitating development. The Freudian vertex is a much more intellectual one, and also contains a view of the analyst as really *doing* something, whereas the Kleinian point of view as it developed, with its emphasis on developmental processes and facilitating them, is primarily one of creating an atmosphere within which growth and development can take place.

But there is, surely, a regressive element in the analytic framework?

I wouldn't think that regression has continued to be a very useful concept in the Kleinian way of working. In the hands of people like Balint it was viewed as the avenue through which therapy took place. And Winnicott also. The therapeutic situation was one that enabled the patient to regress and therefore to re-experience. I don't think this, from the Kleinian viewpoint, is a useful way of describing the therapeutic process. Certainly, in my own concepts, as expressed in *The Psycho-Analytical Process*, I would doubt that the word even appears. It certainly isn't part of my way of thinking about the therapeutic method. There is no doubt that the transference can be viewed as a regression, but Mrs Klein's view of the transference was primarily as an externalization of the immediacy of the internal situation and its concreteness. This implies the view that any reconstructive work is problematic in its scientific value and not particularly of interest for its therapeutic value. If the patient is interested in reconstructing, as many patients are, they can reconstruct. It simply means that the story changes. Of course, if the analyst is interested in the past this promotes the patient's surrender to the regressive movement in himself.

But even if the analyst isn't interested in the past, Mrs Klein describes transference as memory in action and this surely contains regressive elements?

This expression of hers was partly a way of legitimizing the concepts of the preverbal period reappearing in the analysis – that those relationships, those structures from deep in the mind reappearing in the transference, constitute a kind of memory in action. But, to take it literally, as if what is repeated, what is in the transference is a literal repetition of what happened at age six months and so on is not part of what is an essential building block in the Kleinian framework.

How then did your experience of working with children change as a result of your six years of analysis with Mrs Klein?

If there was a tradition in America, it was a tradition of play therapy of a very active sort in which one really played with the children. I would say that my experience here and my expectation that came from reading *The Psychoanalysis of Children*, where Mrs Klein also was very active in her participation with children, was that the movement was certainly fairly swiftly in the direction of observation, thought and talking; rather than any sort of action with the child, other than the action required to maintain the setting. I would say that change happened very quickly within the first two years of my starting to treat children here. And it has continued, although I have not had a young child in therapy for years. The consultation work that I do is certainly of that sort. In my supervision of people working with children that is what I encourage – observation, thought and talking; to keep your seat; to find ways of encouraging the child to

do his stuff and allow you an observing position. You can see Mrs Klein had changed a lot, too, if you compare *The Psychoanalysis of Children* with *The Narrative*, you see in her work a tremendous movement in that direction.

But what of the changes arising from your analysis that were perhaps more personal?

I think I became much less therapeutically orientated and much less inclined to establish goals for therapy, but rather to leave it open-ended. Out of that, there developed the concept of the analysis having its own natural history. The movement away from active to a much more passive kind of observing and commenting participation, where the activity was directed towards creating and maintaining the setting, that movement, I would say, has become my style. And did become my style pretty quickly during my training here.

You have contrasted, in your talks, the harshness of some of Mrs Klein's concepts and your experience of her in your analysis as gentle and humorous.

Yes, well first of all I talked a lot because she had a lot of thoughts and a lot of ideas, and she was humorous, quite witty in her way of expressing things, and the sessions were almost always enjoyable. That was something that I almost certainly learnt from her and was not the tradition of American psychoanalysis at all, where the atmosphere is a very dour one with the analyst silent.

Do you think Mrs Klein was interested in the science of analysis?

Well, I think Mrs Klein didn't know a lot about science and wasn't very interested in science, although she had started to study medicine. She was much more interested in the arts, literature and music. I don't think she was very interested in the scientific status of her work in the way Freud was. I think she was concerned about its humanist value but not its scientific status. I think a certain harshness has grown up in orthodox Kleinian circles which is not in the spirit of Mrs Klein at all.

