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Editorial

With this issue of the *BAP Journal*, Stanley Ruszczynski will be stepping down as Joint Editor. Mary Adams will continue until a new editor is appointed. In preparation for the handover to the new editor, we are taking the opportunity to review where we are as an Association with the Journal and the future direction we wish it to take. James Fisher will be joining the board as interim Joint Editor with Mary Adams during the period of this review.

Recent experience has highlighted differences among BAP members regarding what kind of publication is wanted and needed for the future. We as Joint Editors, along with Council, think it is important to have a discussion among the membership in order to clarify these differences and to set a clear mandate for the incoming editor. We also need to explore questions of potential readership and contributors along with questions of where the Journal fits in the wider analytic community. The decision six years ago to have the Journal published by Whurr reinforced the move towards a professional analytic journal with a readership outside as well as inside the Association. This contrasts with the more limited aims of an in-house publication. Important questions now need to be explored if we are to continue to develop this aspiration.

In this issue we include a paper by Chris MacKenna, 'Faith in the therapeutic process', given at the 2005 BAP Residential Conference and one by Simon Archer, 'Shame, doubt and the *shameless object*', given at a BAP Scientific Meeting. Sue Johnson continues our Classics Revisited section and looks at *The Aims of Psycho-analytical Treatment* by D.W. Winnicott. Our Clinical Commentaries section resumes with commentaries by Meira Likierman, Warren Colman and Ann-Marie Reilly. For our Arts Review Sarah Nettleton guides us through Schubert's *Die Winterreise*.

In our Book Review section we have decided to include a review of *Ethical Attitude in Analytic Practice*, (edited by Hester Solomon and Mary Twyman), which was submitted by the lay member of the BAP Ethics Committee, Patricia Pank.

This issue also marks the end of John Clay's seven years as Book Review Editor. We want to extend our thanks and appreciation to John for the considerable dedication and professionalism that he has brought to the Journal.

Lastly we welcome our new publishers, Wiley & Son, who have taken over from our previous publisher, Whurr Ltd. We wish to express our gratitude to Whurr for the improvements we have been able to make on the Journal, and we look forward to another creative and productive partnership with our new publishers.

The Editors

Shame, doubt and the *shameless object*

SIMON ARCHER

ABSTRACT

This paper discusses the neglect by psychoanalysis of shame as a cause of distress and breakdown. There is an overview of the shift from the idea of shame as a defence to that of shame as a signal anxiety. There is a discussion of hypotheses about the early origin of shame within a system of stimulus and affect regulation. Embarrassment, humiliation and shame are compared and linked, as is the relation between shame and trauma. The concept of the negative therapeutic reaction as described by Rivière (1936) is re-evaluated by taking account of shame. Normal and pathological shame are compared. Shame is compared with guilt, and shame-persecution is distinguished from guilt-persecution. The significance of the link between shame and doubt is explored. Two concepts are introduced, using clinical material: first, the idea of the 'reservoir of shame and doubt' and its importance in manic depression, and second, the idea of the presence of the 'shameless object'.

Key words doubt, negative therapeutic reaction, shame, trauma

Introduction

Unmanageable shame is an instigator of psychic catastrophe and breakdown and yet it has not been properly accommodated within psychoanalytic theory and practice. Western, Judeo-Christian culture, and psychoanalysis, arising of it, emphasizes guilt rather than shame. Sometimes our patients may be using the word 'guilt' while what they are experiencing is shame. A predominantly guilt-based culture provides a screen behind which the agonies of shame may be hidden. Freud's pioneering investigation of guilt and the superego provided the model for our psychoanalytic orthodoxy. The historical emphasis upon guilt, whether formulated in terms of the consequence of attacks upon the primary object or upon the Oedipal couple has obscured the importance of shame. A

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tendency to try to fit all disturbances into a framework of superego/guilt has been both a consequence and a cause of the relative neglect of shame.

There has been a shift away from Freud's idea of shame as a defensive 'Dam against sexual excess' (1905: 191) towards a different conception of it as an expression of anxiety due to a sense of deficiency or failure. Freud suggests this on many occasions, the earliest being when he describes shame as one of the 'distressing affects' that 'may operate as a trauma' (1893: 6). Another example is in his study 'Femininity' where he describes the shame associated with penis envy as being due to a sense of 'genital deficiency' (Freud 1933: 132). In his account of the wolf-man Freud does not use the word shame but describes the experience of seduction as 'offensive to the patient's masculine self-esteem' (1918: 20) and proposes that his aggressive fantasies about his sister are a passive-into active compensation designed to efface shameful memory traces. Shame is described here not as a defence but as an anxiety state giving rise to secondary, defensive aggression.[1]

Shame is associated with infantile sexuality due to the fear of exposure and disapproval of hidden impulses and because of pre-Oedipal and Oedipal fantasies of exile and helplessness. Of course, it is well known that shame accumulates around the events of the anal stage. However, shame is associated with every developmental stage, and with any unwanted exposure of concealed or disavowed aspect of the self, sexual or aggressive and with any sudden sense of failure. Shame is a *signal anxiety* in response to the emergence of unconscious residues of more or less traumatic ego-stress. The ensuing psychic pain leads to particular defensive manoeuvres to avoid the other-who-sees, such as lying, evasion, hiding, faking, seduction, hostility and violence. Thinking of shame in this way helps distinguish between primary hostility leading to guilt and defensive, secondary hostility (with associated guilt), as a defence against primary shame.

Embarrassment, humiliation, shame and trauma

One person's embarrassment is another person's catastrophic, shameful humiliation. Whereas *shame* denotes an affective state, *to humiliate* is a transitive verb implying a sado-masochistic object relationship in which one person humiliates another in order to make him or her feel ashamed. For some patients unwanted exposure activates such an internal object relationship. People will respond to the same potentially exposing situation in very different ways depending on the way that each of them manages shame. This in turn will rest upon the way in which the person has internalized either a facilitating positive enough environment or its negative opposite. A person not prone to chronic shame may find a situation of exposure painful, but will be able to process it mentally after a disconcerting feeling of embarrassment in which thinking is only temporarily suspended. If the negative observation is valid the subject may be

able to make use of the shame in order to change for the better. Rather than flee from shame the person will recover and try to be more like their ego-ideal. A less resilient person will feel a more acute sense of humiliation and will then either use or disavow the shame experience. The effect of unmanageable shame-affect on thinking is profound. Someone with a reservoir of unmanageable shame will experience the same situation as a *trauma* that activates the unconscious residues of countless other past traumas. Some individuals reside in a permanent state of shame so chronic that their ability to think is severely restricted.

In situations where there has been an actual traumatic event there will always be associated shame because of the helplessness due to the ego having been overwhelmed. In the case of patients who have been traumatized in a disaster where others have died, survivor-shame often underlies the cliché of survivor-guilt. Helpless in the face of the biological drive to survive the survivor asks himself the painful question 'what sort of a person is it that goes to those lengths to live?'

Shame, counterfeiting and the Negative Therapeutic Reaction

Because shame plays an important but neglected part in the analysis of hostile, difficult patients it is useful to revisit a well-known paper about such cases.

Joan Rivière's influential *A Contribution to the Analysis of the Negative Therapeutic Reaction* (1936) provides an explanation that links this problem with the failure to resolve deep, unconscious persecutory guilt and this has tended to remain the accepted explanation. Rivière refers to Freud's reference in *The Ego and the Id* to the way that 'certain people cannot endure any praise or appreciation of progress in the treatment' (Freud, 1923: 49). It is commonplace that praise may activate shame. This happens because the subject experiences a discrepancy between the praise and the shameful, hidden belief that he or she is unworthy. Shame-persecuted patients do not see the scrutinizing gaze of the therapist as positive or even neutral. Plagued by hidden, doubting mistrust of the self and the object, the patient has constructed a counterfeit, alternative self. Rivière says the 'carefully selected and arranged material, calculated to deceive the analyst as to its "free" quality' (p. 306) is designed by such patients, only to show 'nothing but good of themselves'. The idea of the presence of shame helps make sense of this. The analyst is viewed with cynical suspicion because the patient creates, out of the projection of this counterfeit system of thought, an untrustworthy, fake, counterfeit analyst.

Patients who have internalized an extreme, negatively regarding object have not experienced the supportive, slow disillusionment that allows them to give up both their omnipotence and the associated idea of an idealized breast. Such patients are driven to try to replace the counterfeit analyst with a superimposed, ideal object. The greater the sense of negative regard by an internal

primary object, the greater the shame, self-doubt and mistrust of the object, and the greater the clinging to an idealized object. The failure of the patient's attempt to force the analyst to become that impossible object re-enforces the patient's sense of shameful helplessness and self-doubt. The patient will then redouble his hostile efforts to project all this onto the analyst who will then be inclined to doubt his own integrity. The fake analyst the patient creates is regarded as behaving in a self-righteous, shameless manner. The patient and the analyst are then in danger of becoming stuck in a shame-guilt cycle of mutual projection.

Rivière goes on to say that such patients 'are highly sensitive and easily mortified' (p. 306). Mortification is a state of mind that is, *par excellence*, associated with shame. Rivière points out the connection Abraham makes with anal omnipotence and the presence of the *mask*, which when removed, reveals the true underlying state of the patient. Rivière attributes this underlying state to unresolved persecutory guilt and the associated manic defences against it. The *mask of compliance* referred to by Rivière may be concealing shameful, as much as guilt-ridden aspects of the self. Hiding, omnipotent control and acute sensitivity are always an indication of the presence of unbearable shame. The manic defences and the mask are used to control the analyst who is seen as threatening to the patient. These patients, says Rivière, are highly sensitive to 'any admission of failings in themselves' (p. 309) and to the 'faintest breath of criticism' (p. 314).

Patients not driven by unconscious, pathological shame understand that while they may wish to be liked, they come for therapy or analysis in order to be understood. Shame driven patients come to analysis demanding the blissful glow of unconditional approval by an idealized object whose existence, paradoxically, they profoundly doubt. For these patients to be understood is to be stripped naked, seen and shunned. This is something that is becoming more understood. Britton in his 'subjectivity, objectivity and triangular space' (1998) refers to both the shame of 'thin-skinned' borderline patients and the corresponding 'existential doubts' (p.49) of the analyst. The container has failed in early infancy and this leads to an inability to manage the triangular situation, which is experienced as a disaster. The container that Britton speaks of has failed in a particular way. It has been internalized by the infant as the source of more or less constant negative value that contributes to what might be called a *minus ego-ideal*, so that there is nothing to aspire to except negativity. Excessively shame-prone, the adult patient profoundly doubts both himself and his analyst. He then splits by devaluing a counterfeit analyst and demanding a substitute, idealized one. As Britton says, the analyst, subject to powerful projections, may begin then to have existential doubts. These doubts may usefully be seen as due to the projection of shame into the analyst.

Rivière wrote astutely of the futility of going head-on at the aggression of such patients. This would only exacerbate the sort of 'shame-guilt cycle' described by Kinston (1983), Miller (1989), and Mollon (1984, 2003). Such

cycles arise when the patient tries to deal with intrusive feelings of shame due to the sudden perception of negative self-images that disturb narcissistic equilibrium. Potentially shameful states of passivity and helplessness (including any dependency) are defended against by means of attacks upon the scrutinizing analyst. This causes guilt, fear and further reinforcement of helplessness and negative self-images leading to further shame, and so on. In this way shame becomes unmanageable and guilt unreachable.

Gottleib in his paper 'Refusing the cure' (2004) describes the sort of patient who will cling to misery in order to enact an object relationship in which they rebuke the analyst with failure. Gottleib links the early traumatic negative containing with helplessness and shame and describes the way that these are lived out in the 'long and bloody war' (p. 679) of the transference and counter-transference. It is my view that during this war the analyst is seen as a *shameless fraud* because of the projection of the patient's counterfeit system. As far as the patient is concerned the analyst is justifiably berated for his shamelessness. All doubt is abolished. The shameless, self-righteous indignation of the patient is directed at a shameless, self-righteous analyst who is relentlessly accused of counterfeiting and extortion. Every analyst will have examples of this kind of situation. One that comes to mind is that of a patient who would goad me with accusations about my lack of real qualifications, my unjustifiable fees and with his insistence that if I was a real therapist then I would work in a proper office rather than a 'back bedroom at home'. (Of course, if I had been in what he thought of as a 'proper office' he would have assumed I had fraudulently obtained or borrowed it.)

Normal and pathological shame

Ordinary, manageable shame arises out of inevitable disruptions of narcissistic equilibrium. Pathological, unmanageable shame arises out of an unconscious overload of layers of unmanageable disruptions that threaten to re-emerge. Erikson said that while shame is necessary, inevitable and useful, excessive shame contributes to the formation of a persecutory superego. He thought of shame as arising out of conflicts during the stage of 'autonomy v. shame and doubt' ([1950] 1973: 243–6) during which the child attempts to master feelings of helplessness. The pre-Oedipal child who orders himself about is trying to master potentially shameful passivity by identifying with the controlling, 'aggressor' parental figure. This internalized figure merges with the developing superego. Shame socializes us by helping us to achieve sensitive and empathic interpersonal (and international) relations but over-control of the developing infant will lead to omnipotent, manic or obsessional character defences. Erikson says 'There is a limit to a child's and an adult's endurance in the face of demands to consider himself, his body, and his wishes as evil and dirty, and to his belief in the infallibility of those who pass such judgment' (p. 245).

Guilt persecution and shame persecution: shame and doubt

Freud linked doubt with obsessionality, jealousy and doubt of the object's love. His well-known aphorism 'A man who doubts his own love may, or rather must, doubt every lesser thing' is from his account of the 'Rat Man' (1909: 241). Obsessional doubt may look like doubt of the object but it is really self-doubt. 'The doubt is in reality a doubt of his own love – which ought to be the most certain thing in his whole mind' (p. 241). This points to the idea of pathological doubt as a narcissistic problem. Freud's explanation of the obsessional wavering is that it derives from the patient's love being inhibited by his hatred. However, is this a description rather than an explanation? Why the excess of hostility? Perhaps the presence of a desired object excites the shame-prone subject's chronic self-doubt. He says to himself 'if she really saw me as I know myself to be she would find me unworthy, dirty and disgusting'. This activates defensive, hostile fantasies (leading to further shame and, of course, guilt), which then have to be undone. The patient suffers from the presence of a domineering internal object that over-controls and negatively criticizes the patient's *true* or autonomous self with its oral, anal and phallic sexual desires.

Doubt for Erikson is 'the brother of shame' ([1950] 1973: 245) and is due to the ever-present threat of the return of repressed shameful awareness within our unconscious of the fact that we turn our back upon our 'behinds'. The mother is experienced as forcefully dominating the productivity of this part of the body and as giving positive or negative value to its products. Excessive doubt about one's autonomy in this area forms a residue which may become the *bedrock of later paranoia* in which the person fears secret attacks *'from behind'* or from *'within the behind'*. Erikson says:

> this stage, therefore, becomes decisive for the ratio of love and hate, cooperation and wilfulness, freedom of self-expression and its suppression. From a sense of self-control without loss of self-esteem comes a lasting sense of good-will and pride; from a sense of loss of self-control and of foreign over-control comes a lasting propensity for doubt and shame. ([1950] 1973: 245–6)

Shaming is used to socialize the infant. This is appropriate provided it is balanced by pride in the infant's progress.

Doubt and the beautiful picture

Mrs Klein does not refer to shame but in her paper 'A contribution to the psychogenesis of manic-depressive states' ([1935] 1975) she comments on a sense of doubt linked to feelings of unworthiness (p. 270). She proposes that these states of mind arise out of defences against projections of bad aspects of

the self. The breast fails or satisfies the infant. The satisfying breast becomes an internal good object because the infant projects onto it his loving feelings. The frustrating breast becomes an internal bad object because the infant projects onto it his sadistic feelings. 2 The infant is then either soothed or persecuted by these alternative projections. In depression the subject has failed to secure a good internalized object and has identified with the bad one.

According to Klein there is within the infant's mind, due to splitting, alongside the attacked and damaged maternal object, a compensatory 'beautiful picture' (p. 270) of the mother. The child knows this is only a picture. The actual mother is experienced as dangerous, damaged or damaging. It may be construed from what Klein says that the infant *doubts* his capacity to repair and restore the object damaged by his attacks and that the anxieties created by this doubt may be defended against by means of manic omnipotence. Omnipotence assures control and mastery of the otherwise dangerous doubt and the dangerous objects. By using the beautiful picture of the idealized mother as a replacement for the anxiety-inducing, disavowed, damaged object, the infant becomes at one with the beautiful object. This is always accompanied by ever-present doubt of the validity of this achievement.

Shame and doubt may play a significant and underrated part in causing depression and mania. States of persecution by a *negatively valuing internal object* are a threat to the infant's and the child's sense of autonomy and this will inevitably activate shame. Chronic states of persecutory anxiety, in Kleinian terms manifestations of the paranoid-schizoid position, are as likely to be driven by shame as by guilt. Within the analytic setting, shame-persecution and guilt-persecution give rise to different defences, transferences and counter-transferences. The analytic frame is designed to thwart the id-wishes of the patient. This will give rise to frustration and to defensive *aggressive* attacks upon the analyst. This requires the analysis of associated guilt-persecution. The activation of the patient's id-demands will also give rise to humiliation and shame. There are two reasons for this: the actual or imagined exposure of shameful oral, anal and phallic impulses, and *the shameful failure of omnipotent wishes to evoke a satisfactory response from the analyst.* This may lead to defensive, sadistic (or masochistic) attacks. This requires the analysis of shame-persecution.

Sadistic or masochistic reactions seek to actively reverse a shameful, humiliating, passive situation and relocate the unbearable pain of shame somewhere else other than in the mind of the patient. A part of the self, a part of the body or the mind of the analyst becomes *the alien other* to be treated cruelly by holding it in a state of shameful failure and hurting. Analysing this can transform the sadism into the ordinary aggression of more direct and open attacks. Failure to attend to shame can lead to the analysis becoming collusive, false or stuck.

