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The British Association of Psychotherapists

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BULLETIN

No. 9 1976

CONTENTS

EDITORIAL

This is the British Association of Psychotherapists' first publication since Bulletin No. 8 in 1971, and we hope that it will now be possible to publish at least one journal or bulletin each year. If members wish to express views on whether they should have their copies free or be charged for them, this would be of interest both to the Association and to the editor, as it would affect frequency of publication.

The new start makes a felicitous beginning with a conciliatory article for "Jungians" and "Freudians", an outstanding "Reading-In" paper on adolescent suicide, and two shorter articles about patients and their therapists.

It is early days for a new editor to think of policy, but a hope may be expressed, that the therapeutic process will be the focus of many contributions to come.

Articles, notes, comments, letters, reviews will be welcome from members of the Association, in preparation for the next issue.

CAN THE STREAMS MERGE?

A paper presented to the British Association of Psychotherapists by Dr. J. R. Wilson on 29th January 1976 in London, concerning the present practice of training the students in two separate streams—Freudian and Jungian.

I

The aim of our training in the Association is to enable students to become competent psychotherapists using analytical methods. It has so happened that two streams have developed, each having their point of origin in one of the two Father Figures of Analytical Psychotherapy.

However, since Jung and Freud parted company, matters have not stood still. Other systems have come into being and are flourishing, mostly developments of the Freudian system, which has itself been modified by thinkers like Melanie Klein, Fairbairn, Winnicott in this country, and Erich Fromm and Erik Erikson and others in the U.S.A. Schools like Existentialist and Gestalt Analyses which have developed perhaps as a reaction to Freud are not represented in our Association as yet.

It is perfectly natural and normal for there to be a variety of models on such a subject as the mind of man, for it presents the most complex of all phenomena. Simple two-dimensional objects can be comprehended by simple unchanging models. Three- and multi-dimensional objects are a different matter. It is inevitable that they are looked at from different angles, and the descriptive models which are produced for elucidation and understanding differ from each other depending on both the point of outlook of the enquiry undertaken and the pre-conceptions of the enquirer. Taken together, however, all such models should contribute to provide a richness in the understanding of the subject matter.

In asking whether the streams can merge, it is not my desire to reduce the complex systems of thought of the two Masters into a single utility system which would be based on the least common denominator of both their works. To do this we would have to go back to pre-1913 before Freud and Jung parted and too much water has flowed under too many bridges since that time for us to try and steam our way back against the current.

It is possible to see some similarities between the two systems, as are indicated in Dieter Wyss' *Critical History of Depth Psychology.*[1] The more, however, each developed in its own way, the less possible is it to find the one-to-one correspondences.

It seems unfortunately to be the case that Jungians and Freudians, like Liberals and Conservatives, are born and not made, and those who sympathise with the general viewpoint

of one school are likely to find that of the other incomprehensible.

So writes J. A. C. Brown, who follows by clearly stating his own personal preference.

> The present writer may as well admit that he comes into the Freudian category, and gets much the same impression from reading Jung as might be obtained from reading the scriptures of the Hindus, Taoists and Confusians: although many wise and true things are being said, he feels that they could have been said just as well without involving us in the psychological theories upon which they are supposedly based.[2]

Are the streams destined to be like parallel lines which will only meet in infiinity, and therefore we do not need to regard our present situation with any sense of concern?

I cannot agree because this is not merely a matter of domestic business affecting our Association and its economics, but one which has repercussions in the academic world, in which our discipline has not yet taken its place along with others.

Freud, as is well known, used the word " Psychoanalysis " in two different ways—first, for the actual practice of psychotherapy: the analysis of the patient, and secondly, for the body of knowledge which grew up as a result of the former and this he called his metapsychology, implying that, like metaphysics, it went beyond psychology. To avoid confusion, I would suggest that we psychotherapists should use two words—PSYCHOTHERAPY for the analytical treatment which we engage in with our patients, and PSYCHODYNAMICS for the body of knowledge which has grown up from the practice.

It is psychodynamics which one would like to see as a respectable academic subject in our universities—a subject concerned with man himself, with the understanding of the inter-actional and intra-actional dynamics, using various metapsychological models for the purpose. At the moment the subject is unofficially diffused among various departments—education, psychiatry and social studies.