Do you think there is a harshness in your work?

I think that the harshness in my work probably comes, if anything, from an overemphasis on internal values. One of the aspects of the development in my work that has come from Bion is the view of the social personality as a carapace that is contributing little or nothing to the actual development of the personality. So, that would be what one would call the harsh aspect of my work.

In regard to the development of personality in The Apprehension of Beauty *you write of 'the innate preconception of the race and its millennial experience' (p. 63). What part do you think this plays in the development of the personality?*

I suppose I have an evolutionary view of the way in which the equipment of the

brain and its availability as an instrument for the mind has evolved. The structure of the brain that has developed through the millions of years, since we came out of trees, I suppose, does dispose to certain particular problems of relationship which are essential for the survival of the infant in the quasi-family and quasi-tribal milieu in which human infants have always grown. I would think that the predisposition of a fox baby or a marsupial baby is bound to be different, and the difference is lodged in the actual structure of the brain and in the immediate and reflexive modes of adaptation with which they respond to the initial shocks of emerging from the uterus. Certainly, the kangaroo baby that can shimmy up its mother's leg is doing something quite different from the human infant that can scream. If we are going to consider the mind as a phenomenological structure (that has arisen from the capabilities of the brain) whose way of operating is to form symbols for thinking about very complex experiences, then we have to assume that it is operating with a brain that is disposed to certain patterns of response. What Freud called the 'id' or Bion calls 'innate preconceptions'. They are, as it were, the material, analogous to stone, clay or wood, from which the building blocks of the cognitive structures are built gradually through the introduction of meaning, through symbol formation, into the experiences of the baby. Certainly, the recent pushing back of the beginnings of mentality to before birth means that we have to consider that emotional experience commences *in utero*. Therefore, rudiments of symbol formation and rudiments of thinking commence *in utero* and birth is an experience and not just a battering.

What is the relationship then between those experiences that are the food of development, and contain a truthfulness, and these innate preconceptions?

I suppose certain clinical experiences that I have written about have rather convinced me that the truth of an experience, which means the *truthful* observation and record of the encounter, really cannot be destroyed. It can only be covered up and therefore can be recovered. There is a certain sort of Freudian aspect to this. It corresponds in many ways to the concept of repression and the way, as Freud described, paramnesias are utilized to cover up the amnesia for the event. This has contributed to the conviction that the problem of mental development is a problem of truthfulness as a mode of functioning, truthfulness of observation and truthfulness of the elaboration of the symbolic forms, which make the experience available for thinking. Untruthfulness manifests itself in a variety of ways, at the different stages in the development of the thought. It can manifest itself in scotomizing the observation, in distorting, in bowdlerizing the observation, and in the formation of distorted symbols which don't really capture but distort the meaning of the experience. Perhaps the most sophisticated form of this distortion is its manifestation in language, and lying. The constant struggle both for the analyst and the patient is to wait for the unconscious and not, as Keats put it, to 'irritably reach after fact and reason', not to

hurry the process but to wait for intuitions to inform you of the meaning of your experiences. To wait for the unconscious to elaborate the meaning of the experience in a truthful way means not to hasten to make a story, whose only aim is to get rid of this terrible feeling of uncertainty. This 'story-making' corresponds to what Freud called the 'secondary elaboration' in the fashioning of the manifest content of the dream.

But is it possible to experience 'truthfully' if you are living predominantly in a state of projective identification?

No. When we are talking about parts of the personality that are living in projective identification, we are talking about parts of the personality that are living in a world where truthfulness simply does not exist as a category. The meaning of everything is distorted by both the processes of the narcissistic identification with the object, with its quality of fraudulence, and by the processes of the claustrophobic anxieties that colour every experience with a sense of persecution, entrapment and of being a 'foreigner', 'stranger', 'alien'. The whole framework of thinking, of time and geography, is disturbed in projective identification so that all the cognitive structures that are founded upon time and geography are themselves distorted. Being inside an object where you don't belong produces an estrangement to the basic assumption group and an eagerness to embrace it.