Shame and guilt: the internal eye and the internal voice

To be is to be ashamed

Shame and guilt are often found together but they are quite different. Manageable shame induces self-reflection. Manageable guilt induces reparation. Guilt results from a transgression of a superego limit. Shame results from the failure to live up to an ego-ideal. A wish to be *punished* indicates unconscious guilt. A wish to be *hidden* indicates unconscious shame. Guilt arises out of a sense that we have attacked and damaged the other, whose retribution we then expect and fear. Shame arises out of a sense that we are no longer seen as we would like to be seen by the other, whose shunning we expect and fear. Acute shame emerges out of a sudden confrontation with the reality that we are who we are and not who we would like to be. The wish to hide from the searing gaze of the other indicates an unconscious wish to annihilate the seeing, shaming other. A melancholic identification has occurred with the shunning object. If this identification is total, suicide may result.

Lacan refers to Sartre:

> The entire phenomenology of shame, of modesty, of prestige, of the specific fear engendered by the gaze, is quite admirably described there...it is essential reading for an analyst'. ([1954] 1998: 215)

For Lacan shame is a signal anxiety that arises in the mirror stage when the infant's narcissistic equilibrium is disturbed by the recognition of his own image. This recognition of the self-as-other contributes to the formation of the ego-ideal and marks the beginning of inevitable *alienation*. This mirror-stage heralds the beginning of a dialectic between a subjective self that is prone to the double gaze of the other and the objective self. Sartre and Lacan understood that *to be is to be ashamed*.

Bio-evolutionary ideas and evidence from infant observation tend to support Erikson's view that 'visual shame precedes auditory guilt' ([1950] 1973: 244). Shame therefore goes unnoticed because it is earlier and is hidden by an overlay of guilt. These bio-neurological ideas suggest that proto-shame begins as one of a number of brain mechanisms designed to regulate incoming stimuli. These ideas about primitive brain mechanisms conform rather closely to Freud's quantitive-economic theory (see Demos, 1995; Tomkins, 1962; Nathanson 1987; Schore, 1999). Proto-shame is at first a purely neurological mechanism with the aim of shutting down the brain in response to potentially traumatic overload. It may be observed in the slumping and turning-away response in young infants (Nathanson, 1992: 135). What seems to begin as neurological event becomes a method of affect regulation and develops into phenomena such as turning away from, and rejection of, ineffective or non-reciprocating attachment with 'wrong' objects (for example, 8-month stranger anxiety.)

Guilt and shame: the psyche and the soma

Although the repression of guilt may lead to secondary somatic symptoms it is a *mental* event from the moment it is experienced. Shame is first of all a *somatic* event. It is initially experienced via the brain's automatic system and signalled by the body. The brain shuts down the mind so that we are paralysed and cannot think. Acute shame precipitates us out of language and into our bodies, into a sudden state of hypochondria. In this state we are lost for words and thoughts.[3] Only after this is shame processed as a mental event. The idea of shame as originating in a primitive neurological control system makes sense of the way that certain patients will suddenly 'go blank'. In the analytic situation it may be useful for the therapist to think of this as a possible indication of unmanageable shame and wait for the return of the ability to mentalize. Once the ego regains control somatic shame gives way to psychological shame with the usual fantasies of disappearing, hiding, turning back the clock or of annihilating the scrutinizing other.

Manic depression: the reservoir of shame and doubt

David, a manic-depressive patient (see Archer, 2002) was a workaholic in order to gain approval from his colleagues. He had joined an accountancy firm as the third partner and by means of his manic work routine of 15-hour days with little sleep he doubled the profits of the company. He was constantly warding off chronic potential shame and self-doubt due to a childhood in which he had been expected to bolster the self-esteem of his depressed mother. He felt that she had treated him as her 'little Rolls Royce' but only with the proviso that he did everything she wanted, otherwise her negative criticism would be relentless. She eventually killed herself. Guilt played a part in his difficulties but more than anything, he had felt helpless to cure his mother and ashamed of his failure to live up to her unrealistic expectations of him.

One day at work a passing remark by a colleague intended as a joke so humiliated him that he retaliated by stealing a huge amount of money and fleeing abroad. He collapsed into serious depression and broke down. Later he returned home and reimbursed the money. There was a cover-up, but having been offered a job by a new company he was threatened with exposure. The company bank manager had discovered what David had done and advised him to move away and change his identity or he would spill the beans. David became increasingly depressed. His wife, worn down by this, told him she had had enough. He later realized that he had taken this to mean that she had seen through him as counterfeit and useless. He felt overwhelmed with catastrophic shame, went blank, took a hammer and bashed in her head in order to annihilate her as a shaming object. She survived.

During the therapy David tried to maintain his bland and charming front of shamelessness and lack of doubt. Initially it was me who experienced all the

shame and doubt. This counter-transference took some time to understand. It was important to sort out, first in my mind and then in the patient's, what was shame-driven and what was guilt-driven. I would feel subtly and covertly undermined by him. He would charm me into avoiding the seriousness of his situation, making me feel foolish and useless. His blandness and lack of concern would sometimes make me feel sadistic and this could make me ashamed. If he felt my critical gaze upon him his righteous anger could be intimidating. I learned that this reaction was usually a response either to his feeling shamefully exposed and seen into by me or to his sense of *failure* to obtain from me the idealized, unconditional care that he wanted. Interpreting the guilt arising from his attacks was futile until I had understood its origin in defences against exposure, failure, humiliation and shame.

For patients like David who are prone to shame and doubt the trigger for defensive action is humiliation and it may be caused by a chance remark made by another, a doubtful thought sparked off by something heard or read, a compliment expected but not paid, a physical illness or injury – anything that casts doubt upon the state of omnipotence. The manic-depressive is very fragile. The same slight that others would ignore or 'edit' creates a catastrophic trauma due to the eruption of doubt and shame. This overwhelms a structure based on fragile omnipotence. Once the defensive wall is breached by doubt and shame, persecution pours in as self-esteem collapses. The only way out of this quagmire is for the subject to run away, which creates unbearable loneliness, to attack the shaming object, which creates potential guilt, or to use omnipotence to reconstruct out of the fragments of the disaster, a collage or picture of the self as a perfect 'Rolls Royce'. This is a picture of the self as ideally good and approved of by a corresponding picture of an approving mother. The reservoir of self-esteem is artificially re-filled again. In this state of omnipotence shame is abolished but the subject knows that the reconstructed version *is only a picture*, a fraud, and so, once again, nagging doubt is ever present. This cannot last and eventually the defensive wall is once more breached and unbearable doubt erupts.

Ms Y and the 'shameless object'

I want to use material from another patient to illustrate the significance of the presence of the 'shameless object'. The shameless object is a fundamentalist object in that it is absolutely free of any doubt about itself. The analyst is objectified as such because of the projection of a particular sort of internal object. The patient has internalized this object as a result of seeing himself relentlessly negatively valued by a counterfeit and shameless parental object that the patient feels powerless to change.

Ms Y came to analysis because she 'felt like shit'. Her difficult and relentlessly aggressive mistrust made the analytic work gruelling but she was

dedicated and committed to the analysis and she had taught me much. She was the kind of patient who would attract the label 'borderline' because of her paranoid mistrust of her objects. She was uncomfortable in her own skin. She complained of a severely hypochondriachal, uncontaining, self-centred mother who had always countered Ms Y's childhood needs with an expression of her own neediness. The patient's relentless contempt for her parents and her husband struck me from the start as shameless. The patient's family on both sides came from backgrounds dominated by the shame of abject poverty. Sexuality was shameful and sex, according to mother, was a dirty, unpleasant duty. The patient grew up in an atmosphere that she experienced as extremely negative. Worse than uncontained, she felt as a child, and now as an adult, relentlessly projected into by both parents. She felt constantly undermined and criticized by a father whom she described as if he were besieged by envy. He rubbished everything and everyone, including any of the patient's interests and potential childhood friends. He would tell her 'what's the point in taking an interest in that shit'. Father wanted her to go to the best university. Any other option, he said, was 'shit'. Ms Y said that absolutely the worst thing was the way that her mother, while dramatically wallowing in self-blame, took no real responsibility for anything.

This internalization of such a negative experience meant, not surprisingly, that Ms Y's sexual development went awry making it very difficult for her to manage the Oedipal situation. Her idea of a parental relationship seems to be suffused with Hieronymus Bosch-like images of violence and rape. Her penis envy was evident in her statement that she hated men because 'they can get away with anything'. Perhaps in identification with her mother she recalled no sexual feelings until well after her teens.

Underneath this harsh, negative and cruel exterior there seemed to be a little girl who longed to be cherished and she seemed to have locked this aspect of herself away for safe-keeping. She was persecuted by a view of herself as useless, hopeless, filthy and deadly. She imagined that I thought of her in this way. She saw herself as deadly. Just as with her mother, guilt caused by her defensive hostility could only be counterfeited in a placatory way. A negative ego-ideal and domineering shame had contributed to a terrible superego.

In the early stages of the analysis the patient would complain bitterly about her situation. Then she might begin a session by apologizing for her behaviour. I would be relieved but nothing would change. I began to think that, as with the mother she described, this was pseudo-guilt designed to ward off my rejecting her. I thought that she was meanwhile warding off shame about her dramatic, relentless and destructive moaning, (which at times had an excited, sado-masochistic quality). The patient was effective in creating a particular kind of counter-transference trap in which she would relentlessly rubbish me, inviting me to retaliate, switch off or avoid trouble by being nice to her. All this would make me feel incompetent and ashamed. I then had a choice: I could

either deal with my shame by trying to make myself more like the analyst I thought I ought to be, or avoid the shame by going blank. Worse, I might temporarily succumb to cruel, critical impulses in order to relocate this shame in her. This would make me feel further shame (and guilt, the guilt that was beyond her reach).

Ms Y, like the patients described by Rivière, was hypersensitive to any hint of criticism, which would make her feel both triumphant and frightened. If the patient sensed that I had given in to sadistic impulses she could imagine she had levelled the playing field. If she could project her shame into me she would no longer have to envy what she perceived as my freedom from shame. And so the patient would frequently shout at me, accusing me of being utterly complacent and self-centred.

An analytic session

Ms Y berated me relentlessly for about twenty minutes, telling me in an increasingly excited way:

> You are useless, I don't, and can't trust you, you have not said anything useful for years, when you do speak all you tell me is that I am rubbish and shit. You pay no attention to how difficult my life is. When you do say something it is based on some stupid analytic theory. I may as well end the analysis.

She fell silent and I thought she was waiting to see what I would do. I asked her what happened now she was silent: What did she imagine I might feel or think? She replied 'I don't think you feel anything, I think you are thinking you want to get rid of me'. I asked her why I would want to do this and she replied 'because I am useless'. She began to work herself up again as she launched herself into her complaint. This time it lacked the force of the previous attack. She began to sound *doubtful* in contrast to her previous doubt-free, fundamentalist position. She ran out of steam and I asked her why if I wanted to get rid of her, I wouldn't tell her so, but would instead carry on putting up with her. She replied 'because I don't think you work that way. You would continue to make things so awful for me that I would eventually just go'.

She began to work herself up again but seemed to realize that she had might go too far. Perhaps needing to reassure me, she said that if she were discussing herself as a case with someone else, then that person might say to her 'don't worry, she is just being difficult, awful and foul, you've just got to wait'. I chuckled at this and she laughed in response. The she reprimanded me by saying 'I don't know why you are laughing. You don't ever seem to think I think about anything'. I said that I thought she knew that my chuckle had been affectionate and that I thought that this was more frightening for her than the usual complaint. The patient said 'Well, it means I can't be as angry as I was which is

a relief, really'. She began to sob. Then she said 'but it doesn't sort anything out'. I told her that I thought she was right, that it did not sort out what went on when she got herself into a state of mind where she rubbished both herself and me in a relentless way. The patient took this up by saying:

> Well, I hear that as you saying to me that it's never your fault, it's never down to anything to do with you', and as you telling me that it's all due to my internal state – or some such theoretical crap. I'm just not a suitable patient for this kind of work. I can't see any way forward.

I said 'um'. The patient said 'saying "um" is cheating. It is like you are saying "come on, you can't carry on being that horrible."' (The patent was much calmer than she had been.) She continued: 'Somehow I always end up feeling blamed and then I can't think. I just feel you think everything is my fault all the time'. I said 'I think you are seeing me as utterly self-righteous, as never admitting that anything is ever my fault'. Ms Y replied 'I had not thought if it as you being self-righteous. I have never thought about that before, which is odd.' I told her that actually that was not quite true – we had talked before about how she could see me as shamelessly self-righteous. The patient then said, thoughtfully, 'Like my mother not taking responsibility for anything'. I said 'Yes, "mea culpa" but shameless, no real responsibility'. The patient took this up by saying:

> Yes, and I get furious and then I flip and become just like her! Not responsible for anything, utterly self-righteous. It's not so easy to just leave now. I do wonder why I am so furious when the things you said that made me furious were about two years ago and you might actually change your mind. When I get furious I forget I think that.

I think this shows how this patient was determined to put me in the position of the utterly shameless, fundamentalist object about which she complained. When we chuckled together she quite rightly pointed out that this in no way let me off the hook. As a shameless object, if I did not accept my shame then I could not change. It was no good me just cheering us both up. From the patient's point of view, if I could accept my shame then I could become a better analyst.

After this session the patient reported a dream in which there is another chair between my chair and the couch. I move into this chair, which is closer to her. This dream seemed to show that our difficult exchange had led us to some closer understanding of the situation.

Seeing such patients from the viewpoint of shame can help avoid the problem of intractable, retaliatory shame-guilt cycles in the transference and counter-transference. It can help such patients move towards the possibility of seeing their objects as being able to resist the impulse to shamelessly devalue

and reject them. This may help with slow progress towards the relinquishing of extreme, masochistic *shameful submission* to a shameless, fundamentalist object.

Afterword

I am sure that as the investigation of shame continues it will come to take its rightful place within psychoanalytic theories of unconscious motivation and conflict. Over 400 years ago Robert Burton published his study of depression, *The Anatomy of Melancholy*. Linking shame with failure, exposure, hiding and envy he says

> Shame and disgrace cause most violent passions and bitter pangs... Generous minds are often moved with shame, to despair for some public disgrace. And he...that subjects himself to fear, grief, ambition, shame, is not happy, but altogether miserable, tortured with continual labour, care, and misery. It is as forcible a batterer as any of the rest: Many men neglect the tumults of the world, and care not for glory, and yet they are afraid of infamy, repulse, disgrace...they are quite battered and broken, with reproach and obloquy...and are so dejected many times for some public injury, disgrace, as a box on the ear by their inferior, to be overcome of their adversary, foiled in the field, to be out in a speech, some foul fact committed or disclosed, &c. that they dare not come abroad all their lives after, but melancholise in corners, and keep in holes...Yet a modest man, one that hath grace, a generous spirit, tender of his reputation, will be deeply wounded, and so grievously affected with it, that he had rather give myriads of crowns, lose his life, than suffer the least defamation of honour, or blot in his good name. And if so be that he cannot avoid it, as a nightingale, dies for shame if another bird sing better, he languisheth and pineth away in the anguish of his spirit...' I know there be many base, impudent, brazenfaced rogues, that will be moved with nothing, take no infamy or disgrace to heart, laugh at all; let them be proved perjured, stigmatised, convict rogues, thieves, traitors, lose their ears, be whipped, branded, carted, pointed at, hissed, reviled, and derided...what care they? We have too many such in our times. (1662, Subsect. VI– Shame and Disgrace, Causes)

Burton knew 400 years ago what psychoanalysis is having to rediscover: excessive shame, or its disavowal in the form of shamelessness is central to the creation of much that troubles the mind.

Notes

1. See Susan B. Miller (1989) for details of this other Freudian view of shame.
2. This is questionable as far as young infants are concerned: while frustration in the infant will surely give rise to instinctual aggression, sadism is a sophisticated condition requiring knowledge that there is another who can be kept in a state of hurting.
3. This may be what accounts for the so-called blank or 'essential depression' that is 'without an object and without guilt' described by the Paris psychosomatic school (Marty, quoted in Aisenstein, 1993: 376). These patients seem to have pathologically separated themselves from their vulnerable

bodies and are made catastrophically and shamefully aware of them when they become ill.

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Faith in the therapeutic process

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ABSTRACT

The 'social dreaming matrix' raises significant questions about unconscious communication and the arena within which dreams are formed. Put simply: is psyche 'in' us, or do we live 'in' psyche? Beginning with some of Freud's early thoughts about unconscious communication and telepathy this paper explores aspects of post-Freudian, Jungian and Group Analytic thinking, and suggests that quantum field theory may have important implications for psychological understanding. The paper is also an appeal for analytical psychotherapy organizations not to lose their nerve, in the present rather daunting legal and managerial climate, but to seek ways of attending to the 'wisdom of the unconscious' in their collective deliberations. An attempt to do this, at St Marylebone Healing and Counselling Centre, is described. This may provide a link to more ancient religious understandings that supplied one of the roots that grew into the analytical psychology movement.

Key words faith, social dreaming matrix, unconscious communication

> What science will ever be able to reveal to man the origin, nature and character of that conscious power to will and to love which constitutes his life?
>
> Teilhard de Chardin, *Le Milieu Divin* (1964: 77)
>
> To discover how to be human now
> Is the reason we follow this star.
>
> W. H. Auden (1994: 370)

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Introduction

Every paper has a story. This paper arose, at least in part, from my experience of the social dreaming matrix (SDM) at our last residential conference. That experience puzzled me: dreams told, heard and associated to, in that setting, sounded different from dreams told in therapy. In the SDM the dream becomes a public event with collective significance. But where do dreams come from? Are they merely individual products? Or do they arise from a deeper matrix in which, somehow, we are all contained?