I would like to think that our Association was in some small way contributing toward the establishment of a single discipline of psychodynamics, and not holding back the time when this can take place. It is heartening to see that there is to be a session at the coming Conference of the British Psychological Society to be held at York in April 1976 when Mr. James Home and Dr. Rosemary Gordon will consider: " The relationship of Freud's and Jung's approaches to psychology in the light of current developments in both schools ". Unfortunately the perpetuation of the two streams in our Association, which historically go back to the break of Jung from Freud and has resulted in the two societies,

the Institute of Psychoanalysis and the Society for Analytical Psychology, is not aiding the unity which I hope will emerge in the establishment of Psychodynamics. We have partly modelled our training for the two streams on that given by the respective parent societies, so that we too perpetuate the consequences of the break, and we too look back at the parent associations, depending as we do on members of each for our separate training programmes. Rather I think we ought to be concerned with the emergence of one discipline, which can hold together the various theories, if not in uniformity, then in common understanding and respect. The advantage of having a number of schools of thought under the umbrella of one basic discipline would be that a whole variety of means of dealing with similar phenomena would be available, all of which have worked with certain therapists and clients.

Physics is a single discipline in our universities, and under its umbrella there is a variety of schools of thought. There are no official Max Planc streams of physics which keep their students studying only along the lines of Planc or official Einstein streams whose students only work along the lines laid down by Einstein himself or his direct followers: there is only the unified subject of physics in which each student is exposed to all kinds of theories so that cross-fertilisation of ideas can take place. In one single department or faculty it will be possible to meet individual teachers who are specialists in particular schools of thought, and students have to rub shoulders with them and make up their own minds. As well as common understanding and respect between the teachers within the faculty there will be healthy and sometimes violent disagreement, but the ends sought must be for unity of knowledge in truth.

Now I believe that neither the Institute nor the S.A.P. with their loyalties to their respective traditions are as free to contribute towards making psychodynamics a unified discipline, in the same way as we and bodies like the Tavistock Institute are. There is no reason for us to be tied to their pasts. How then can we make the significant changes in our training programme in which all our students will be exposed to the various schools of psychodynamics, and be able to express what preferences they have, whichever system is meaningful to them, whilst being open to others?

II

I think our first task is to understand the logical status of the various psychodynamic models. Freud used the word METAPSYCHOLOGICAL of his theories, and it is a word which equally applies to those of Jung. In order to handle the sheer quantity of phenomena and data, Freud was forced to construct systems

of thought, or patterns or models of comprehension. These enabled him to handle the vast amount of data which accumulated in his clinical work. As metaphysics takes us beyond the physical and factual, so these models of Freud go beyond consciousness, and therefore the word metapsychological is appropriate.

Jung developed his individual models in a similar fashion.

> No practical science can get along without its tricks of the trade (*Handwerkeregeln*). That is the way to look at anything I may say about the structure of the soul. There is no question of my producing incontrovertable truths—they are simply ideas thrown out in an attempt to bring a bit of order into bewildering conglomerations of psychic realities . . . All our present psychological theories are subjective assertions which we defend jealously, in a highly partisan spirit, because they echo powerful currents in the human soul . . . .[3]

Freud claimed that his metapsychology was scientific—a claim which has been much disputed. Classification of data was very much a part of the scientific practice of Freud's time, and Nigel Walker[4] may well be right when he regards it as a typical produce of nineteenth-century science, " an attempt at a reconciliation between his technique and his scientific beliefs ". Freud was only being faithful to the traditional practices of his time when he constructed his metapsychology.

Anyone who reads Freud, however, especially his case studies, will be struck by his magnificent powers of accurate observation and his great ability at describing in ordinary language, the details of his cases. Freud could have been a very great novelist. Yet he is apologetic about his descriptions, and in order to maintain his place among the scientists of his time, he hurries away quickly from his case descriptions to the transformation of his material into the language of his model. He overvalues his models and undervalues his critical descriptions. Nowadays it may be possible to value Freud the novelist, more than Freud the modelist, the so-called scientist. The novel language is preferred to the model language. This is in line with the claim made by Rycroft[5], Home[6], and others that psychoanalysis should be considered along with the humanities, and not along with the sciences, as it deals with reasons and motives behind the symptom, and not causes. It is descriptive in nature and lacks the vital ingredient of scientific disciplines, namely the power of prediction. So Freud the novelist, who displays sympathy and understanding, may be preferred to Freud the scientist whose metapsychology employs mixed physico-chemical and biological language[7].