I now want to ask you about 'the essence of babyishness'. You have described, in The Apprehension of Beauty, *the essence of babyishness as residing in the potential in the infant, that is, the infant as a container for parental projections. Are there implications in this model for adolescent development; that all these projections will be thrown back at the parents?*

The problem for parents with their adolescent children is primarily a problem of the loss of contact with the child as he becomes swept away from the family as an organization, into the adolescent community as an organization. This causes a severe loss, in the parents, of a view of the child's potentiality and often results in a loss of a feeling not only of closeness but also loss of concern and interest, and sympathy. The child becomes a member either of a gang or the basic assumption group of the tribe or adolescent community – and becomes, in that sense, a stranger. In the analysis of patients whose children are adolescent, and who are suffering from this loss of contact, loss of interest, loss of sympathy, the thing I always try to emphasize is the necessity of finding, establishing and clinging to a standby position; waiting for the child to come back to a family orientation, not being judgemental about the child's participation in the adolescent community, about which one has great difficulty in having any valid information. My view places less emphasis on the child's sexuality, which has always been emphasized in psychoanalytic writings about

adolescence. Parental hostility to the child's emerging sexuality seems to me to be secondary to a loss of contact with the child who becomes sociologically a stranger to the family and begins to use the household simply as a lodging house.

But what about all the parental projections the adolescent has to cope with?

Well, the pitfall of this 'essence of babyishness' is that it allows, and encourages, parents in their view of the child to see the baby as a potential adult, but also allows a lot of projecting of their idealized self, their bad self or their unfulfilled ambition and expectation. It invites a lot of projecting and this is a great difficulty in the relationship between parents and babies. It probably is less in the very earliest months of life than once the child begins to manifest a social behaviour that extends beyond the mother. While it is still the mother–baby relationship it probably is not so available for these kinds of projections and is much more inclined to be a sort of love affair. But once the child begins to reach toward other members of the family and to become integrated as a member of the family, and not just mother's baby, then all of these invitations to projections seem to take hold. But families are very complex and very fluctuating organizations, as Mattie and I tried to describe in our 'Model of the child in the family' (reprinted in *Studies in Extended Metapsychology*, Chapter XIV). The roles shift, the qualities that emerge and are enacted shift from one situation to another. One really cannot describe a family in any sort of static terms.

You mentioned Mrs Martha Harris and I would like to ask you about the development that occurred in your work as a result of your working with her. In what ways did you influence one another?

Well, Mattie certainly had a tremendous influence on me. I think my influence on Mattie was probably far less, because Mattie's orientation came out of English literature and teaching rather than her psychology degree, which hardly influenced her at all. Her interest was only very secondarily in psychoanalysis as a therapeutic procedure, and hardly at all as a research procedure. She was really interested in development, and in child development, and interested also in the development of this profession of child psychotherapy. Her influence on me was very profound. I really had my education in literature through her and her daughters and I would say that her views of the mother–baby relationship, that came out of her work with Mrs Bick and the development of infant observation, also had a profound effect on me. Probably my Kleinian training had led to my assumption that the first two or three months of life were not ones of intense emotional experience but were either satisfactory or unsatisfactory from the general psychological point of view. It was certainly through Mattie that the opening up of this infantile period as a period of intense experience was borne in on me. How it actually changed my

therapeutic work is very hard to say. The idea of the sequestered relationship of mother and baby, and the experience of birth just became much more real and vivid to me and I began to see its manifestations in the clinical material. I think that she also had a certain temporizing and modulating effect on my own more muscular tendencies, my tendencies to impatience, to hurry. Those were her supreme influences on me.

Is your present interest in the relationship between literature and psychoanalysis a development out of this interest that Mattie started in you?