These questions chimed, in my mind, with long-term wonderments about processes such as unconscious communication, projection and introjection. We use these concepts all the time, but what do they actually involve? Is there a sense in which we are psychically permeable by each other and, if we are, what are the metaphysical implications?

These wonderments have particular resonance for me, interested – and, indeed, professionally committed – as I am to thinking about the psychology of religious experience and the resonances and conflicts between analytical understandings and religious beliefs. But they also seem to me to have important implications for psychological and spiritual health – not least the health of psychotherapy organizations – particularly those committed to the exploration of unconscious processes. Can we thrive in the present rather daunting legal and managerial climate unless we make time to dream together, to allow the wisdom of the unconscious to inform our collective deliberations?

These are some of the questions which drive this paper and which take me on a roundabout route through Freudian, Jungian and Group Analytic thinking, until I reach a place where I think I can begin to make sense of the SDM. Because these thoughts are intended to have practical application, I also describe my experience with colleagues at St Marylebone, where we have been seeking to explore a space which is somewhere between social dreaming, free association and prayer.

Freud

In *The New Introductory Lectures on Psycho-Analysis*, Freud maintains that psychoanalysis must accept the Weltanschauung of contemporary science (Freud, 1933: 158); and he sometimes delighted to present himself as a hard-headed rationalist claiming, for example, that 'Analysts are at bottom incorrigible mechanists and materialists' (Freud, [1921] 1941: 179). However, Freud's scientific outlook did not preclude an active interest in the paranormal and in a series of papers written during the first 20 years of the last century (Freud, 1899: 623; 1901: 260f; 1912: 115f; 1913: 320; 1915: 194), he elaborated a theory of unconscious communication which culminated in his paper *Psycho-analysis and Telepathy*, which he read to a small group of his most trusted colleagues in 1921.[1]

In this paper, Freud describes the analysis of a young man who came into analysis shortly after the marriage of his younger sister, to whom he had been devoted with what Freud calls 'more than brotherly affection'. Before this marriage, the patient had taken his prospective brother-in-law on a climbing trip, which had nearly ended in disaster, and he offered 'little objection' to Freud's interpretation of this adventure as 'an attempted murder and suicide'. (Freud, [1921] 1941: 182). A year or more later, Freud's patient consulted a fortune-teller, giving her the brother-in-law's date of birth without 'mentioning his name or betraying the fact that he had him in mind'. The fortune-teller pronounced as follows,

> 'The person in question will die next July or August of crayfish- or oyster-poisoning.' After telling me this, my patient added: 'It was marvellous!' (Freud, 1941 [1921]: 183)

By the time Freud learned of this prediction summer had passed and the brother-in-law had not died. So why was it 'marvellous'? Because, said the patient,

> My brother-in-law is passionately fond of crayfish and oysters and so on and *last* August he really did have an attack of crayfish poisoning and almost died of it. (Freud, [1921] 1941: 183)

Trusting his patient, Freud was in no doubt about the veracity of his story. Indeed, he adds:

> I myself was so much struck – to tell the truth, so disagreeably affected – that I omitted to make any analytic use of his tale. (Freud, [1921] 1941: 183).

In retrospect, though, he made two deductions. First, that the event is (only) explicable if we are prepared to assume that the knowledge was transferred from one person's mind to the other 'by some unknown method which excluded the means of communication familiar to us' (Freud, [1921] 1941: 184). And, second,

> that what has been communicated by this means of induction from one person to another is not merely a chance piece of indifferent knowledge. It shows that an extraordinarily powerful wish harboured by one person and standing in a special relation to his consciousness has succeeded, with the help of a second person, in finding conscious expression in a slightly disguised form. (Freud, [1921] 1941: 184f)

Freud's hypothesis is that the fortune-teller, making use of an unknown channel of communication, correctly intuited a historical fact, but was confused by her client's continuing death wish towards his brother-in-law into

imagining that the man would shortly die; which suggests that telepathic communication, if it exists, does not give objective access to the 'whole truth', but is influenced by the feeling tone which attaches to the unconscious content concerned. Freud concludes the paper by saying,

> Perhaps the problem of thought-transference may seem very trivial to you in comparison with the great magical world of the occult. But consider what a momentous step beyond what we have hitherto believed would be involved in this hypothesis alone. (Freud, [1921] 1941: 193)

Freud was not alone, in the early years of psychoanalysis, in pursuing an interest in the paranormal. He was enthusiastic about publishing a book by Ferenczi on his thought transference experiments (Totton, 2003: 7) and Devereux edited a collection of papers on *Psychoanalysis and the Occult* (1974), which included contributions by several analysts who were well regarded in their day.[2] The interest continued into the 1940s and 50s, but thereafter, as Totton says, 'silence' (2003: 4). Why did interest wane? Totton points to a dispute, in the *International Journal of Psychoanalysis*, which followed the appearance of a paper by Jule Eisenbud in 1955, in which he described a patient's dream of seeing a worm-eating warbler in New York's Central Park, at a time of year when these migratory birds had never been seen. Rising at 5 o'clock the next morning the patient, a keen bird spotter, went to Central Park and the bird was there (Eisenbud, 1955). In the correspondence that followed, Eisenbud appears to have won the factual argument, but his disputant, Charles Brenner, seems to have carried the day. Years later, Brenner wrote:

> I have a private rule of thumb in such matters: When a thing is impossible, it cannot be so. Like all rules of thumb, it is not infallible. Some things that are impossible turn out to be so, but they are the rare exceptions. In my opinion the rule holds good for psi phenomena. (Totton, 2003: 6)

As psychoanalysis consolidated itself after Freud's death and underwent the inevitable process of institutionalization, there was less desire to challenge the accepted tenets of science – as Freud had done when he placed unconscious processes at the heart of his psychology. In 1973, for example, the psychoanalyst Robert Stoller wrote a paper on a series of dreams – his own and his patients – which appeared to be telepathic and gave it to his supervisor, Ralph Greenson, to read.

> While Greenson was much impressed by it (indeed, 'shaken' and 'permanently affected,' . . .) [he] purportedly told Stoller that if he valued his career as a young and reputable psychoanalyst he would, at least for the moment, put it away and try not to publish it. (Lloyd-Mayer, 2001: 630)[3]

Perhaps psychoanalysis was a victim of its own success: because it had become routine to think in terms of unconscious communication and to acknowledge that people in psychotic and borderline states are sometimes able to conjure information about their analyst's inner worlds 'out of the air', no one stopped to ask the hard metaphysical and scientific questions about what these observations implied. Besides, psychoanalytic energy was vested elsewhere, not least in England, in dispute over the contributions of Melanie Klein; but by a strange twist of fate it is the contributions of Klein and some of her successors that have reopened the metaphysical debate in the psychoanalytic camp.

In his book *Therapy or Coercion? Does Psychoanalysis Differ from Brainwashing?* (1997) Hinshelwood explores the implications of primitive mechanisms – splitting, projection and introjection (which he illustrates with clinical material) – for our understanding of identity and the integrity of the personality; and contends that there is something about what he calls 'Kleinian splitting' which provokes philosophical unease (Hinshelwood, 1997: 182, n4). The reason for this is that whereas 'Well founded common-sense psychology takes the unity of mind and person as an *a priori* assumption,' the Kleinian notion of splitting suggests that *parts of one mind can exist in more than one body.* Or, as he puts it in another place,

> One person's belongings can become another's, and the primitive psychological mechanisms of exchange . . . are such a trade. (Hinshelwood, 1997: 188f)

He writes,

> if these are valid phenomena, then the common-sense metaphysical assumptions and claims about the unity of the mind and of the person have to change. (Hinshelwood, 1997: 181)

To me, these statements are metaphysical dynamite. What is going on in the therapeutic process? Have we adequate models to describe it?

Jung

Hinshelwood is interested in the most primitive psychological mechanisms. If we are psychically permeable, as he suggests, it is likely that the clue to the mechanisms involved will be found at this primitive level. If we turn, now, from the psychoanalytic tradition to Jung's psychology, we find ourselves in a psychological environment which reflects Jung's own massive pre-Oedipal struggle: the battle to differentiate himself from an all-encompassing mother – just the level at which Hinshelwood's Kleinian mechanisms are most likely to be observed. *Psychology of the Unconscious, A Study of the Transformations and Symbolisms of the Libido* (Jung, 1991) – the book which marked Jung's final break from Freud – is, at least in part,

Jung's first titanic effort to free himself from this stifling inner confusion by making some sense of it. The final chapter headings tell their own story: 'Symbolism of the mother and rebirth', 'The battle for deliverance from the mother', ' The dual mother role' and 'The sacrifice'. If Freud's psychology attended, primarily, to whole people in relationship, Jung's is about the struggle to separate, to individuate and to achieve a working balance between the operations of the ego and the unconscious (MacKenna, 2000).

Jung came from a family, on his mother's side, in which paranormal phenomena were not just discussed, but expected (Bair, 2004: 14–18; Charet, 1993). *Memories, Dreams, Reflections* (Jung, 1995) gives many examples. Jung attributed some of these experiences to what he called 'participation mystique': a state of 'unconscious identity' in which 'The unconscious is . . . projected into the object, and the object is introjected into the subject, becoming part of his psychology' (Jung, 1957: para 66). (Note the resonances with Hinshelwood's contention that parts of one mind can exist in more than one body.)[4]

There is a considerable difference, though, between fused states of unconscious identity and a state of mind in which there is space for mutual experience *and* reflection. Much of Jung's writing is concerned with the development of this space which he 'located' in inter-psychic space *between* the patient and analyst. He made this point in a conversation recorded by Professor Charles Baudouin, in October 1934.

> We were speaking one evening of 'telepathic' dreams where, between persons who are emotionally close, a mutual unconscious communication and penetration appears to take place. Jung finally, to sum up his thoughts on the matter, acted them out as follows: with brief, firm gestures he touched first my forehead, then his own, and thirdly drew a great circle with his hand in the space between us; the three motions underscored the three clauses of this statement; 'In short, one doesn't dream here, and one doesn't dream here, one dreams there.' And *there* the hand kept turning . . . (McGuire and Hull, 1980: 91)

The 'third space'

The establishment of this third space between patient and analyst, with the suggestion that this space is, in some sense, a telepathic space and that dreams arise within this space, moves our thinking forward.

So far, I have been exploring the possibility of high degrees of psychic-interconnectedness between people, giving rise to occasional, striking phenomena. Psychoanalytic theory can comprehend these events if they are seen as some kind of regression, perhaps akin to an early state of maternal reverie, or as radical forms of splitting and projective identification; but what happens to these capacities as we grow up, especially if we grow up in a scientific climate, or in a culture which does not believe in them? Is there any way in which they can find continuing, mature expression, or are they doomed only to

find a home in some kind of psychic freak show? This is an area, I believe, in which Jung and his successors have some interesting ideas to contribute to analytic thinking.

When Jung wrote about the transference he did so through a study of the illustrations in an alchemical text, the *Rosarium Philosophorum*. He found this text suggestive because it described a developmental process which moved through a stage of fusion in which the symbolic king and the queen, the partners in this union, are 'dissolved' in the alchemical bath – this corresponds to Hinshelwood's primitive psychological mechanisms – and then on into stages of differentiation which enable genuine intercourse to occur. Jung called the non-physical moments of conjunction which occur in psychotherapy – when analyst and patient are united in states of conscious and unconscious integration and harmony – 'coniunctio', and writes that whereas a union in unconscious identity:

> could be compared with the primitive, initial state of chaos . . . or rather with the state of *participation mystique* where heterogeneous factors merge in an unconscious relationship . . . The *coniunctio* differs from this not as a mechanism but *because it is by nature never an initial state: it is always the product of a process or the goal of endeavour*. (Jung, 1946 : para 462, my italics)

Writing more recently, Reed explains that,

> the *coniunctio* is . . . an interpersonal event between patient and therapist, which either partner can access by a special form of relational insight that is sensitive not to events *within*, as in insight, but to events *between* the self and another . . . By respecting and attending to the spontaneous images and those felt, almost-images as *a real domain of information*[5] [my italics], the therapist can, if he proposes, directly apprehend the activities of the *coniunctio*, or the events taking place 'in between'. (Reed, 1996: 84)

A clinical illustration[6]

I sometimes find this imaginal approach to what is occurring in the space *between* myself and my patient extremely revealing. Either in the session, or afterwards, I allow my mind to float free and 'see' the pictures which emerge. Are we playing, or fighting, or hiding, or am I attacking my patient, or are we making love? Often my dreams, or my patient's dreams, illuminate this imaginal realm. For example, I once worked with an able and highly motivated female patient. Together, we seemed to be 'doing everything right', frequently there was a highly charged emotional atmosphere in the room, and I think we enjoyed working together, but nothing seemed to change. Then, one day, she brought a dream about being involved in a sword fight in which she was fighting someone in a mask. In the dream she was enjoying the fight, revelling in her strength and energetically parrying the unknown person's

thrusts, but there were great unthought questions about what would happen should she relinquish her sword. The dream moved us on, giving us a symbolic picture of our relationship and enabling us to begin to get to grips with the underlying fears and exciting sado-masochistic fantasies which, unconsciously, we had been enacting. Does this differ from analysis of the transference? I think it does, to the extent that the dream enabled us jointly to recognize, not just the contents of her inner world that she was unconsciously projecting on to me, but the drama in which we were *mutually* involved.

In a major paper reviewing the concept of transference, Hinshelwood distinguishes between the 'Kleinian emphasis on the epistemic goal of analysis – to know what is happening' and the Independent Group of Psychoanalyst's 'aim for a joint or mutual creativity within the 'in-between' of the affective relationship' (Hinshelwood, 1999: 808). My reaction to this distinction is to wonder whether each group is responding particularly to the needs of patients at different developmental stages. In more disturbed states of mind, or in deeper levels of regression, communication will be by participation mystique or projective identification, which, in their more pathological forms, may be experienced as possession, or violent impingement. When working at this depth, the counter-transference will be our principal clue to understanding. But as the work progresses I have sometimes found that the 'stage' shifts and, instead of being lodged in the 'theatre' of my body, it moves out into the interpersonal space *between* us – which might be thought of along the lines of a 'field' in physics.[7] If, by my attitude, I were to reject a patient's need to regress to a more primitive state of mind and 'demand' that they meet me in interpersonal space, then, I imagine, I would be re-enacting some aspect of their mother's inability to receive their projections. On the other hand, to stick rigidly to monitoring my internal processes, while declining to allow my imagination to 'meet' my patient in interpersonal space, might risk 'imprisoning' them in more primitive forms of communication. Either way, I agree with Hinshelwood that all interactions need to be exposed to 'verbal conscious enquiry or scrutiny'.

On the occasions when the 'stage' does shift into the interpersonal space, I find myself juggling two dimensions. First, there is – metaphorically speaking – the horizontal dimension: what is occurring *between* myself and my patient. Then there is, as it were, a vertical dimension: as if we are both earthed in some deeper reality, through which we are joined, but which also, somehow, wishes to express itself through us. It is as if the matter of our meeting flows both from within us and beyond us. In terms of my patient's dream, we might interpret it as the patient fighting me, the masked analyst; but the 'patient' in the dream *might* be a composite of the two of us, unconsciously resisting the appearance of some unconscious content.

Jung remarks that,

> The unconscious is commonly regarded as a sort of encapsulated fragment of our most personal and intimate life – something like what the Bible calls the 'heart' and considers the source of all evil thoughts. . . . This is how the unconscious looks from the conscious side. (Jung, 1954 : para 42)

But once we have worked through the repressed conflicts that originally brought us in to analysis, we may begin to find ourselves in a different relationship to the unconscious (and to our therapist), and in this different place the resources of the therapeutic space start to feel less bounded. In this state of mind, Jung suggests that:

> you are now more inclined to give heed to a helpful idea or intuition, or to notice thoughts which had not been allowed to voice themselves before. Perhaps you will pay attention to the dreams that visit you at such moments, or will reflect on certain inner and outer occurrences that take place just at this time. If you have an attitude of this kind, then the helpful powers slumbering in the deeper strata of man's nature can come awake and intervene, for helplessness and weakness are the eternal experience and the eternal problem of mankind. . . . Prayer, as we know, calls for a very similar attitude and therefore has much the same effect. (Jung, 1954 : para 44)

Where have we got to?

I am exploring the idea that unconscious communication, originally described by Freud, is a mysterious business. Once we entertain the idea that we are psychically 'permeable', that parts of one mind can be 'vested' in another person and that two people can inhabit a psychic space which is open to another dimension, the world becomes a rather curious place. Although some of this interconnectedness occurs at deeply unconscious and fused levels of psychic activity, I am also suggesting that, once we are aware of this third space and are prepared to 'wait on it', it may become the source of unexpected help: the unconscious as a well of creativity – perhaps, even, as the threshold of divinity.

I now want to extend the conversation by noting the group analytic concept of the 'foundation matrix' and use it as a stepping stone to the social dreaming matrix.

The foundation matrix

Group analysis begins with the challenging assumption that the whole is more elementary than the parts: what we experience in the first place is the *group as a whole*. Foulkes and Anthony suggest that, when a group begins to function:

> Particularly through their nervous systems and brains the organisms of the group members are in a state of interaction, in a common field, in interpenetration and communication. They speak now through one mouth, now through another. Active currents within the group may be expressed or come to a head in one particular person, between particular persons, or may, in a sense, be 'personified' in individuals. (Foulkes and Anthony, 1973: 258f)

I have written elsewhere about my group analytic experience and the question which often gripped me, 'Am I a "me", or are we a "we"?' (MacKenna, 2005). At these moments I felt I understood what Jung meant when he said, 'the greater part of the soul is outside the body'; and, again, 'man in my view is enclosed in *the* psyche (not in *his* psyche)' (Mogenson, 2004: 32).