When we look for novel-language or case-histories in Jung, we have to look very hard indeed. As Storr[8] points out, we may find some dissertation on Eastern religion or the Trinity, for Jung was much more interested in ideas than in people. So the novel lan-

guage is largely absent from his works, as are considerations of interpersonal relationships and child development, and their effect on subsequent life. But Jung, like Freud, is rich in model language, in metapsychology.

Today, however, there is a common inhibition on all metaphysical thought; this is a feature of modern philosophy[9] and it is not surprising that psychology has been affected. When metaphysics is employed in understanding data, one incurs the danger of creating and thereby increasing metaphysical facts and when placed side by side with the original empirical facts, nonsense statements can easily result. Empirical data have a quite different logical status from metaphysics, and the two cannot be used together in the hope of making meaningful sentences or statements. " What begins in a mixture, continues in a muddle and ends in a mess." If metaphysics are used, they can only be used in place of data, so it is argued, and not alongside of them, for the data are always fundamental[6].

While philosophy has shut the door on metaphysics, the physical sciences more and more have opened the windows wide to allow models to fly in, for they are being employed more and more to explain phenomena, and have great utilitarian value as such. I recently heard a scientist explain how he used the state of the political parties in Britain—two large and one small—to explain the structure of carbon in a protein chain. Not every philosopher would regard the metaphysician (or metapsychologist for that matter) as " a misplaced poet " who " produces sentences which fail to conform to the conditions under which alone a sentence can be literally significant ".[10] Dorothy Emmet would regard metaphysics as " an analogical way of thinking ", for " man is an analogist " and has the impulse to create forms in which the imagination can rest, and this impulse lies at the roots of all mental activity.[11] Emmet follows Ernst Cassirer that man is a symbolising, myth-making animal. She argues that all experience includes interpretation of some kind and no one can get back to primary experience, simply because we are unable to think away all forms of interpretation and " catch ourselves with some raw pellet of experience ". As Gestalt psychology teaches, we all have our systems and " sets " for perception. I cannot go into the richness or do justice to the brilliant arguments in Professor Emmet's seminal book. However, she does make clear that we cannot escape metaphysics, as man instinctively interprets his experience through symbolic forms, and these are an inevitable form of analogical activity. Analogical thinking is a form of thinking as legitimate and as productive as logical thought. John Wisdom came to the same conclusion. " In order to grasp complex patterns we are always using models ".[12] So (to quote another writer) " the

question is not whether men can or cannot do metaphysics, but only whether they do it well or badly ".[13]

It should now be clear that the metaphysics I am talking about are not the old-fashioned kind involving statements about a transcendent reality; rather these kind of metaphysics are a revolt against such systems; they are constructs based on empirical data, or, as they have been called " metaphysics from below ". Both those of Freud and Jung claim to be of this kind. Can we say more about their logical status?

The book which I find expressing most clearly the nature and uses of models is that of the late Ian T. Ramsey; " Models and Mystery ".[14] Basically, Ramsey argues, there are three kinds of models. (1) a Scale Model or replica, which he calls a " picture model ". (2) a Disclosure Model, e.g. a mathematical formula. Both these models enable us to be articulate about some aspects of the physical universe; they " chime in " and " echo with " the phenomena, thereby granting a disclosure about some mystery in the universe. Ramsey uses such homely phrases as " the ice breaks " or " the penny drops " to explain how these models work. From such models it is possible to gain verifiable deductions. It is clear that neither of these models apply to psychodynamic models such as the metapsychological ones of Freud and Jung. However, Ramsey goes on to speak of model (3); which he calls a Theological Model. This model stands or falls according to its success in harmonising whatever events are to hand and no derivative deductions are required of it. This kind of model works more like the fitting of a shoe or boot, or like a roll call. It is judged by what Ramsey calls " empirical fit ". These are the kind of models which both Freud and Jung used.

Freud in his *New Introductory Lectures* speaks of his theories being based on " the accumulation of empirical data " . . . and . . . " in no other way ".[15] Jung is also quoted[16] as saying: " As a scientist, I proceed from empirical facts which everyone is at liberty to verify ". Ferenczi puts the matter as follows: [17]

> It was necessary to sift the enormous amount of material which the new method had collected and to classify it scientifically. Whether for good or evil, Freud had to formulate a skeletal outline for his theory, a construction which, though it has been altered, modified and remodelled many times, remains sound in its main details up to the present day (i.e. before 1933 when Ferenczi died). This construction is the so-called Metapsychology . . . *every scientific theory is fantasy;* and it is serviceable as such as long as it meets practical requirements and agrees with the facts of experience. Freud's metapsychological system does this fully.