Yes. It was really when her two daughters were reading literature and they were sending me their essays from Oxford and Cambridge, and I was reading along with them, that I had my literary education. It resulted in an absolute drying up of my interest in the psychoanalytic literature. It has been many years since I have taken a medical interest in the psychoanalytic literature. And I have stopped writing papers that were intended as contributions to the literature and begun writing books that were an expression of my experience and the development of my ideas. I still do write papers when they are requested but I don't write for journal publication.

I would like to return now to your actual work with children; when did you actually stop working with children, and why?

My last child in systematic therapy was probably about 10 years ago, an autistic child, and it didn't have a very successful outcome. I have continued to participate as supervisor and consultant. There are a number of children, some of colleagues, that I see periodically in therapeutic consultations. Occasionally in adolescence they have come into analysis with me. That is the extent of my direct work with children now.

But why did you stop working with children?

Well my theory is that every time I saw a child in consultation who needed therapy there were five child psychotherapists who needed a patient. I never found work with children very tiring, any more tiring than work with adults. I always had an easy kind of communication with children. So I don't think it has been a lack of interest in children. I think many psychotherapists of children, by the time they get to their middle or late forties, do find it too tiring but I don't think that has been my reason.

Apart from your theory do you perhaps have some other idea about why you have stopped analysing children?

No, I think I'll stick to my theory.

I would now like to ask you about what you have described in your writing as the

necessity, when practising as a psychoanalyst, to be outside the group. What you have described as the loneliness and incipient persecution of such a position. Has this been your experience?

Well, of course I am describing there the experience of being inside the consulting room and the realization that one can never really communicate to anybody the real facts of the situation, that any attempt to put it into either the language of written or verbal communication is always at least a first echelon of interpretation and doesn't really capture the facts of what is going on. This is what contributes to the loneliness, but that loneliness is also something one comes to welcome because any analytic group is always permeated with political orientations, groupings and the readiness to criticize or adulate in ways that distort what one can communicate and what is understood from what one does communicate. The one result of this is that I am hardly willing, except under duress, to lecture. The teaching that I do is all clinical teaching, based on the presentation of case material and the discussion of it. It seems to me to be the only possible way, in this field, of people in an audience having any reasonably uniform idea of what is being talked about and what is meant by what is said. I am equally reluctant to write anything that isn't absolutely centred on the clinical material – that hasn't grown out of the clinical material.

But how much, too, has this loneliness got to do with what you refer to when you write of the courage to face one's passionate attachments?

Well, for instance, the intimacy of many analyses, the interest in one another and the intensity of the feelings of love and hate are in their very nature extremely private. Not every analysis, of course, reaches that pitch of passionate involvement. But it is my view that analysis is a unique situation and its approximation to the intimacy of the mother–baby and dyad of lovers is such that its privacy almost implies a certain persecution by an auditor. It isn't possible just simply to tell the truth about what goes on, partly because of its ineffable quality but also partly because one doesn't wish to violate that privacy.

But you publish a lot of this clinical material?

It makes writing difficult when you don't feel that the patient welcomes your writing about the experience. But I must say that most of my patients that I have written about (and there was a period when I did almost make it a policy to write about all my patients whether I published it or not) have welcomed it. I can think of two occasions when the patients deeply resented this, I mean deeply resented. One patient took seven years to recover from this resentment and make her peace with me. On the whole, my patients have welcomed it, and I must say that the people whose work I have published, the people who have been in supervision or in seminars abroad, have been very generous and have

also welcomed it. Again, there is only one person whose work I used which put an end to that friendship and that was a long time ago.

When we began this talk you were coming to England to study with a particular group, to have analysis with Mrs Klein. At this point we find you outside the Institute ploughing your own furrow, or being ploughed by it, and I wonder what your understanding is of this now. What do you attribute this to?