Bion rejected the notion of a 'herd instinct' and the claim that a group is 'more than the sum of its members' (Bion, 2001: 169); but he also wrote that 'There is a matrix of thought which lies within the basic group, but not within the confines of the individual' (Bion, 2001: 91) and described a quality he called 'valency', which he defined as:

> The capacity of the individual for instantaneous combination with other individuals in an established pattern of behaviour – the basic assumptions.[8] (Bion, 2001: 175)

He found the ways in which the basic assumptions operate puzzling, believing that there were:

> no observations at present available to the psychiatrist to explain why emotions associated with a basic assumption were held together with each other with such tenacity and exclusiveness. (Bion, 2001: 100f)

In order to explain their characteristic features he was forced to postulate the existence of what he called 'proto-mental phenomena' – exactly as Jung had previously been forced to hypothesize the existence of archetypal patterns of fantasy and behaviour. Just as Jung distinguished between the archetype and the archetypal image, so Bion distinguished between the prototypes of the basic assumptions in the proto-mental system, where each exists as 'a whole in which no part can be separated from the rest' (Bion 2001: 101) and a different level where events emerge as psychological phenomena, at which the components of each basic assumption differentiate into their characteristic forms. Again, as with Jung's 'psychoid unconscious' (Samuels et al., 1986: 122; Bright, 1997), Bion pictured the proto-mental system as a matrix in which physical and psychological or mental are undifferentiated, and from which physical or psychological diseases may equally emerge (Bion, 2001: 101f).

But where is the proto-mental system located? Bion tried to draw an analogy from physical medicine, but acknowledged that it broke down because this

would suggest that proto-mental events are contained within the individual, whereas:

> in my opinion the sphere of proto-mental events cannot be understood by reference to the individual alone, and the intelligible field of study for the dynamics of proto-mental events is the individuals met together in a group. The proto-mental stage in the individual is only a part of the proto-mental system, for proto-mental phenomena are a function of the group and must therefore be studied in the group. (Bion, 2001: 103)

What seems to be emerging is the notion that the roots of our physical and emotional life are something which we hold (or, perhaps, realize) in common, rather than owning as an individual possession. Jung says,

> The deepest we can reach in our exploration of the unconscious mind is the layer where man is no longer a distinct individual, but where his mind widens out and merges into the mind of mankind – not the conscious mind, but the unconscious mind of mankind, where we are all the same. (Jung, 1935: para 87)

We are now in a position to turn to the social dreaming matrix.

The social dreaming matrix

Gordon Lawrence, the pioneer of the SDM, found his own way into these deep waters. Writing as a Tavistock trained group relations consultant, he has described the uncertainty he used to feel – given his psychoanalytic background – about handling dreams recounted in a group context, particularly when the dream seemed to speak to the experience of others or, more dramatically, when one group member seemed to hear from another a dream which they could not remember for themselves (Armstrong, in Lawrence, 1998: xvii, xx).

The aim of the SDM, as it has evolved through workshops conducted by Gordon Lawrence and others, is to provide a container within which we can surrender our analytic preconceptions about dreams and dreaming and discover what it means to be part of a wider social system, one which is open to this experience 'which is not oneself alone'. Writing, now, on the basis of many years experience, Lawrence says,

> Human beings create boundaries to explain what they perceive as well as to defend themselves from the anxiety of the terror of living in a boundary-less, infinite world. But dreams connect us fundamentally to the roots of life in a world governed by quantum mechanics, in which life and matter cannot be differentiated absolutely. (Lawrence, 1998: 1)

This is the level of Bion's proto-mental system and Jung's psychoid unconscious. Again, Lawrence writes,

> It is the dream . . . that links the individual to ultimate reality, which Bion signified as 'O'. For a praying person, O will signify the godhead the person is experiencing; for a psychoanalyst, O is the upcoming emotional truth of a session. (Lawrence, 1998: 41)

In his latest book, *Introduction to Social Dreaming: Transforming Thinking* (2005) Lawrence presents case material to illustrate the uncanny knowledge sometimes manifested through the matrix and draws on quantum theory to suggest an explanation of its functioning. Reading his work, it seems to me that social dreaming provides a matrix, a third space, in which many of the old divisions between Freud and Jung are transcended, by being lifted into a wider context.

Practical considerations

This paper has taken us on a roundabout journey. Beginning with Freud's early investigations into unconscious communication and telepathy, we have moved into the mysteries of interpersonal space where patient and analyst, or the members of a group, may discover, not just their personal interconnectedness, but an infinite realm which appears to be genuinely transpersonal.

If the world is as mysterious as the therapeutic process suggests, are there any practical implications for the ways in which we organize our life together? In the final section of this paper I want to share something of my experience, with colleagues, in the Healing and Counselling Centre, at St Marylebone and use this experience to wonder about our corporate life in the BAP. Is there, for example, a 'spirituality' appropriate for psychotherapy organizations?

St Marylebone

When I became Director of the Healing and Counselling Centre at St Marylebone, the Centre had been closed for over a year. All we had was an empty space. Into that space a group of colleagues came, several from the BAP, all committed to the analytical approach, but also seeking ways to bring psychotherapy into conjunction with the resources – and also the conflicts, contradictions and difficulties – of religious faith. How could we begin? As far as I am aware, no one has yet written a 'liturgy' for psychotherapists and besides, we were from different analytic and Christian traditions. Perhaps because we had nowhere else to begin, we began by telling our stories and were soon deeply moved by each others' struggles, as much with our psychotherapeutic as with our religious traditions and experience. Both were seminal to us but, as we discovered, both could restrict and even impale us.

What do you do when you have told your story? My memory is that, instinctively, we wanted to preserve the freedom and reflectiveness that we had begun

to enjoy as we moved in and out of these spiritual-cum-therapeutic areas. Some of us wanted to pray, but were aware how easily set forms of prayer can do violence to others' inner experience and conviction. What finally emerged was a spontaneously adapted variant of the social dreaming matrix. Instead of beginning with a dream we begin with a Bible reading appointed for that week. No one has to believe it, to like it, even to understand it. It is just there, an expression of the tradition we inhabit. The reading is 'dropped' into the group like a pebble into a pond. As it reverberates around the group it triggers reactions – feelings, memories, associations, experiences, dreams – which people are invited to share, as they feel able (there is no obligation for anyone to speak; the only rule is that everyone's association is accepted – no one has the right to criticize or challenge another's contribution). No two meetings are the same, but very often a 'dance' builds up around themes initially triggered by the reading, but which are then, increasingly, free associations profoundly expressive of people's inner thoughts and worlds.

Over the last four years certain themes have emerged which had particular resonance for the whole group and some of these have become themes of our public conferences, among them days that we called 'God and the unconscious', 'Evil and the unconscious', 'Free association or prayer?' and 'Sexuality and the Church'. As we have gained confidence in this freely associating process to provide energy and direction, so we have gradually changed the format of our days; now we have shorter formal contributions and more space within which participants can experience the matrix in action. St Marylebone is an Anglican Parish Church, but we find that Quakers, as well as psychotherapists are at home in these meetings.

This matrix is a place in which we have all, I think, experienced some resonance between psychotherapeutic understandings and the spiritual traditions of the Judaeo-Christian world. As I am coming to understand them, the psychotherapeutic and the Christian journeys are both threshold experiences. In both, knowledge is often closer to Keats' 'negative capability' than to formal propositions; and both are liable to the ossification, which occurs when dogma begins to substitute for experience, or structure takes precedence over the unfolding dream.

The BAP

Does this have any relevance for us, the members of the BAP?

One of the prime reasons why I have been anticipating this conference with slightly anxious excitement – 'anxious' because, on one or two occasions over the years, our internal tensions have nearly blown us apart – is the fact that it provides us with a precious opportunity for a good number of us to get together, away from our usual Sections and preoccupations and not just be together, but also dream together.

To my mind there is something curious, even slightly sinister, about psychotherapy organizations if they get so caught up in business and management – important as these are – as not to make time and space for their members collectively to dream and free associate. After all, what a betrayal it would be if we, the inheritors of the depth psychological revolution, were to conduct our business at a purely cognitive level that disallowed the unstructured space which lies at the heart of our endeavour. The social dreaming matrix at our last (and first) residential conference remains, for me, one of the most significant experiences in my 25-year membership of the BAP. For a short time we inhabited that naked space in which something, or nothing, might happen – but being there felt important.

Perhaps there are particular obstacles which impede the realization of my dream. In the way of things, our personal analyses are kept separate from our social and professional intercourse, so we have little experience of a setting in which the youngest member can dream the dream which is needed by the oldest; or the longest standing member encourage the most recent by their folly. We can so easily be daunted, even mesmerized, by all the multiple demands for higher standards and accountability, or by the threat of legal action, or imposed schemes of registration, which are currently in the air. Sadly, from time to time, I hear some colleagues saying that they feel anxious about expressing their uncertainties at our meetings; and others saying that we now live in a culture in which we dare not make (or own) mistakes.

What is becoming of our freedom not to know, to be empty handed, and yet to believe that there is a truth, an insight, a possibility – call it 'O', or 'the unconscious', or, as I prefer, 'God', if only we dare to own our poverty and wait on that which transcends our understanding?

Am I alone in feeling this? I don't believe I am, and I think that many people who might be interested in training with us will choose to do so – only – if they perceive that we are animated not just by a professional spirit, or by an organizational spirit, but by a inquiring spirit which is genuinely open to the wonders, the horrors and the mysteries of life. In other words, that we have faith in the therapeutic process.

Notes

1. Abraham, Eitingon, Ferenczi, Jones, Rank and Sachs (Freud, [1921] 1941: 175).
2. Among others, Dorothy Burlingham, Helene Deutsch, Jule Eisenbud, Edward Hitschmann, Géza Róheim and Paul Schilder.
3. I am grateful to David Black for drawing this paper to my attention.
4. I am also reminded of Isakower's concept, reported by Jacobs, of the 'analytic instrument', which he describes as 'belonging to both patient and analyst and as being composed of the temporarily fused unconscious of

each'. To communicate effectively, he said, the minds of patient and analyst must be in a state of temporary regression, a condition that is facilitated by the use of the couch, by free association, and by the analyst's stance of expectant silence and evenly hovering attention. Only when these conditions are met, he said, can the instrument operate so that the images, fantasies and memories that arise in the analyst's mind as he listens be meaningfully related to the patient's unconscious (Jacobs, 1999: 583f).

5. See Reed's papers for experimental evidence to support this statement.
6. I am grateful to my patient for agreeing to the publication of this material.
7. For the application of classical and quantum field theory to the analytic relationship, see Spiegelman and Mansfield (1996).
8. i.e. fight-flight, dependence and pairing.

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CLASSICS REVISITED
D.W. Winnicott, 'The aims of psycho-analytical treatment'*

SUE JOHNSON

This paper, although seldom quoted, could be said to be one of Winnicott's minor classics. It was presented to the British Psychoanalytical Society on 7 March 1962. It is short – just over four pages long – but it brings together a number of elements of the clinical attitude for which Winnicott is so well known.

Winnicott begins the paper by saying that in doing psychoanalysis he aims at keeping alive, well and awake, being himself and behaving himself. Although this appears to be written in a somewhat light-hearted way, Winnicott gave the paper shortly before he turned 66 and he had had his first coronary approximately thirteen years previously, so keeping alive and well were serious matters. However, he is writing not only about his personal state of being when he is at work, but he is also defining very simple aims which must be met if analytic work is to take place and which, if not met, would result in the analyst's 'failure to survive' (1971a). Regarding 'keeping awake', he may be referring back to this on the following page in writing that when he nears exhaustion he begins teaching.

Winnicott then questions what are the 'deeper aims' of treatment. He states these clearly at the beginning of the paper as 'communicating with the patient from the position in which the transference neurosis (or psychosis) puts me' ([1962] 1965: 166) and at the end of the paper as being 'to verbalize the nascent conscious in terms of the transference' (p. 170).

Although the title of the paper is 'The aims of psycho-analytical treatment' I believe it could as easily have been called, 'Modifications in treatment' as I think it is this theme that Winnicott is principally addressing. He approaches this in two ways – first, in terms of adaptations *in* treatment and second, in terms of modifications *of* treatment.

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His first variation on the theme comes on the first page of the paper when he writes, 'I do adapt quite a little to individual expectations at the very beginning' (p. 166). This sentence reads awkwardly. By beginning the sentence with the phrase, 'I do adapt', Winnicott appears to be preparing the reader for a strong statement, but he backs off from this by following it with what might seem to be a contradictory phrase, 'quite a little'. The use of the word 'quite' is ambiguous. Is he meaning 'quite' as in 'completely, altogether, absolutely', or 'quite' as in 'rather, to some extent'? (*The Little Oxford Dictionary* 1969: 437)

He reserves his strong statement for the next sentence when he emphasizes his point about adaptation by saying, 'It is unhuman not to do so' (p. 166). This reads like either an instruction to trainees or an admonition to colleagues.

I believe Winnicott would say that his willingness to adapt is what earns him the right to eventually be in a position for doing what he refers to as 'standard analysis'. This is one area of modification that seems to him to be a normal part of any beginning treatment, and is the analytic counterpart of the mother who provides a facilitating environment through adaptation to her infant at the stage of 'absolute dependence' (Winnicott, [1948] 1982; [1949] 1982; [1953] 1982; [1956] 1982; [1960] 1965).

In terms of what Winnicott calls 'manoeuvring into the position for standard analysis' ([1962] 1965: 166) he is keeping within the tradition of Freud (1913c: 139) who wrote:

> The next question with which we are faced raises a matter of principle. It is this: When are we to begin making our communications to the patient? When is the moment for disclosing to him the hidden meaning of the ideas that occur to him, and for initiating him into the postulates and technical procedures of analysis? The answer to this can only be: Not until an effective transference has been established in the patient, a proper rapport with him. It remains the first aim of the treatment to attach him to it and to the person of the doctor.

The aim of Winnicott's adaptations would be to facilitate the patient's ability to form an attachment to the treatment and to the analyst.

Within the space of six sentences, however, Winnicott swiftly moves to the position of the mother at the stage of 'relative dependence' ([1960] 1965) whose function is 'to provide *graduated failure of adaptation*' ([1949] 1982: 246). He writes of one of his reasons for making interpretations as:

> If I make none the patient gets the impression that I understand everything. In other words, I retain some outside quality by not being quite on the mark – or even by being wrong. ([1962] 1965: 167)

Again, the short space of time of the adaptation corresponds to the stage of absolute dependence in which the mother protects the infant from impingements. In Winnicott's terms this would be the analyst protecting the patient

from impingements caused by the analyst's failure to adapt. Here Winnicott is moving away from being either the merged analyst or the idealized analyst and into a two person relationship with the patient, or even possibly a triangular relationship, with the 'being wrong' representing the third, the Winnicottian father who comes between the mother and the infant (1960).

The adaptation and the gradual de-adaptation lead to the building up of ego strength in the patient. On the third page of the paper, Winnicott gives a brief sketch of the phases of ego development during the treatment, beginning with ego-support provided by the analyst (which strengthens the ego of the patient), the patient's experimenting with ego independence, and lastly the patient's ego independence and an experience of existing in his or her own right. Although he had written specifically about this aspect of treatment previously ([1954] 1982; [1955–56] 1982), he subsequently elaborated on this theme in three papers written in 1963 (Winnicott [1963] 1965b, c and d).

Modification *of* treatment is the second variation on the theme. On the first page of the paper Winnicott has already boldly stated,

> If the patient does not need analysis then I do something else. In analysis one asks: how much can one be allowed to do? And, by contrast, in my clinic the motto is: how little need be done? ([1962] 1965: 166)

On the third page of the paper he asks, 'What about modified analysis?' (p. 168). He answers his own question with, 'I find myself working as a psycho-analyst rather than doing standard analysis when I meet certain conditions that I have learned to recognize' (p. 168). He lists a number of 'illness patterns' that make him 'sit up'. He says that what is essential about his work is that he bases it on an individual and a social diagnosis, and he continues to diagnose and to work accordingly as he goes along. He then states the following:

> When I am faced with the wrong kind of case I change over into being a psycho-analyst who is meeting the needs, or trying to meet the needs, of that special case. I believe this non-analytic work can usually be best done by an analyst who is well versed in the standard psycho-analytic technique. (p. 169)

These two simple sentences contain a number of elements. Winnicott has just defined the 'right' kind of case as being someone who wants, needs and can take analysis. He does not say that with the 'wrong' kind of case he stops being a psycho-analyst. Instead he states clearly that he is a psycho-analyst who is meeting needs or trying to meet needs, and he makes no apology for deviating from what some might see as being the role of the psycho-analyst, namely to analyse. He calls this work 'non-analytic' but says that his training as an analyst has equipped him for the 'doing of something else'. My understanding of what he means here is that because of his training, he was always working with the unconscious and the transference, whether or not he was interpreting them.

The 'change over' was a natural clinical attitude for Winnicott. He elaborates on it in the Introduction to *Therapeutic Consultations in Child Psychiatry* (1971b) when he writes about applying psycho-analysis in the practice of child psychiatry. There he refers to it as 'making sense of psycho-analysis in economic terms' (1971b: 1) He was clear in his own mind that many children and adults could benefit from either a single or a series of therapeutic consultations.

He concludes the paper with the following:

> In my opinion our aims in the practice of the standard technique are not altered if it happens that we interpret mental mechanisms which belong to the psychotic types of disorder and to primitive stages in the emotional stages of the individual. If our aim continues to be to verbalize the nascent conscious in terms of the transference, then we are practising analysis; if not, then we are analysts practising something else that we deem to be appropriate to the occasion. And why not? ([1962] 1965: 170)

Winnicott was aligned with Freud in terms of this therapeutic attitude. In his classic text Greenson (1981) begins his first chapter by writing about the historical development of psychoanalytic therapy and says that the technique was not suddenly invented but that its evolution was gradual as Freud struggled to help his patients. He writes:

> He had the boldness and inventiveness to explore new regions of thought vigorously and creatively. When proved wrong, he had the humility to change his technique and theory'. (p. 8)

Winnicott, too, had that humility.

One could say that the numerous forms of therapy and counselling that exist today had their roots in Freud's early formulations. There are many of us who trained as psychoanalytic psychotherapists who are doing short term and long term work, from once a week to five times a week, in our consulting rooms as well as various other settings, and perhaps at times using a variety of approaches such as CAT, CBT, EMDR, as well as teaching and supervising.

No doubt some of formulations in this paper could lend themselves to abuse by practitioners to justify their poor analytic practice, resulting in what Winnicott once referred to as 'the frightening fantasy of being infinitely exploited' (Winnicott, [1963] 1965a). The important point is that provided we have retained the internalized analytic process and attitude, when we are 'doing something else' we continue to be psychoanalytic psychotherapists as our personal analyses, experiences of supervision and extensive training are always informing our work. I consider this paper of Winnicott's to be a powerful reminder of this and an important living text.

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CLINICAL COMMENTARIES
Clinical material: Leslie

The patient is a man in his early 40s, in therapy for six months, only twice a week.

Session one

The patient came in looking distraught. He lay down saying that he had felt desolate at the weekend. He had suicidal thoughts. He was cheered up, however, by watching his son play football (at this point he felt a bit brighter). Then he told me, angrily, how upset he was when his wife expressed jealousy of a secretary in the office. He wished she would stop being so difficult. He had never given that secretary a thought. He went on in this vein for a few minutes. It was all a waste of time, he thought, and wanted to tell me about a strange dream he had last night.

> He was in a garage-like room. It had brick walls and a tiled roof, but was open at the front and the back. It had no ceiling – just bare beams. There were two stone dogs by the front opening. They were perched on a contraption that could be pulled out to make them into guard dogs at the entry. The place was very low – one couldn't stand or even drive in a car. The patient was lying on the floor with the said secretary. He looked out through the opening at the back and saw a snake. Then the snake appeared at the front opening. The patient thought it was OK; it was only an adder and he would have enough time to get to the hospital if bitten. The snake came in through the front opening, the patient lifted a chair to defend himself but it only angered the snake that proceeded to bite him. He felt a paralysis coming up his legs – it frightened him and he knew that he would not have time to get to hospital.

We started looking slowly at the dream. He thought that this small garage-like place was the space he got himself stuck in psychically – that I called a claustrum. He was a prisoner there, although he could not understand 'why' – after all, he could have walked out. Why would he have wanted to be stuck like that? The beamed ceiling reminded him of a barn where a girl he knew had hanged herself in the past. I reminded him of the suicidal thoughts he had been having. He agreed, but could not understand why he was lying next to the secretary: there was no sense of love-making at all in the dream. I said that both

he and the secretary had incurred the wrath of his wife; but also how angry he was with the girl who had hanged herself. I felt that the secretary in the dream was the suicidal girl part of him. He went very quiet and thought it made sense. Then he said, with a slight contempt masquerading as humour: 'I know what you will make of the snake'. I asked him whether he remembered how we were talking in the past about his anxiety and despair and fear of loneliness that propelled him to seek refuge in a fantasy world of being so glued to somebody else that he would get lost there and find himself stuck, imprisoned, losing the ability to recognize the world as it is. He was right that I would interpret the snake as a penis, as he slid right into mummy's behind to escape his sense of abandonment and find a safe refuge. However, once inside he had a phantasy of daddy's penis attempting intercourse with mummy that attacked him – enraged by the patient's presence in her genital. The attack promoted paralysis...

We had five minutes of thoughtful silence. He said in a small voice: 'Of course, one of the main reasons I came was to be helped with my fearfulness and passivity and, because I can't assert myself, I have failed to achieve my true potential'. He wondered about the stone dogs. I said that as a child he needed and expected to be protected and guarded by mummy. I added: 'however, your poor mum was often too ill and unable to cherish and safeguard you'. He started crying softly. After a while he said bitterly: 'I suppose you could say she had stone breasts. I remember some hugs, though, but her heart wasn't in her arms, there was always something missing...I always ended up lying on the cold flagstones...'

He then said that he had always felt that he could never have enough of women's softness and kindness and gentleness; it had always felt like a desperate longing, but he was frightened of being misunderstood by women, so he probably came across as aloof. I commented that it was hard to ask for mothering from a wife. He agreed, saying: 'she doesn't want another child – she wants a man...' He was wiping tears in silence. I decided to take a risk and said: 'I am not your wife...' After another silence he said in a very small voice: 'I have only two hours a week...' The silence became very painful. I felt sure that he was asking to increase his sessions; I was wondering whether the risk of refusal or the risk of consent made it more frightening to ask for it. It was close to the end of the session, though, and I decided to say no more.

Session two

'Something very unusual has happened', the patient started saying, even before he fully lay down. He had always been on time for his sessions; he got the timing of his cycling to my consulting room down to absolute precision. He never wanted to be late – he does not approve of it, nor has he ever wanted to be early – he hates waiting. Today, however, he arrived ten minutes too early. He had no idea how it could have happened, he had been very anxious for the

past couple of days, could not sleep properly, felt in a daze. He felt that something was left hanging in the air, and couldn't for the life of him think what it might be. He felt humiliated to be walking forwards and backwards in my street waiting for the correct time to come in. I asked whether there was anything that caught his attention. 'Oh, yes, there was a lovely woman coming out of your path.' I said that it is always difficult to notice another person when you are used to being the only one. No, he thought, 'it couldn't have been your patient – she was too nice. It might have been your younger sister.' A few minutes silence followed.

He wanted to tell me about the visit to his mother. It was very painful. It had always been very complicated to arrange a visit, but he was hopeful this time. He did not feel angry, but wanted to make contact by telling her something about himself and how he felt. And yet, again it was impossible to talk to her. There was no emotional contact and no communication. Whenever he tried to convey something, such as his sadness about his perceived academic failure, or about the misery of his boarding school, or even about his children now, his mother started talking about somebody else. She was not able to keep her mind on him. A very detailed story followed involving information about many other members of the family. He felt like giving up, and yet he was determined to keep trying, and sort out with her whatever he could before her death.

A few minutes later, he said that he had found it very hard to fall asleep the previous night, and when he finally did, he had 'the weirdest' dream.

> In this dream he was driving on a narrow country track, to a meeting about a planning application. None of this made sense. He came to a small village where all the houses were individual. It was a bit like a place near where he grew up. The houses 'started old' but during the years people added different extensions and changed their shapes. He thought that, perhaps, this happens to children when they grow up. He remembered that the first time he met me I said something to him about wanting to grow up. The house of the meeting looked like a very nice white house, but when he came closer he realized that it had a tower added on top, a bit like a church tower, but it looked as if it had meant to be like a spire but didn't – it was as if it had two buttresses joined together. The bell to the house was on the tower bit, but he could reach it and rang it. (I found myself thinking about combined objects and his zonal confusion, but I did not have a coherent idea.) The door was opened by a plump, bald, middle-aged man, who looked a bit like an old boss of his who had been very full of himself. He then went on talking about the clash between his mother's religiosity and his father's atheism and about his father's arrogance, with many examples of his memories. (By this time, I felt quite sure that the description of the house in conjunction with the man was a fair representation of his confusion about the relationship between his parents, and his unclear role in it, and consequently the unease about his sexuality. He was in full flow, however, and I was not going to interrupt.) Then the image of the dream moved outside that house. There was a platform with a black-haired woman on it, and a man who was playing a game with her. The other people were on the ground (like in a country fête). The game consisted of the woman throwing a ball at another person who had to bat it back to her. The patient thought that

> those were easy throws and there was no problem. The people who batted kept swapping. When his turn came, the ball became much smaller, and the throws were unpredictable. The woman put a contraption on his head that had a V like 'sights' – like on a gun. It was meant to make him aim better, but it was very uncomfortable and confusing. Then the platform began to rise very high (by some hydraulic machine) and he was very frightened. He did not want to bat because if he made a mistake, he would fall down and break his back...

I was quite awed by the amazing complexity of this dream. I had no doubt that we were faced with his sexual anxiety seen mainly in sporting terms –about his fear of loss of control at great heights (and orgasmic highs), of the pain of his passivity, his lack of ambition and his suspicion of lacking a backbone and terror of paralysis – all this against the background of his infantile confusion about parental sexuality. Clearly, there was no time in the session to address it all. I decided to concentrate on the present. I said that it seemed to me as if he felt that we were playing a game which was very easy for everybody except for him, when his turn came. I also inquired whether he felt that an audience was observing us. He ignored the last sentence, but thought that I had a point regarding a game. He thought that he knew what therapy was about when he first came, but now he couldn't identify any rules anymore. It wasn't like anything else in normal life. My responses to him had been so unpredictable that he didn't know what to think anymore. I said nothing for a while, and nor did he. I asked him whether he thought that I was wrong in some of my comments, meaning that I believed that I gave him in-'sights' which should have made him use his perception better, but he had been experiencing them as uncomfortable and confusing. He thought that it was not so clear-cut. In many respects he had been feeling safer and thinking more clearly; but on the other hand, he was discovering problems and pains where there had been none.

I asked whether he had any idea what the 'planning permission' was about in the dream. (I was thinking about our first meeting and the discussion about the frequency of sessions. I was also very much aware that he referred to that first meeting – in relation to the dream – when he recalled what I had said then about growing up.) He had no idea. I told him that it occurred to me that it could have something to do with a thought he might have about therapy as 'planning', as he had believed that he could have anticipated my responses to him. He went very quiet for five minutes. Then he said with a combination of anger and bewilderment: 'there is a break coming soon; just as I thought I could be getting somewhere'. I asked whether there was anything specific in his mind. He said that he remembered what I said when he first met me about working a few times a week, but he was pleased that we settled on two sessions, because the break would have been even worse otherwise. I asked whether we could recap so that I could be sure that our memories were compatible. 'OK', he said. He was shocked when he first came to see me because I told him that I worked three times a week or more, and it had never occurred to him that he would

come more then once. Then, I gave him two names – of a man and a woman – who worked once a week. He did meet both, and found it very hard to come back and ask to have therapy with me twice a week. He was worried that I might have been thinking that he was bargaining. He was very surprised that I agreed. I asked if he had any idea why I agreed. He said he didn't but didn't know whether he could ask. I said that I did not mind telling him. It was because I believed him when he said that he couldn't imagine being able to have anything to say so often; and I thought that it was something he needed to discover for himself. He went quiet and I noticed him wiping tears.

He became angry and asked why I was raising this so close to a break. I was tempted, but chose not, to remind him about his comment last session on having only two hours. I said instead that when faced with an oncoming break in three weeks, it was hard for him to think about the absence of therapy during a break, or the absence of additional sessions in term time.

Clinical commentary: Leslie

MEIRA LIKIERMAN

These two sessions show the patient in an agitated state of mind, yet struggling to make use of his therapist. He does this partly through bringing vivid material and detailed dreams. At a more unconscious level, there is a sense that he is opening himself to the therapeutic experience and allowing some catastrophic unconscious states to surface. This would suggest that he has an intuitive trust in the therapist, and feels sufficiently contained to allow himself to delve into his inner world.

The therapist is greatly influenced by Meltzer, but interestingly, does not take up material in relation to the 'here-and-now' relationship. I do not get a clear sense of the quality of the counter-transference, nor how it is used by the therapist to understand what is happening.

The first session begins after the weekend and shows the patient in a 'fraught' suicidal state of mind, apparently triggered by the jealous outbursts of his wife. His dream is a painful one. He describes being in a garage-like room, open at the front and back, and with bare beams, which in his associations lead to the memory of a girl who hanged herself in a barn. My own understanding of this material is that it works on a number of levels. At one level, it might indicate the patient's worry about something 'open ended', perhaps the apparent chronic nature of his depression and suicidal thoughts. In his dream he has put himself in a place where people hang themselves. But this suicide-inducing place is not an arbitrary choice. It is a kind of garage, open to the elements. This suggests a transference communication, showing the patient's representation of what therapy makes him feel at present: it feels to him like a temporary shelter during the week, which is open and unprotected from the elements at either end. It is also an excluded, outside place, a garage and not a home. Its openness to the elements means that a snake can come from the outside and threaten the patient, and he wonders if he will have time to get to hospital.

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During the session he suggests wryly that the therapist will take up the snake as a phallic symbol, which she proceeds to do. My feeling is that at this particular moment the patient has set a trap for the therapist, inviting her to become a stereotypical and stereotyping object that is not securely focused on his personal meanings.

By contrast, the snake led me to think of the hanging rope intimated in the patient's associations, and I therefore see it as representing his fear of being bitten by poisonous, suicidal feelings. At a more primitive level it seems that both snake and rope represent phallic issues that might be partly accountable for his suicidal feelings.

The patient also describes two stone dogs at the entrance to the garage-like place. They can be pulled together to block the entrance. The stone dogs are reminiscent of flagstones mentioned later in the second session, when the patient remembers lying on them as a child in despair when his mother did not respond to him. Lastly, it is of interest that the suicidal feelings at the weekend were caused by the patient's wife's jealous accusations about the secretary, who also appears in the dream.

Taking all these elements together, there seems to be a transference communication to the therapist about the weekend experience. The patient felt abandoned and exposed, excluded and barred by hard, stony objects. In this state, poisonous sexual jealousy arose in him, which he split off and located in his wife. Suicidal feelings then threatened to 'bite' him irrevocably and he wondered if he would get help on time, that is, hold onto his feelings until he sees his therapist.

My instinct, in the light of this, would be to start the session where the patient is, taking up with him how hard it must have been to have felt so distraught and exposed to difficult feelings over the weekend. I would partly regard the dream contents as reporting on the weekend, but also, simultaneously, as serving to represent unconscious dimensions of a current state of mind. The pain, jealousy and anger of the patient are vividly communicated in the 'here-and-now'.

This theme is amplified in the second session. The patient reports having had two very difficult days, with something that felt 'left hanging in the air'. Yet again there is an oblique reference to suicide by hanging that figured in the previous session. The patient also arrived early to this session, and paced outside the therapist's house in evident desperation to get help. In the intervening time he had visited his mother and now seems very aware of how much she deflects his feelings. Indeed, he experiences her mind as unreceptive, hard and 'stony', much like the stone dogs. The patient then reports another dream in detail.

In it he goes to a meeting in a village where the houses are 'very individual'. His destination is a 'very nice white house', which has a tower added on top. The doorbell is on the tower part and, upon inspection, the tower turns out to

be composed of two buttresses. This part of the dream suggests that the patient is searching for a psychic 'home' that will be individual, but finds that he cannot gain admittance to his object (ring the doorbell) without also noticing the possibility of a male presence in his therapist's life and mind. The therapist feels that the house and tower reveal the patient's confusion about his parents, their relationship and his unclear role in it.

At a more immediate level, the patient is bringing a state of mind that is very exercised by feeling excluded. The tower on top of the house turns out to be two buttresses. Images of the two blocking stone dogs from the first dream are yet again invoked, as are the hard flagstones on which he lay desperately as a child. The buttresses therefore suggest not simply that he is experiencing a parental union, but that he is experiencing one of a very particular kind, which is telling about his condition. It seems that the patient feels excluded by a cold, hard parental couple, which unites in order to buttress itself against the baby's distress. Infantile feelings are left in the cold, and the infant is excluded from all sense of family and home.

At this point in the dream the patient watches a ball game between a black-haired woman and a man. Balls have to be thrown and batted back, with participants swapping sides. When it is the patient's turn, the ball becomes smaller and his throws are ineffectual. There is a sexual connotation here, but underlying it and at a more primitive level the patient feels that his projections are ineffectual and weak, not reaching his object. This primal scenario of feebleness might be at the root of difficulties with a masculine image that belong to a later period of development.

When the material is thought about as a whole, it indicates that the patient is communicating an inner world of great anguish. His objects are hard and inaccessible, he feels in danger of poisonous feelings of jealousy and suicidal despair and is worried that help will come too late. His internal parental couple does not offer a secure psychic home, but a stony defence, a batting back of his projections and needs. The despair conveyed in this is very great, vividly captured in the image of a child lying desperately on flagstones.

The material also reveals something about the possible background that has led to this state of mind. There is a lot of reference to insecurity in masculinity. We hear about the patient's unhappy situation with his wife and in the dream, the game/intercourse of the black-haired woman and her partner emits no warmth and security. This is echoed in the patient's thoughts about his real parents who are described as divided and different, but as united in one respect – in deflecting his communications and making him feel excluded. Something seems to have been so difficult in the family that there was no opportunity to experience a couple united creatively, and thus no opportunity to begin to tackle Oedipal issues.

Lastly, there is the detail in the second dream, which shows the patient on a platform that is suddenly rising dangerously, threatening his balance. I feel that

this is his experience of the sessions at this stage. The therapist as maternal object is felt to pick him up in a precarious way, only to threaten him with a big drop. This transference makes sense in relation to his inner world and, apparently, his actual background. It is most important for this patient to find containment for these unbearable states. My own feeling is that he will be further helped by a focus on the transference relationship in the here-and-now.

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Clinical commentary: Leslie

WARREN COLMAN

I was aware of approaching this material with certain presuppositions set up by the indications of the therapist's Kleinian/Meltzerian orientation. For example, I expected to find an approach to analysis that focused entirely on the session, often referred to as working in the 'here and now' transference. In the main, this expectation was borne out: the therapist restricts her interpretations to the patient's inner world and there is no discussion reported about external events, such as the wife's jealousy, the patient's relationship with his secretary or his visit to his mother.