Oh, this is purely a function of my personality. I have never been a person who could participate happily in groups of any sort. Even team games were never really to my taste. My participation in the Klein group was overly enthusiastic for years on the basis of thinking of it as a family. That illusion was easy to maintain while Mrs Klein was alive but impossible to maintain after her death. And as soon as it became clear to me that it was a group and not a family my distancing from it just proceeded. I went in the direction of being particularly close to certain people like Mrs Bick or Roger Money Kyrle and progressively more distant from others. And I suppose I became a sort of gadfly in the Society, Mattie and myself feeling that the training had proceeded in a wrong direction and particularly that child analysis was not being given any proper place there. My decision to come to Oxford, which happened before I came together with Mattie, was part of the move to separate myself from being involved in the actual running of the Society. I spent some years on committees until I discovered I was no good at it and that I wasn't having any useful influence.

Do you regret that it isn't within your personality to have an influence in the larger psychoanalytic group?

No. I suppose I comfort myself by ceasing really to believe in the constructive role of politics. I have come to consider it more or less to be part of the entertainment industry, and that it is the work group that actually does the constructive work in the world. So I have actually lost interest in politics of all sorts. I could no longer honestly call myself a socialist, I'm just an ex-socialist. I'm an unsociable person.

You don't think very well of compromise, yet you contrast the courage required to face one's passionate attachments with kindness as the essential basis of family life. There is surely a compromise here. Truthfulness is not always kind.

No. I think the kindness I am referring to is the kindness based on forgiveness. One always has to forgive people for not fulfilling one's desires and hope to be forgiven in turn. The essence of forgiveness is to relinquish punitiveness, all desire for revenge. This I learnt from Money Kyrle, who, along with my father, was one of the two most kind men I have ever met, kind almost to a fault, where kindness and weakness become a little indistinguishable to other people. Although neither of them were weak men by any means.

Was your mother also kind?

Yes my mother too, although she was probably less sentimental than my father.

Where were you in your family?

The youngest and the only boy, of course!

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Obituary

Donald Meltzer, 14.8.1922 (New Jersey) to 13.8.2004 (Oxford)

Donald Meltzer died in Oxford on the eve of his 82nd birthday. The tributes at his funeral described a beloved only son, the youngest child of three, whose romance with European culture started when he was taken on a grand tour as a young adolescent. He loved nature and working in the soil, trying his hand at basic carpentry, fascinated by making and repairing things. An early desire was to be a sculptor working in stone. In his private life he displayed physical strength, muscular energy and a passion for horses. In his professional life, his patients, supervisees and colleagues encountered his mental and emotional strength and a passion for psychoanalysis.

The two types of strength and the two passions were highlighted at a conference in Barcelona in October 2002, when a Spanish participant recalled his reaction to reading Meltzer's (1984) *Dream Life*. 'This fellow has *duende*'[1] he thought to himself. Meltzer responded with his thoughts on Lorca's essay[2] (which presents a bullfight as a metaphor for creativity). He described duende as 'the love of the matador for the horns'. A turbulent creativity was at the heart of his passion for 'serving the art of psychoanalysis', for persistent search for the truth, for facing – day in and day out – the danger located in the perverse and destructive parts of the personality.

Donald Meltzer graduated in medicine at Yale University, continued his medical education at the Albert Einstein College of Medicine in New York and trained as a child psychiatrist in St Louis, Missouri. There, he discovered the works of Melanie Klein. He arrived in London in 1954 to take his place on Mrs Klein's couch and commence his psychoanalytical training with the British Psycho-Analytical Society. He became a member of the Society and then a training analyst, a position he would retain until ideological differences with the psychoanalytical establishment led to his departure in the mid-1970s.