I had also expected that a Kleinian therapist would make more use of transference interpretation than a Jungian like me but here my expectations were confounded. Although the therapist does take up the transference in the second session, I was surprised to find myself wanting her to make more transference interpretations. I began to see a possible explanation for this in that I also noticed an almost complete absence of reference to the counter-transference. This led me to wonder whether the therapist was being powerfully affected by as yet unprocessed counter-transference. This is not a criticism – real counter-transference is unconscious and a positive sign of the therapist's empathic immersion in the work (cf. Jung's image of immersion in the 'alchemical bath').

In the discussion about the first dream of the snake in the garage, it is not quite clear whether the reference to the claustrum was made as an interpretation in this session or, as it seems, is a reference to previous interpretations. This lack of context makes it difficult to assess whether the image is a 'pure' product of the patient's unconscious that 'proves' the existence of the claustrum (as an unconscious phantasy, say) or whether it is the outcome of prior therapeutic work that has already familiarized him with this way of thinking about himself. The dream probably indicated the imaginative use that the patient is

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able to make of the therapist's way of conceiving of his difficulties. The therapist provides metaphors, which, while sometimes uncomfortable and confusing, enable him to understand himself in a new and illuminating way. We can see the fruitful use he is already making of the therapist's language when he makes his own interpretation of the stone dogs as stone breasts. I would also like to see evidence that the therapist is learning the patient's language, so that the shared language that eventually develops will include both idioms.

The patient is reserving judgement, however, when he says 'I know what you will make of the snake'. The therapist did not take up this meta-comment about what he thinks of her work (the 'slight contempt') although she does respond to it insofar as she is careful to place her interpretation in the context of previous discussions about his emotional situation so that it makes more sense to him. It is often difficult to judge whether or not to interrupt the flow of the material by taking up meta-comments of this kind but they can often be an indication of important issues that the patient is not talking about. I wondered whether the therapist might have asked for the patient's own associations to the snake in order to discover whether further meanings might then have emerged, which may have either confirmed or challenged her interpretation. The danger in going ahead with an interpretation that the patient has already indicated he is expecting is that it may be vitiated by the unanalysed contempt.

The therapist's interpretation does rely on the assumption that there are two different snakes (a small one round the back and a big one round the front) although this is not actually stated in the dream. Her intuitive leap identifying the secretary with the hanged girl has an emotional impact but it then makes it difficult to address the hidden sexual aspect of the dream. I wondered whether 'lying' with the secretary indicated that he was 'lying' about his sexual interest in her – to himself, as much as to his wife and therapist. And this issue also leads on to his sexual interest in his therapist. My own associations to the dream image (i.e. hypothetical interpretations) included the idea that the biting snake might represent the patient's fear of his own phallic potency that will 'bite' him if he becomes excited with the therapist/secretary. He then becomes paralysed (impotent?) but fears he won't be able to get to the therapy-hospital in time to be rescued by the therapist in her maternal aspect.

The therapist/patient couple's mutual libidinal interest in each other emerges in the latter part of the session. The therapist becomes warmly maternal to the extent that I felt that she was identified with the patient's own longing to feed from a loving mother with breasts full of love. I think this explains the somewhat odd interpretation of the stone guard dogs as the patient's wish to be protected by a cherishing mother. The patient corrects her, pointing out that the 'breasts' in the dream are made of stone. Here, though, some splitting occurs between the therapist and the mother so that the therapist continues to identify herself with the soft, loving breasts (out of what seems to have been a powerful counter-transference) while the stone breasts are

split off as belonging to the actual mother. Thus she is unable to take up the negative transference – the patient's anxieties that she will have stone breasts, misunderstand him, find him aloof, etc.

The splitting then continues with the therapist encouraging the patient to make a split between his wife and herself. We begin to see why the wife is angry and jealous about this woman whom her husband pays for services (the therapist/secretary). It is the therapist who says it is hard to ask for mothering from a wife and then, having got his agreement, takes the 'risk' of saying 'I am not your wife ...' By this she seems to be saying 'your wife won't offer you mothering but you can get it from me'. But why is she so enigmatic and allusive? This seemed to me to emphasize the emotionally thick, intense and seductive atmosphere in the room: by being ambiguous and full of unspecified implications, she is encouraging the patient to ask for a lot more than increased sessions. In the patient's state of confusion (of which the therapist is aware in another part of her mind), maternal nurturing, feeding and fucking are all mixed up together. Even if the therapist knows the difference, the patient is bound to take her 'offer' as a seductive invitation.

While I do think this is an enactment, I do not think it was a 'mistake'. It is simply a sign of the deep mutual involvement that is developing between patient and therapist, much of which is inevitably going on the level of what Jung calls 'unconscious identity' or ' a relation of mutual unconsciousness'. Unless this relationship can happen in the therapeutic encounter, it does not come alive. Only later can it be understood and interpreted.

It did strike me as problematic that the therapist seems to be reinforcing the patient's infantile longings while downplaying or even discounting his adult sexual (phallic) desires but this too may be a counter-transference reflection of the patient's difficulty in being a man. If the therapist is enacting a mother who is more aroused by the infant in him than the growing man, might this refer to some Oedipal difficulty with his actual mother who might not have been able to acknowledge his phallic strivings? Or is it to do with the prohibiting Oedipal father who puts in an appearance in the following session as the man at the door of the house, blocking the way to mother?

I wondered whether unconsciously both parties felt frightened and guilty about what happened in the first session ('something very unusual' as the patient says). This could explain why, in the next session, the therapist does not take up the implications of the patient wanting more (arriving early) and his fear of being humiliated if he dares to allow himself to ask for more and know about his erotic/infantile longings. Instead, the therapist draws the patient's attention to the other woman leaving her house as if to say 'now, don't go thinking that you can have me all to yourself, you greedy baby you'. She doesn't follow up the patient's view of the other woman as 'too nice' to be a patient – too nice for what? Too nice to have the bad dirty needy feelings that he has? Nor does she follow up the implicit idealization of the 'too nice'

therapist. Here he is already putting her on a (stone?) pedestal that turns up again in the platform of the dream.

Again, the therapist does not take up the patient's difficulty in communicating with his mother or link it with his wish to make contact with her. These issues are so clearly expressed in the material that I am assuming that the therapist holds back for emotional reasons (i.e. from her counter-transference), not because she is unaware of what the patient is saying. Either she is embodying the image of the enigmatic woman (cf. Jung's concept of the anima) or she is herself 'paralysed' and fears that something overwhelming might happen between them. Either way, it looks like the therapist is unconsciously being powerfully affected by the patient's projective identifications, notwithstanding whatever conscious technical reasons are also operating. One clue to all this is her comment at the end of the session about the patient needing to discover his needs for himself. This shows the therapist at her most sensitive and empathic – an approach that is clearly bearing fruit. Nevertheless, it does also hint at the patient's fear of an overwhelming mother – perhaps a mother whose own needs overwhelmed him as a child?

When it comes to the second dream, I hear it as being not only about the patient's internal world but more directly about what is going on in the therapy. He is wanting to get into the therapist's nice white house (cf. the 'too nice' woman) but is blocked by the full of himself boss/arrogant father. This follows on from the biting snake of the first dream, suggesting that it represents a frightening, forbidding Oedipal father super-ego figure (and/or the patient's own feared 'puffed up' state – cf. puff adders, puffed up penises, etc.?). This would be the key to his sexual paralysis. It may then be that some of his regressive infantile wishes are in order to avoid his Oedipal fears. This would suggest that there might also be something defensive in the therapist encouraging his more infantile aspect.

I thought the image of the 'uncomfortable and confusing contraption' was a wonderful reference to the way the patient must have experienced the therapist's occasional tendency to use jargon, particularly in evidence in her interpretation of the 'snake' dream with its rather awkward references to 'daddy's penis' and 'mother's genital' that come straight out of Meltzer and Klein. I also noticed that there was a contraption in the first dream as well, on which the stone dogs were mounted. Could this suggest an unconscious perception that the therapist is guarding herself against his wishes to get inside her and 'batting' it back to him in the form of interpretations ('contraptions')? There does seem to be a problem about getting into some sort of intercourse rather than merely 'batting'. But as the therapist recognizes, he is also afraid of things getting too high and out of control, albeit she does not explicitly recognize this as an issue between the two of them. I think this is probably because she is also affected by this fear. From one point of view this means that she is 'in tune' with the patient. On the other hand it could be seen as an

unconscious collusion. It is not easy to see that it could be both at the same time or to acknowledge that sometimes being empathic requires us to be in unconscious collusion, sometimes for several years. This is what going at the patient's pace means, as long as it does not prevent the issue being addressed in the therapy eventually when the therapeutic relationship is established as a strong enough container to be able to bear it.

I was less comfortable with the interpretation about therapy as planning. Something odd happens here in that the interpretation that the therapist gives the patient turns out to be different from the one she seems to initially have in mind. She recalls the discussion about frequency of sessions, implying that she understands the 'planning permission' as the patient's wish to get permission for his plans to come more frequently. But she then interprets it as the patient's wish for predictable control. Here I felt she was indeed batting it back to the patient, perhaps because she was feeling uncomfortable about his unconscious comment on her 'insights'. She becomes slightly defensive, as if to say that it is because of his expectations of 'planning' that he is finding her confusing. There is evidence that the therapist is also struggling with confusion. Thus she does not have a 'coherent idea' of the dream but then becomes 'quite sure' and has 'no doubt' as if she is needing to ward off the patient's chaos and confusion that she fears might invade and overwhelm her. So the unyielding stone breasts are present in the counter-transference too, albeit in a more muted way than the soft, loving breasts.

Perhaps it is not surprising that the patient reacts with anger and bewilderment. Just when he thought the therapist was offering him more ('I'm not a wife...') she seems to have pulled out the contraption with the stone dogs and to have become guarded and defensive, batting back supposed 'insights'. As he says, it is not clear-cut. I wondered whether the break that is being referred to is therefore a break in understanding that is happening in the 'here and now' of the session.

I would like to underline how different the process of commenting on a session like this is from the experience of it. I expected the therapist to be more 'here and now' in her approach than I am, yet in commenting on her material, I have turned out to be more 'here and now' than she was. Of course, this is an artefact of the process of commentary. I have had the leisure of thinking about the session, whereas the therapist has to deal with what is happening as it happens, in the here and now in fact. The therapist is *in* it whereas the commentator (or supervisor) is out of it. This may create a wider vision, less dominated by unconscious factors but it is only through the emotional power of the unconscious relationship that the real therapy takes place. In this sense, the therapist/patient couple remain the ultimate authority for the reality and truth of the therapeutic process.

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Clinical commentary: Leslie

ANN-MARIE REILLY

On first reading this account of work over two sequential sessions where the patient presents two complex dreams, I felt quite overwhelmed by the material and somewhat intimidated by the therapist's interpretations and thoughts, particularly with regard to the patient's infantile sexual phantasies. There was an initial experience of panic about what was expected of me. Was this my counter-transference to the material and a reflection of the patient's experience of the treatment?

Alongside these feelings there were, however, a few things that caught my attention and took me away from the details of the dream material. First, I was struck by the therapist's comment about '*only* twice a week'. Was the therapist concerned about the patient managing anxieties and feelings with twice a week therapy? Or was there in the word 'only' a judgement, an expectation that the patient should be in therapy more than twice a week? I was also interested in the 'unusual' happening at the beginning of the second session where the patient arrives ten minutes early, a change from his usual obsessional behaviour where he arrives exactly on time. I noted too that the patient, a man in his early 40s, had been in therapy for six months and I wondered what it meant for this patient being at the entry stage of therapy. Finally, I took account of the frequency of sessions, which meant that each session either followed a weekend break or anticipated one and I observed that there was 'a break coming soon'. Frequency of sessions and the impact of the break are explored by the therapist at the end of the second session. However, I wanted, with the benefit of hindsight, which the therapist didn't have, to look at the detail of the material again whilst keeping an overview of the total situation.

On rereading the material with the above in mind, I thought the patient was expressing his ambivalence about being in therapy and commenting on the relationship with his therapist. In the dream he reports in the first session, the

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patient tells us that he is lying next to the secretary but 'there was no sex between them'. I thought this might be a comment on the lack of intercourse between him and the therapist. The 'garage-like room' is a very uncontained space and I wondered what it was he 'can't stand'. After six months in therapy the patient is likely to have let go some of his defences and become attached to his therapist. However, he is not sure he can stand the feelings and anxieties that are stirred up when he is left at the weekend. His defence, 'a chair', is not enough to protect him from being poisoned and he fears he will die because there is not enough time to get help. I wondered if the patient was expressing his fear that being dependent would leave him vulnerable and defenceless. Is he frightened that therapy, rather than helping him, could lead to a breakdown?

This material is brought after a weekend break where the patient 'felt desolate...and had suicidal thoughts'. We also know that the patient is anticipating a break. Having experienced feelings of dependence, does he now fear being abandoned by a 'cold' therapist? As he said about his mother 'I always ended up lying on the cold flagstones'. I wondered then if this was not only a way of interpreting the dream material but also a reflection of what was happening in this session between the therapist and the patient. Was there some disconnection between them where the therapist was unable to hear the distress of the patient following the weekend break and instead focussed on the infantile phantasies about his parents? Did this too leave the patient 'lying on the cold flagstones'?

Betty Joseph's (1985) ideas about a total situation being transferred came to mind. She describes a type of projective identification where object relationships are acted out in the transference. In this example, I suggest, what is being acted out is the relationship between an unavailable mother who perhaps could not deal with her child's infantile needs (we know from the therapist that the patient's mother was often too ill to look after her child though whether this was a physical or mental illness is not specified) – and an infant who defends against this by giving the mother what he thinks she expects rather than risk not being understood.

At the end of the first session the therapist does, however, make contact with the patient. The patient tells the therapist about his desperate longing and his fear of being misunderstood. The therapist responds and talks about taking a 'risk' when she tells the patient 'I am not your wife'. I understood this as the therapist communicating to her patient that she was there to listen to and understand his anxieties. Was her feeling of 'risk' a projection from the patient about the risk involved for him in allowing a relationship because of his fear of not being understood? When the therapist took the risk it led to more contact and this I think is evident at the beginning of the next session.

At the commencement of the next session the patient, I suggest, having introjected a containing therapist, feels safe enough to let go some of his obsessional control and take the risk of being dependent. Previously, by being

precisely on time he has prevented any feelings from slipping out. He tells the therapist how 'humiliating it was to wait'. By the therapist asking a question and thus moving away from what the patient has said, I think the therapist becomes the mother who does not want to know about the patient's difficult feelings. As the patient tells us in reference to his mother: 'He wanted to make contact by telling her something about himself...There was no communication – she was not able to keep her mind on him'.

We are told that there was then a silence followed by the patient reporting another dream. I thought the dream might have been brought at that moment in response to not being heard. I am suggesting it was a way of keeping the therapist happy and giving the patient something to hold on to and also served to avoid contact with the therapist and defend against the anxiety of not being understood.

I thought that this dream, like the first one, could be seen as a communication about how precarious the patient is finding the experience of being in therapy. The dream begins with something that seems familiar, 'like a place near where he grew up'. However, nothing is quite what it seems: the houses change shape; the nice white house has a tower – or was it meant to be a spire? The game initially seems easy but when his turn comes it becomes unpredictable, confusing and frightening. He does not want 'to bat', it is too risky, he could 'fall and break his back...'

I propose that the dream material, like the first one, acts as a smoke screen, making it difficult for the patient and therapist to stay in contact with the immediacy of their relationship. The therapist seems alert to this. She comments on the complexity of the dream and despite the many ideas that the dream stimulated decides to 'concentrate on the present'.

The patient responds and is able to talk about his anxieties about being in therapy, its unpredictability and his confusion because, like in the game in the dream, he can no longer 'identify any rules'.

However, it seems difficult for patient and therapist to maintain contact and for the rest of the session they seem to be in a bat and ball game where there is little connection between them. There is reference to the patient 'growing up' and I wondered if an important part of the transference relationship being acted out was between a mother, who because of her difficulties in responding to her child's infantile feelings, expected and perhaps needed him to be grown up. The therapist comments on the patient's difficulty in making use of the insights she has given him, as if expecting something from him for which, perhaps, he is not yet ready. The patient also must 'discover for himself' the need for another session. On the other hand, the patient's 'anger and bewilderment' about the forthcoming break is heard but sidestepped.

My feelings of being overwhelmed and intimidated on first reading the material seem to reflect both the patient's anxieties about being in treatment and what is expected of him and also the pressure on the therapist who is

presented with highly stimulating material and as in the first dream invited to respond: 'I know what you will make of the snake'. I think the therapist does well to make contact when she does and perhaps an acknowledgement of how difficult this is would facilitate better understanding between therapist and patient.

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ARTS REVIEW
Schubert's *Winterreise*: a threefold journey

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Schubert died at the age of 31. During his extraordinarily prolific composing life he produced over 600 songs, but only two song cycles. The first, *Die Schöne Müllerin*, tells a tale characteristic of German Romanticism. A young miller sets out on a journey, he experiences the joy and pain of love and finally, rejected, he drowns himself in the millstream. When Schubert came to write *Die Winterreise* during the last 18 months of his life, this Romantic template was revisited, but from an entirely different perspective. This cycle of 24 songs is widely considered to be the culmination point of nineteenth-century Lieder writing; for many who love it, it seems to represent a sort of ultimate experience.

In this paper I shall be giving a personal interpretation, for which I make no claims except that it helps to explain something about my own response. As I shall suggest, I believe it is the cycle's capacity to evoke intense individual significance that accounts for its unique quality.

* * *

Die Winterreise begins with an ending. The traveller sets out on a journey, but it is not towards a goal; it is a journey away from his love and his life. This is an interior drama, an exploration of the unconscious underpinnings of a mind that is breaking down. We are not concerned with his individual history – the circumstances and events of his life are left behind as the cycle begins – yet we explore in the most intimate and subtle ways his shifting self-states. The physical wandering through the frozen countryside is therefore mirrored by his psychic journey. However, there is also a third aspect: as we listen to the cycle, we are drawn into a journey of our own.

We find ourselves moving progressively away from observing the traveller as a protagonist. Increasingly, we experience him – as though from inside his head. We see and feel through his projections. His internal world consists of dreams,

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images and memories with few connected, developed thoughts. The songs represent a succession of pure emotions, expressed with stark simplicity and directness; like the traveller himself, we are assaulted by their intensity. The cycle juxtaposes many psychic levels and also various temporal dimensions. The balance shifts from sequential, linear time, represented by the stages of the physical journey, through remembered time – a Proustian jogging of memories and associations – to experiential time, the ebb and flow of feeling and fantasy. Eventually there is timelessness.

In the Romantic tradition, elements of the natural world are often used to represent emotional experience, but here the interplay is more subtle. Instead of nature providing a straightforward metaphor, there is a complex and evolving reciprocal relationship between inner and outer realities. As the traveller's objective links with his surroundings become more tenuous, his increasingly primitive psychic experience is projected onto features of the landscape. Perception turns gradually to psychotic hallucination, and nature becomes antagonistic; it exists to mislead and persecute him. The fiction of the Romantic pastoral idyll is replaced by a reality of the most fundamental kind. This is the jagged, compulsive reality of a shattered internal world – violent id impulses, superego castigation and the struggle of a battered ego to avoid ultimate fragmentation.

From the first word of the opening song, *Gute Nacht*, we learn that this is a story of alienation. '*Fremd*': the traveller identifies himself as a stranger, a foreigner, an outcast. However, the poignancy of the opening bars draws us into an immediate empathic relationship; we have a long way to go before alienation becomes a subjective reality. In this first song, a clear descriptive image locates us in space and time. As we picture the traveller striding out past the darkened house in which the family is sleeping, the musical form and syntax contain us in a world we can recognize. The physiological link provided by the walking-pace rhythm conveys that mind and body are connected; we are rooted in external reality as the voice is rooted to the piano.

The traveller's thoughts are full of the girl he is leaving behind. At this point she has a clear identity for him and he talks directly to her in his mind. As he wishes her goodnight, the sweetness of her presence is achingly represented by the modulation to the major in the final stanza. But these are not love songs. We never learn the details of the relationship with his beloved, and her fate as an internal object will be evidence of his growing detachment. During the first half of the cycle she remains alive in his memory and he is continually reminded of moments they have shared. He is still living in a relational world, but this is soon to disintegrate as his connectedness with her weakens. In the fifth song, *Der Lindenbaum*, she can still be conjured up in fantasy; later she can be recalled only unconsciously, in a dream. In the second half of the cycle she is never mentioned explicitly again. She has been absent too long – he cannot sustain his internal picture.

As the journey begins, specific states of mind are reflected in the features of the winter landscape. In the second song, *Die Wetterfahne*, we are swept without warning into emotional turmoil. There are already hints of a paranoid element which will become pervasive, but the traveller is connected to concrete reality and a sense of location, as he pictures his beloved's house. There are violent contrasts – anger, mockery. His emotions are alive. However, in the next song there is a new, schizoid quality which heralds the mental disintegration to come. The traveller is becoming detached from himself: he finds there are tears on his face without knowing he has been crying. Then, in *Erstarrung*, he is overcome with another wave of passionate emotion. He recalls walking with his beloved, and he has a fantasy that her footprints must still be there beneath the snow. But there is a premonition of extinction which will be echoed more intensely at the end of the cycle; her picture is frozen in his heart, and once it is thawed it will be gone.

In *Der Lindenbaum* we witness a transient moment of daydream. The traveller's mind is still object-related; memories are poignant and there are clear fluctuations between past and present and between internal and external realities, indicating that these are still securely separate. His consciousness drifts from the sound of rustling leaves, evoking past contentment, to his inner turmoil, then back again into memories. The song is a dialogue between levels of his mind.

In the next song he is still in touch with thoughts of his beloved and of the house and there is still the desire to return, but then, in *Irrlicht*, we enter a strange and disconnected world. With extraordinary economy, Schubert evokes a Romantic landscape of echoing caverns and barren crags. The eerie light is a malevolent decoy which tricks and misleads him. The traveller is receiving messages from the landscape – paranoid ideas of reference. For the first time there is no mention of the loved one; something has become detached in him and we are plunged into a new, bizarre reality.

The eleventh song, *Frühlingstraum*, offers a vivid depiction of shifting self-states in the process of mourning. At first, on the edge of sleep, a wish-fulfilling dream image fills his mind. But it is fragile; dissolving into the painful reality of the present. There is anger at the awakening, then this is supplanted, in turn, by nostalgia, realization, sorrow and resignation, before he returns longingly to the memory of the dream. There is still a fluidity in his psyche; he has not yet lost touch with the reality of past and present, and he is still yearning for what is lost. However, unlike the first song, this is no longer a sustained narrative. We have come some distance on our journey away from events and towards pure subjective experience. We are shown fluctuations of mood, broken, interrupted thoughts, ideas flitting across the mind – a truly free-associative state.

In the first half of the cycle Schubert returns repeatedly to walking rhythms, showing that the traveller's self-experience is rooted in his physical reality. In the second half, however, there is little sense of movement. As he becomes

increasingly estranged, the focus is drawn inwards towards his psychic disintegration, and the relationship between internal and external realities becomes complex and clouded. There is a new dimension of intensity, a sense of threat. Mirroring the psychic fragmentation, there is a breaking down of the previously cohesive, programmatic accompaniments, and there is an extreme economy and concentration in the writing. As the beloved fades from his mind, we also forget her, drawn in to the deepening internal journey.

Der Greise Kopf depicts an experience of depersonalization. The traveller has a delusion of himself as an old man; his own body has become alien. The semi-recitative style of the vocal line, unfettered by the accompaniment, conveys a wandering mind, a state of schizoid dissociation. In the next song, *Die Krähe*, the delusion is extended; we are no longer sure where external and internal meet. There is a beguiling charm in the music, as though his loneliness might be alleviated through this contact with another living being. But what does the bird represent? Does it exist in reality or is it merely a paranoid projection? There is a sinister undertone; the crow is a scavenger, it lives on death. The echoing of the vocal melody in the left hand of the piano conveys that the crow is shadowing him. It persecutes him with its presence and he begs it to leave him, but says it has been there since the beginning of the journey. The sweetness of the melody and the quietly insistent flow of the accompaniment evoke an uncanny, disembodied calm. Out of sight, unmentioned, unconscious, the crow represents, perhaps, a violent and punitive part of the self from which the traveller has become dissociated but from which he can never be free. His connection with the winter landscape is no longer one of metaphor; his own mind is now the determinant of his reality.

In *Letzte Hoffnung*, the poem speaks of the last leaves falling from the trees. The staccato notes of the introduction might be heard as illustrating this, but we have to remember that we hear the music before we know what the words are describing. In fact, Schubert is communicating on a deeper level. By this stage in the journey, he is not merely evoking an imaginative response to the words; he is working on us directly. We move from witnessing the traveller's dilemma to experiencing our own.

Comparison with the opening song of the cycle allows us to appreciate how far we have travelled at this point. In the chords of the opening bars of *Gute Nacht*, Schubert established tonality, pulse and a secure, traditional structure of melody and accompaniment. The introduction certainly drew us in, but at that point we were listening to a song, witnessing a narrative. Although we empathized with the traveller he was firmly separate from ourselves.

With the introduction to *Letzte Hoffnung* we find ourselves in a different universe. The structure of the traveller's mind is breaking down, and with it the structure of the music. Deprived of conventional tonality and a recognizable rhythmic frame, we experience disorientation at first hand. Schubert pushes every boundary of the nineteenth-century musical vocabulary in order to

produce an abstract representation of an internal state. Whereas in *Gute Nacht* we were contained within a balanced, spacious, strophic form, this song is condensed and fragmented. Sections follow one another abruptly, as though transitional space itself has been shattered (Winnicott, 1953). Only when the agonized traveller cries '*Wein, wein*' ('Weep, weep') is there a moment of traditional harmony and searing melody – he is briefly in touch with emotion once again, but it is unbearable. By the end, hope has died.

In the next song, *Im Dorfe*, we are in a paranoid world. The traveller wanders on the outskirts of a town, but there are no people. The streets are inhabited by dogs – persecutory, primitive objects which chase him away into renewed isolation. In *Täuschung*, Schubert again gives an added dimension of psychic depth. The poem tells of the traveller following a mirage, an imaginary light which he hopes will lead to shelter. But the music provides us with a more subtle and complex illusion. The introduction is incongruous – strangely disturbing. It gives a fleeting glimpse of sophisticated Viennese charm, as though the present hallucination is combined with fragments of another life, images from a distant past. The illusion becomes temporal as well as visual.

In *Der Wegweiser*, the next song, the traveller's intimations of destruction are projected as something concrete and terrifying: he comes to a crossroads where he finds a signpost that points towards Death. There is a sense of imminent peril ordained by fate. In the central section, the repeated notes in the piano part seem to indicate a moment of indecision, suspension, but he has no choice – he is drawn onwards towards an unknown but inevitable destination.

There is an intriguing and crucial historical discrepancy in the order of the final three songs. The poet, Wilhelm Müller, originally placed *Die Nebensonnen* earlier, leaving *Muth* as the penultimate song in the cycle. Apparently, it was the editor of the magazine in which the poems were originally published who altered the order, interpolating *Die Nebensonnen* before the final song, *Der Leiermann*. We cannot know whether this is to be ascribed to accident or to insight, but if it was accident then, from a psychoanalytic point of view at least, it was a masterly stroke of the Unconscious.

Muth is an outburst of fury and defiance, a tirade against fate. Müller's original order seems to have implied an optimistic ending to the journey – the traveller refinds his courage, finally transcending adversity to achieve a quiet resignation in the final poem. However, the position is altered radically when *Muth* is followed by *Die Nebensonnen*, allowing Schubert to offer a psychological depth and universality which far surpasses Müller's conception.

He invites us to understand *Muth* in terms of a manic defence. The traveller becomes an imposter, mimicking the courageous Romantic hero, but this is just another split-off part of his fragmented personality clutching at a transient memory in a last ditch attempt to salvage a self. In *Die Nebensonnen* this mania has deserted him, to be replaced by a surreal moment: he looks into the sky and

sees three suns. Müller apparently said that these two additional lights represented the eyes of the beloved, echoing an image used earlier in the cycle. However, I believe that, yet again, Schubert offers a much more profound psychological truth, one that involves a more primitive and fundamental loss.

There has been no clear reference to the loved one since the first half of the cycle; surely by now she no longer exists in the traveller's broken internal world. After the turmoil of the previous song, the accompaniment lulls us with a sarabande rhythm; we are contained by the gentle rocking motif – it is soothing and tender yet it has a halting fragility. It is as though the traveller is reliving, semi-consciously, a timeless, shared rêverie – the primary experience of being reflected in the eyes of his mother (Winnicott, 1967). He knows that when the light of these 'suns' goes out, his own existence will be extinguished. It can be understood as a memory of the birth of the self, recalled at the moment of psychic death.

The reality, perhaps even the mechanism, of psychic disintegration is thus played out in *Die Nebensonnen*, leaving us with *Der Leiermann* as an ultimate enigma. This song, the culmination of the cycle, has elicited a wealth of theories as to its significance. Does it refer to death, suicide, autistic withdrawal, the final abandoning of emotion? Does it represent a reconciliation to the human condition, an acceptance of alienation, the relinquishing of conflict, a stoical indifference to tragedy? Does it promise a new relationship, a new beginning, even a transcendent apotheosis? The last line implies that the journey must continue – the poem ends with a question and the voice does not come to rest. But will it continue into renewed human contact or into ultimate abstraction?

This is the traveller's first and only human encounter during the journey, and it is with someone who is an outcast from society – a *Fremder*. Who is the organ grinder? Is he a *Doppelgänger*, a projection of a split-off part of the self ? Does the traveller recognize a soulmate, or is he faced with a vision of what he may become when he has abandoned the hope of contact? The final words suggest that he is a potential companion; is there, perhaps, the promise of an ideal, merged attachment, free of pain and passion? The traveller seems to observe the organ grinder from another dimension, as though he himself were invisible. He addresses him, but it is a soliloquy – there is no communication, no interchange. His utterances are spasmodic, distant, without development or exploration. What is conveyed is a state of being.

The long, searing emotional journey has drawn us away from external reality far into the internal world, and now it seems that there is a retreat even from intrapsychic activity itself. The sensitive representations of volatility and fluidity are gone; now there is only a pared down, constricted melody and a repetitive accompaniment which is tied harmonically to the bare fifths in the left hand. Schubert adds no expression marks. Although it is unbearably poignant, the organ grinder's playing is mechanical; the two characters have no

effect on one another and he can have no effect on his music. He is denied expressiveness, choice, creativity; all he can do is to turn the handle. The organ melody and the vocal line are unconnected, unrelated. We could not be further from the closely interwoven relationship with which the cycle began. What has happened now to transitional space? There can be none if the primary object is lost. And yet, in spite of all this, the music suggests that on some level there is a harmony.

It is impossible to assign a specific meaning to *Der Leiermann* because Schubert brings each one of us to hear this final song in the context of our own internal objects, our own associations and projections. *Die Winterreise* faces us with a compelling paradox: the further the traveller retreats into schizoid alienation, the more intimately we share his internal world. Perhaps, in the end, the sense of apotheosis relates to our own journey. It reflects our final inhabiting of the traveller's reality.

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Books reviewed

Jung: A Biography
By Deirdre Bair
London, Little Brown, 2004, pp. 879, hbk £25.00

This is a Big Book about a Big Controversial Man and it took me several months to both read and ponder it. Its publication in January 2004 stirred up controversy and the press reviews generated considerable alchemical heat. It unleashed much criticism of Jung and Jungians and of the author. A.C. Grayling (2004), in the *Financial Times*, says of Bair's writing style: 'it is lazily and redundantly written'. Adam Phillips, rather bizarrely, starts his review in the *Guardian* talking about flying saucers and ends speculating that the 'more we know about Jung the less real he becomes'. It made me wish they had given the review to a Jungian for a more balanced picture. Sometimes comments were rather too close to home at the BAP. Stephen Frosh (2004) wrote rather sharply and dismissively in his review in the *Telegraph* of 'lost souls who turn too soon to Jung'. This understandably caused concern amongst our own MSc Jungian students, and among the staff course team from the postgraduate course we run jointly with him at Birkbeck College.

Jung lived a long and active life, from 1875 to 1961, in a period of great historical upheaval and complexity. Jung's life and work are inextricably interwoven in an impressive and sometimes messy weave of the personal, professional, cultural and political. He understood his speculative, empirical theories as a subjective journey amplified with endless clinical and cultural material. He explored the depths of his own and others' psyches to map out what he argued could not only be understood at an individual developmental level. The roots of a Jungian psyche go beyond the individual plant pot and garden, deep into the collective earth. As we experience our unique individuality we connect with our capacity to be human and humane: psychic health, most would agree, is a capacity to be special *and* ordinary, one *and* many. And yet, what people tend to want to know about Jung are not his ideas, resonating still in the twenty-first century, but whether he was a racist and how many of the women around him he had sex with.

Bair has bravely tackled all of this in her biography, which is a good fascinating read. She starts with the 'Swiss-ifying' of his paternal grandfather Carl Gustav 1 Jung, after whom he was named, into nineteenth-century conservative Basel, and ends with the 'aunt-ification' of Jung's controversial autobiography *Memories, Dreams and Reflections*. She has researched more specific information about Jung's life than anyone else. There are 39 chapters, usually titled with an apt quote from his life. There is also a 200-page book-length section of notes, which I found I continually referred to in order to understand her narrative sources.

Bair is outside of Jungian circles; she is a literary journalist and academic with prize-winning biographies of Samuel Beckett, Simone de Beauvoir and Anais Nin to her credit. Her dedication and persistence to her task over the eight years it took her is impressive. She went and lived in Zurich, waiting patiently for permission from Jung's heirs to read archive material, which wasn't always given – most notably she never examined his famous Red Book. Whilst waiting, other people contacted her with anecdotes, letters and diaries. She had to agree to grant anonymity to many of these contacts, which sits rather uneasily with the meticulous recording of the majority of her sources. She brought her German up to speed to read from originals. She met and interviewed an exhaustive range of Jung's family, friends, patients and professional circle. Her timing was pertinent, as some of the older analysts she interviewed, who knew Jung, have since died.

Bair tackles the disturbing controversial issues with careful attention to the available material. As she writes, 'The facts are few compared with many interpretations' (p. 432). There are important chapters exploring Jung's affiliation with German psychoanalysis from the Nazi solidification of power in the 1930s through the first years of the war. Jung insisted that his primary reason was to aid Jewish practitioners, but motivation is usually more complex. Bair presents a picture of him as explaining his theory of cultural types, not in itself racist, but naïve and arrogant in the context of Nazi ideology. In her words,

> For a man of such highly attuned sensitivity in the consulting room, within the larger world he was often insensitive to the feelings of others and did not recognise the damage his words could do. He was also a product of a particular moment in his Swiss culture, and he represented much that was not its finest, particularly the attitude of the time toward foreigners, refugees, and especially Jews. (p. 563)

Such a vast canvas is painted with dedicated detail. The smaller strokes fascinated me as well as the broad controversies. He was a scientist of the soul who also loved his red Chrysler convertible, named 'my old darling'. Emma Jung is a quiet, dependable presence, yet three times she planned to divorce him. His mother Emilie Jung, often portrayed as 'hysterical', was beloved by the grandchildren as she baked cakes, laughed with them, and floated in the lake in enormous trousers to contain her large body. During the last months of Jung's life, despite high blood pressure and failing health, he doggedly wrote, not in

his circuitous German, but in clear English, the essay 'Approaching the unconscious'. This was published posthumously in *Man and his Symbols* (1964) for a different audience. His will power was fuelled by a dream in which he realized he could explain himself and be understood in a public forum. I urge you all to read or re-read this paper.