He soon proved himself to be an original theoretician and a talented clinician. He leaves an impressive opus of eight books and numerous papers (a few are collected and published in *Sincerity and Other Works*; Hahn, 1994). Among his many contributions to psychoanalytic theorizing, many practitioners find Meltzer's theory of aesthetic conflict most illuminating. It

postulates a link between aesthetics and psychoanalysis in a search for the forces of creativity in the inner world. Alberto Hahn[3] points out that Meltzer's thinking on the subject started with a dialogue with Adrian Stokes: *Painting and the Inner World* (1963). It finally flourished in *The Apprehension of Beauty* (1988) co-written with his stepdaughter, Meg Harris Williams, a writer and artist and a long-standing collaborator. There, he draws on Klein's concept of the concreteness of psychic reality and on Bion's notion of internal space for reverie. According to Meltzer, a baby meeting the beauty of its mother (which stimulates its aesthetic sense) is also faced with the enigma and uncertainty of the nature of her inside, as compared with her outside. The baby experiences both pleasure and pain in his contact with the mother and the ensuing conflict gives rise to the growth of the epistemophilic instinct with its search for knowledge. The struggle to resolve that conflict, to integrate L(ove), H(ate) and K(knowledge), forms the basis of creativity. That theory questions Klein's view that the paranoid/schizoid position precedes the depressive position. For Meltzer, ambivalence towards the object exists from the beginning and the splitting mechanisms constitute a defence against the resulting mental pain. The creative process entails working through the aesthetic conflict, rather than the sublimation of the depressive position, in a search to recreate the lost object.

The next year saw a short piece entitled 'Concerning the stupidity of evil' (1989) that graphically explains what happens when the aesthetic conflict is avoided. That, and an earlier seminal paper 'The relation of anal masturbation to projective identification' (1966), led to the development of a new theory in *The Claustrum: An Investigation of Claustrophobic Phenomena* (1992). The book describes in detail the internal world of a person whose epistemophilic drive refuses to bear the pain of learning from experience, and instead seeks knowledge through intrusive projective identification. These narcissistic, borderline and psychotic patients become ensconced very concretely inside the object and have very little capacity for observing external reality from their 'retreats'. John Steiner (1993) describes a similar unconscious mechanism, but conceptualizes the psychic retreats as metaphorical, whereas Meltzer adheres to Klein's notion of the concreteness of psychic reality.

Donald Meltzer had a phenomenal capacity for observing minute nuances of the verbal, bodily, cognitive and emotional expressions of a patient. They were, in turn, transcribed for his listeners or readers in intricate and lively detail. One can see this in an early paper, 'Note on a transient inhibition of chewing' (1959) and in the 1960 Tavistock 'Lectures and seminars in Kleinian child psychiatry' (in collaboration with Esther Bick).[4] This rigorous yet delicate presentation of the complex interaction between transference and counter-transference in a single session is at its most impressive in Chapter 7 of his first book, *The Psycho-Analytical Process* (1967), a publication that is a *tour de force* description of the development of the internal world in the course of analysis.

Meltzer's persistent search for the truth, by means of a ruthlessly detailed and comprehensive examination of the patient's material and his own countertransference, is paramount. His paper, 'Temperature and distance as technical dimensions of interpretation' (1976), for example, concentrates on the 'ingenuity of verbal expression'. In this paper, Meltzer considers the need for honest spontaneous communication on the part of the analyst without falling into an all-too-ready trap of acting out in the countertransference. Verbal communication can be much enriched by understanding: the primitive innate roots of language (as in Wittgenstein and Chomsky); the lexical level for conveying information; and the poetic function, which uses external metaphors to describe the inner world. Through the modulation of the interplay of those three levels of language, the analyst can control the temperature and distance of his communication. By controlling the musical emotionality of the voice one can heighten or dampen the atmosphere while observing the different parts of the personality that emerge on the couch from one moment to the next. The complexities of such intense observation of various parts of the personality are 'a useful preparation for the patient's introjection into his internal objects of analytical qualities of mind in view of the hope of his becoming capable of self-analysis in the future'(Meltzer, 1976; cited in Hahn, 1994: 377).