I was pleased to have to read this book and will return to it many times. It has made me think again about being 'a Jungian', which for me has always been about the resonance of the tradition in the consulting room, not for a personal connection to Jung. It has stimulated a new critical interest in biography generally, a genre I have not read before. It has also re-motivated me to read more within the rigorous 'New Jung scholarship' as in Shamdasani's recently published *Jung and the Making of Modern Psychology* (2004). Robert Segal, in a review of both Bair and Shamdasani's books in the *Times* (2004), values the latter's intellectual history more than the former's biographical facts. He writes: 'Bair's biography stays on the surface – the factual surface. She concerns herself with immediate issues. She does not place Jung in his times. For all its scrupulous, invaluable detail, her biography seems superficial'. This is too harsh, but I know what he means. Read this biography yourself and ponder.

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MIRANDA KENNY

Inside Lives: Psychoanalysis and the Growth of the Personality
By Margot Waddell
London, Karnac Books, 2002, pp. 268, pbk £17.99

Margot Waddell begins the second edition of this impressive book by saying: 'in these pages I have set out to tell a story'. She certainly does this. She is a gifted writer but just to call her gifted and wise would not do credit to the fact that this book is a distillation of a great deal of experience and hard thinking. To do what she has done in only 268 pages is a feat that she has achieved because she writes in a style that adds no unnecessary words and demonstrates the clarity of her thought. The result is an absorbing account of how psychoanalytic thinking

can be used to illuminate the vicissitudes of all stages of life. The author says 'My interest is... in the ordinary creative development of a person'. Indeed by the end of the book I think the reader will be convinced by the authenticity and integrity of her interest in the individual lives of the people she describes. Each of these, whether infant, child, adolescent or adult, is depicted as movingly engaged with his or her unique struggle with the universal developmental tasks of the human psyche.

Before the story proper begins the author sets the scene with a concise and erudite summary of the Kleinian and post-Kleinian foundation for her thinking. Waddell is interested in *states of mind* and the way that these states of mind – paranoid-schizoid, projective-introjective or depressive – continue to emerge and re-emerge throughout life. These states of mind, rooted in early, internalized object relationships, may be re-activated due to internal or external stresses throughout the various stages from cradle to grave.

These stages of life with their associated tasks and hurdles are described by means of clinical and literary examples. What gives the book its special quality is the way the author weaves into the chapters, and into the clinical work, clear summaries of the theories that frame her thinking. For example, the third chapter, 'Infancy: containment and reverie', begins with a strikingly concise (one and a half page) account of the development from Freud to Bion via Klein. Bion's alimentary mode of digestive, maternal containment is then used to focus upon an everyday example of a child accompanied by its mother doing a jigsaw. In this way the author demonstrates her skill at getting to the bottom of and helping the reader to understand complex and difficult ideas.

Chapter 5, 'Weaning and separation', includes an observation of an 11-month-old boy playing in his cot. It might seem unfair to home in on this as an example of something that sometimes goes unquestioned but it is assumed that the large teddy that catches his eye, which he soon throws out, is a 'third factor' in the mind of the child that disturbs his play with an activity centre. His play with a plastic dome is assumed to represent his relationship with the breast that is then *disturbed* by the large bear. The problem is that we do not know. It could just as easily be that he has tired of the play with the activity centre and has turned to the bear for stimulation or comfort and for some reason he then becomes frustrated. He does seem to become anxious but it is not clear what about. It is just as possible that the child splits his feelings towards the bear into good and bad so that the bear is still a primary object and not a *third*. I am focussing on this only to illustrate a fairly widespread tendency elsewhere (not in this book) to use infant observation to support one favoured theory. It could be more useful to present a range of hypotheses about an observation.

The book is not only a chronological journey through life. It also explores the stages of development in terms of defences and the way that these same defences will reoccur in different guises throughout life. The consequences of loss and the importance of mourning are tracked through development into old

age. As one would expect of a contemporary Kleinian volume there is an appropriate emphasis upon projective processes, the shift from one mental 'position' to another and phenomena such as splitting.

The insights Waddell provides are a distillation of years of thoughtful clinical work with patients and supervision of therapists and child analysts. It does indeed read like an adventure story, full of life and lived lives. This edition begins and ends with an account of the re-emergence in later life of infantile conflicts. The message underlying each of the chapters is that the psychic work of infancy is never finished and that it is never too late for insight. Sometimes sadly it is too late for the insight to be gained by the sufferer herself, as in the case of an elderly mother with dementia. It is the surrounding family via analytic family observation that is able to make use of the help to manage its anxiety. The elderly mother's ego-structure has broken down allowing her infantile conflicts to emerge in their raw state. Unable to read her needs, the woman's children are not able to understand what the mother needs, until the analytic observation helps clarify the situation. This tragedy is infused with Waddell's sense of calm humility and sympathy in the face of the family's predicament.

The first chapter, 'Beginnings', includes an account of a mother's pre-natal preoccupations and fantasies and the ways in which these might influence the subsequent mother-infant relationship. Then the play and associations of a 3-year-old boy are tracked in relation to the traumatic events of his birth and the mother's state of mind. For me this illuminating account was a little spoiled by a brief digression into un-testable speculations about possible connections between the child's subsequent play and his having been stuck in the birth canal. The links the author makes between the mother's postnatal depression and the anxieties of the infant are, on the other hand, not only beautifully delineated but also psychoanalytically convincing. The speculations about pre-birth or birth experiences are an example of a tendency within psychoanalysis towards satisfying but clinically quite improvable ideas. However this is a very minor gripe and probably some readers would disagree with this opinion.

The author has already demonstrated the breadth and depth of her literary understanding in her co-authored book *The Chamber of Maiden Thought* (1991). In *Hidden Lives* Waddell uses her impressive insights into the novels of Jane Austen and Charlotte Bronte to illuminate the exploration of adolescence, adulthood and marriage. With admirable skill she links the two areas, clinical work and literature, to provoke the reader not only into wanting to think more deeply about clinical work but also to return to reading these novelists.

I will not take the prospective reader through the whole of the book but having tried to provide a glimpse into it I hope I have encouraged those who have not yet done so to read and enjoy it. This volume covers manifold aspects of the effect upon the individual of various life events such as puberty, marriage and parenthood. Central to it is the way that these developmental events

interplay with pre-existing *ways of learning* , which in turn are determined by the way the individual has structured his or her self in order to manage the inevitable anxieties of existence.

Sometimes, when we have read a book, we say we have 'finished it', but this does not seem an appropriate thing to say about something that will serve as a continuing source of insight and inspiration.

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SIMON ARCHER

Jacob's Ladder: Essays on Experiences of the Ineffable in the Context of Contemporary Psychotherapy
By Josephine Klein
London, Karnac Books, 2003, pp. 279, pbk £22.50

Jacob's ladder, which gives the book under review its title, was 'set on earth and the top of it reached to heaven'. This seems to me an apposite metaphor for this illuminating series of essays: Klein's work is meticulously grounded in erudition (indeed her familiarity with the work of the mystics and writers on religion is awesome), but she is equally at ease with feelings and spiritual matters, 'the spiritual realm' or 'fifth dimension'.

In her introduction she acknowledges having been inspired by the German writer Rudolph Otto, as quoted in the foreword to the first English edition of his *The Idea of the Holy* to 'make a serious attempt to analyse all the more exactly the *feeling* which remains where the *concept* fails and to introduce a terminology which is not any more loose or indeterminate for having necessarily to make use of symbols' (Otto, 1959: 13).

Her own approach is impressionistic. In a series of apparently unconnected essays she describes experiences of the ineffable in music, literature, mysticism and psychotherapy. In the first chapter she compares the languages of Bach and Handel (both words and music) and, I think, by so doing sets out what is the leitmotiv of the book – that there are two ways of experiencing the ineffable. She also introduces the concepts of 'quiddity' and 'transparency'. Handel rejoices in the sensory accompaniment of glory in nature, but Bach, though appreciating these, sees beyond them. 'For Bach, the wonders of the world are transparent windows through which he sees something at least as splendid beyond' (p. 13). She illustrates further these two ways of apprehending reality

by comparing two writers as different as Gerard Manley Hopkins and C.P. Snow, and concludes by relating this duality to the world of psychotherapy. These attitudes (or should I say dispositions?) can be found in patients and therapists alike.

In the following essay, she sets out the limits of her project and the method that will structure her work. 'Given the elusive nature of the topics to be discussed, how can we proceed to consider them in an orderly fashion?' (p. 33). She, however, takes up the challenge: 'In spite of problems of expressing what we mean and defining what we are talking about, we seem compelled to try' (p. 43), and she begins her exploration in a daring and poetic manner. Using the lion (in this case Russell Hoban's in *The Lion of Boaz-Jahin and Jachin-Boaz*, 1991) as a symbol of an awesome and unavoidable presence, she subsumes under this name others' experiences of the ineffable and their attempts at describing it. In the process she introduces and quotes a number of writers who have struggled with the concept and the experience, among others, John Hick and David Black as well as the writer of *The Cloud of Unknowing* (Anon, [C14] 1971) and Karen Armstrong. She then narrows her frame of reference further and focuses on the numinous experience itself: the 'Mysterium Tremendum et Fascinans', quoting those mystics who seem to have been more intimately in touch with the ineffable, Isaiah and St Francis. Staying within a western Judeo-Christian context, she compares the ways in which Luther and Calvin experience the deity and follows the spiritual journey of figures such as John Buchan's hero, Leithen, and Bunyan's pilgrim, Christian. She ends that chapter with some clinical considerations, ponders why some people have a strong sense of the Holy and others not (as the desire to worship does not seem to be linked to a specific type of personality), and wonders whether it may be linked to the search for a good object. She notes that that type of experience is not discussed in mainstream psychotherapy journals or in the consulting room (unless it can be called psychotic) and remarks that both worship and psychotherapy often take place in dimly lit places and in silence and warns her colleagues not to respond reductively to the experience.

The two essays that follow are about that most ineffable of feelings, love, and for me they are the kernel of the book. What she is writing about is selfless love as opposed to anaclictic love. This is the kind of love that takes the depressive position in its stride, and she examines the ways in which that kind of love (or the capacity for that kind of love) becomes part of the psyche. She looks at the theories of Freud and Melanie Klein (concern being the start of unselfish love) and concludes with Winnicott that we gain in love and selflessness by means of the love and selflessness of another person. The whole point of this kind of love is that it is a recognition of the other person as other. I especially enjoyed her reading of *The Rime of the Ancient Mariner* (Coleridge), her understanding of Dante's love for Beatrice and, in a way more directly

relevant to psychotherapy, Kenneth Wright's contribution and his perceptive thinking on recognition and relatedness.

The following chapters are more centred on psychological processes: concepts of the I and the You and how they intersect. Her references are numerous and include the theories of Buber and Jung, as well as Matte Bianco and Hinshelwood among many others. This is where, I think, for the sake of completeness, the book loses its clarity.

In the last chapter she puts forward the hypothesis that mysticism might be the mystics' remedy to narcissism – whether it be attempted through *via negativa* or *positiva*.

> *Via negativa* can take us into the realms of psychoneurotic perversion, if it combines unfortunately with self-centredness, sentimentality or self-hatred. Manic self-esteem may take a person into unwarranted identification with a phantasized superlatively good object, or, conversely, unwarranted identifications may take a person into manic self-esteem when feeling in the presence of a superlatively good, or at least strong, object... (p. 241)

In *via positiva*, people look at, or relate to a blissful other.

> *Via positiva* is a prophylactic and a remedy for narcissism, it is based on the idea that blissful communion is the most natural thing in the world. (p. 250)

She notes that the anti-narcissistic training of the mystics and psychotherapy have the common goal of self-knowledge and concludes that the only remedy for narcissistically afflicted people is recognition, which is the natural opposite of narcissistic loving. So, in spite of the writer's methodical attempt at coming closer to an understanding of the ineffable, its true nature escapes definition. The book's success, however, is to make us aware of, and respect, its presence.

Though I found the book fascinating and the depth of its learning made me long for further reading, I found it difficult to think about and to review, as though its kaleidoscopic approach had splintered my thinking, or as if I had had too rich a meal which I could not easily digest. Apart from the irritating recourse to dictionary definitions, paradoxically the very abundance of quotations, which is one of the riches of the book, is also an obstacle to hearing the voice of the writer. I should have liked to see some clinical instances of the numinous in the consulting room, in what she calls 'the intersect'. Those are the Buberian moments of recognition of the other, when in the silence, something ineffable takes place. I have called these instances 'moments of kairos' (Wiener, 1996) and believe that this is where psychotherapy and spiritual experience meet. Jo Klein herself writes about Dante's and Beatrice's meeting: 'to know and be known, an ecstatic and frightening aspect of love. To recognise and be recognised for what one is, and what the other is' (p. 86). As a colleague said to me, 'knowledge is grace'.

My reservations are few. Klein has dared to go where angels (and psychotherapists!) fear to tread and has done so with erudition and sensitivity.

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YVETTE WIENER

The Ethical Attitude in Analytic Practice
Edited by Hester McFarland Solomon and Mary Twyman
London, Free Association Books, 2003, pp.183 pbk £18.95

This review is written by a lay member of the Ethics Committee of the British Association of Psychotherapists. The writer's approach to both the reading of the book and this review is as a representative of the public with a vested interest in the ethical behaviour of psychotherapists and registration of the profession. In line with other professions registration requires adherence to the law, respect for patients' human rights, accountability and clarity about the manner in which standards of education/training and practice are monitored.

Lord Alderdice's foreword to the book sets the scene. He wisely points out that the reader looking for answers to complex ethical questions raised in psychoanalytical practice will not find ready solutions, but that 'those who are already thinking about ethics in psychotherapy practice will find much to develop their understanding'. Some chapters are written with more clarity than others and are therefore easier for those outside any particular 'psychotherapeutic club' to understand and analyse.

The book is structured in five sections. Section I is an introduction. In Section II, 'Mostly theory', four writers examine philosophical and psychoanalytic/analytic psychological theories. Fiona Palmer Barnes (Chapter 5, Ethics in practice) also touches on important ethical principles and concepts and their application to the psychotherapeutic community, highlighting some of the complexities inherent in the work.

Section III, 'In the consulting room', describes the ethical dilemmas encountered in different clinical settings, including how the analytical alliance between practitioner and patient can come under pressure from unconscious forces and provide 'fertile ground for ethical transgression'

(MacKenna, p. 53). This section also addresses important ethical and professional issues such as informed consent, the nature of the treatment and the risks, not harming the patient, confidentiality and the public good. It highlights not only ethical attitudes but also the essential requirement that practitioners should aspire to – ethical knowledge and a clear understanding of ethical reasoning. These can be supported by Codes of Practice, but go beyond rules and regulations, which may not be enough if the profession is to be accountable and trusted.

Many of the chapters in Sections IV, 'Confidentiality and publication'; V, 'Applications: thinking analytically about ethics in different settings'; and VI, 'The ethics of supervision', make constructive contributions to the ethical thinking and pragmatic considerations inherent in psychotherapy practice, learning/teaching and organization of the profession.

The question constantly in the mind of the layperson on reading this book is about trust, as this would seem to be fundamental in any professional therapeutic relationship. Is it safe enough for vulnerable patients to embark on psychoanalytic psychotherapy as an act of faith relying on the assumption that, because the psychotherapist has been analysed and has also benefited from the experiences and observation of their supervisor's 'ethical attitude', they will have an 'ethical attitude' and behave ethically themselves?

It has been shown, both in this book and in the public domain, that harm can be inflicted on patients who have put their faith in psychoanalysis. Onora O' Neill (2004) states 'public policy in the UK has aimed to replace "club" cultures and their supposedly suspect reliance on trust' and asks us to consider 'intelligent accountability' by combating 'professional cosiness'. She asks us to look for intelligent ways of holding professionals and institutions to account.

A number of contributors to this book have aimed to address complex ethical issues essential to the accountability of the profession. Christopher MacKenna (p. 55) reassuringly examines 'three currently vexed questions: consent to treatment, consent to publish case material, and the psychotherapist's duty to protect against harm'[1]. These three questions were linked to a number of the uncomfortable debates within the book related to matters of trust, both trust in the training and regulation of the profession and trust in the psychotherapist's practices – including issues such as intense and intimate relationships, boundary setting, power relationships, unknown territory of people's inner worlds, transference and counter-transference, interpreting what is really in someone's unconscious mind, maintaining confidentiality, and so on. This chapter not only demonstrates a sense of ethical reasoning which would engender trust in the patient/therapist relationship but also challenges some of the fundamental attitudes which have informed psychotherapists' practice and training. It would seem that a number of the ethical dilemmas quoted in the book – such matters as confidentiality, secrecy, different kinds of

disclosure, the analyst's responsibility as a citizen and the reporting of clinical material essential for the progression of the profession, truth telling and record keeping – could be tackled with greater clarity by applying appropriate ethical principles, ethical reasoning and 'intelligent accountability'.

Notes

1. Christopher MacKenna's ethical reasoning is supported by the work of Holmes and Lindley (1989: 56) who say that the 'American conception (of informed consent) has much to commend it from a moral perspective which takes autonomy seriously' and he goes on to list how American law holds the four following ingredients necessary for informed consent:
   1. Understanding the nature of the treatment.
   2. Information relevant to making the decision (e.g. fees, holidays, missed sessions, objectives, length of treatment, chances of success, etc.)
   3. Risks attendant on the treatment.
   4. Alternative treatment possibilities.

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Reviewed by Patricia Pank

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