Another paper, 'Routine and inspired interpretations: their relation to the weaning process in analysis' (1973), shows Meltzer's courage in laying himself open to the full intensity of a patient's massive projective identification and the use of his countertransference to make a new discovery. He states almost nonchalantly 'patients in states of projective or other types of narcissistic identification with the analyst hold up a fun-fair type of mirror, full of distortions and exaggerations no doubt, but revealing the truth in caricature' (Meltzer, 1973; cited in Hahn, 1994: 292). He describes in detail his patient's dream, associations and attempts at self-interpretation. Meltzer also recounts with great candour his own thoughts and associations, paying particular attention to his experience of a persistent intrusion into his mind of Velasquez's 'Rokeby Venus'. Having ascertained that the patient had discussed the painting with friends a few days before the session, the analyst was able to present an alternative interpretation, which in turn created an atmosphere of passionate co-operative exploration and discovery. The 'inspired' interpretation described in this paper was made possible by his special interest in the creative aspects of dream interpretation.

Meltzer always claimed that good clinical work was made possible by the analyst's faithful reliance on good internal objects; on the psychic reality of a good, beautiful and creative parental couple at the centre. His patients underwent such experiences on his couch. His audiences enjoyed such experiences listening to him talking, without any notes, with his eyes closed, his narrative punctuated with gaps while he was 'listening' to his internal objects

and formulating the next spoken paragraph. It was Donald Meltzer's absolute conviction that life both was, and should be, lived from the inside out and not the outside in; that is to say, that it is in the internal world that meaning and understanding are generated, and that this meaning and understanding is not only communicated to but also profoundly influences the external world of the person and the actual events that happen. This conviction was clearly exemplified in his placing of dream life at the centre of his work in the consulting room. The truth about the patient's psychic reality at any given moment becomes clear at the intersection between the patient's dreaming and the analyst's counter-dreaming (Meltzer's development of Bion's concept of maternal reverie). The interpretation of those dreams was where his profound understanding of unconscious fantasy and unconscious processes joined the art with the science of psychoanalysis. He sat in a characteristic pose – with his eyes mostly closed – coming up for air, as it were, from time to time, while the dream was told. Some dreams would be met with a one-sentence response, given like a précis of a passage of prose read from a page, amazingly illuminating the state of mind of the patient and telling you something also about their character and personality. Others were approached more like a difficult poem – a few questions would be asked, a thread would appear and you could feel him working his way into the heart of the dream – separating out the images, unpacking their elliptical content, then joining one image to another until the underlying meaning of the dream-poem gradually emerged. He was enormously patient in this process, fully prepared to be baffled and puzzled, as he quite clearly believed that, over time, the dream would eventually yield its secrets. As either patient or supervisee, one did not always understand the detail of the steps Dr Meltzer had taken to reach his understanding, and this not knowing would sometimes be quite painful to bear. But it could be borne, because one felt safe – contained by his kindness. At the same time, enough of the courage required to descend into the depths of the human psyche was conveyed to help one stay with the task and continue in the best way one could – one's own psychoanalytical process.

Meltzer often used the metaphor of Virgil guiding Dante to describe himself as guided by his internal objects. The Barcelona conference suggests another metaphor. It seems that Donald Meltzer's internal objects, like Ariadne, created the *duende* that enabled him to help Theseus/patient to overpower his internal Minotaur and use the provided thread (of the psychoanalytic process) to emerge from the labyrinth/claustrum.

Notes

1 Meg Harris Williams (personal communication). 'An appropriate translation might be "demon" as was used by the English romantic poets especially Keats and Byron – the "demon poesy", seen as a female. Also the demon/daemon of Socrates – Lorca writes of Socrates' "happy demon".'

2 Frederico Garcia Lorca, 'Play and theory of the Duende', in *In Search of Duende* (New York: New Directions, Bibelot series, 1998).
3 Hahn A. An obituary of Donald Meltzer. *The Times*, 6 September 2004.
4 Meltzer never tired of his commitment to children and their emotional development. He and his late wife, Martha Harris, established centres of teaching child psychoanalysis and treatment of children all over Europe.

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