Ferenczi still thought of psychoanalysis as a science, but if we adopt Ramsey's third kind of model, we cannot classify it as scientific in any way, as casual explanation is not fully operative and prediction cannot be made. Similarly, Victor White,[18] a follower of Jung, writes:

> Like every empirical science, psychology also requires auxiliary concepts, hypotheses, and models. But the theologian, as well as the philosopher, is apt to make the mistake of taking them for metaphysical *a priori* assertations. The atom of which the physicist speaks is not metaphysical hypothesis; it is a model.

The metapsychological model arises from empirical data and works by meeting empirical needs, and its validity is constantly being tested in clinical psychotherapeutic situations. The metapsychological models which form the subject matter of psychodynamics are therefore both justified and logical, but they are metaphysics from below, always arising from empirical data and needing to be checked by them. They have no independent existence—this unfortunately is often forgotten, and they become regarded as some form of statements concerning transcendent reality. This is the one sin to which adherents of the various schools of psychodynamics are prone. Forgetting the logical status of the theories or models, we hear statements like: " You cannot do psychotherapy without the archetypes ", OR " Any therapy which does not adequately deal with the superego is not analysis ". These statements reveal an attitude which has transformed what should be metapsychology " from below " into transcendent realities, " metaphysics from above ". No one has seen an archetype through a microscope; no one has cut up a superego in the pathology lab; no one has observed the culture of an internalised object grow in a human brain. They are hypothetical models and should not be regarded as anything else. Moreover, fresh data made Freud alter again and again his ideas. As Guntrip pointed out, the history of any discipline, be it science, theology or psychology, is strewn with discarded hypotheses, and this is an inevitable process.[19] Freud's metapsychology was constantly changing in the light of fresh clinical material, which should remind us that psychodynamics does not deal with transcendent realities, or unchanging principles.

When Joan Riviere was translating *The Ego and the Id*, she pestered Freud about some passages which she found obscure, and requested clearer expression of his thought. He became exasperated and replied: " The book will be obsolete in thirty years ".[20] As A. D. Ritchie wrote: " the permanent thing about science is its methods not its theories or conclusions ".[21] The same criterion applies to psychodynamics. Let me conclude this

section with a quotation from Erik Erikson which sums up the problem: [22]

> Freud used the thermodynamic language of his day, the language of the preservation and transformation of energy. The result was that much that was meant to be a working hypothesis appeared making concrete claims which neither observation nor experiment even attempt to substantiate.
>
> Great innovators speak in the analogies and parables of their day. Freud, too, had to have the courage to accept to work with what he himself called his " mythology ". True insight survives its first formulation.

III

As far as Psychodynamics is concerned, the method, if not permanent in A. D. Ritchie's sense, is certainly traditional, namely that the data emerges from analyses. A movement similar to Melanie Klein's idea of ego up-building takes place, of projection and introjection, and (to switch to Piaget) the introjection is assimilated and accommodated and then projected out again. Data emerge to supply the theory, and the theory is brought back in such circumstances where the principle of " empirical fit " seems applicable. I am convinced that the basis of training for our psychotherapists must be a personal analysis in which the unconscious or unrecognised aspects of oneself are brought to light, interpreted according to whichever psychodynamic model the therapist/analyst employs for his sustaining concepts, and the attendent emotions with resistances and defences are worked through within the transference situation. It will be normal for theories other than those of the therapist to enter into the analysis, as most students, by their reading, attendance at psychotherapeutic and encounter groups etc., are picking up and absorbing fresh data and theorisings, all of which can be brought into the analysis and worked through. An analysis enables a student to see in what way theories apply to himself, or are completely inappropriate, and through this emergent self-awareness has an experiental command of psychodynamics. The method of analysis is not stereotyped by any means. The procedures of analysis, and their professional goals, may appear to be very different from each other. An analyst may use a chair or a couch; he may employ primarily reductive or primarily explanatory methods, both of which are found in part in every analysis. Both schools would admit, however, that greater awareness of oneself, and of one's personal relations, are essential and together form the basis of a training analysis. This is common ground.

Difficulties lie, however, in the theoretical formulations. Sidney Smith, the famous Dean of St. Paul's, once witnessed a noisy

slanging-match between two women who were standing at their doors and facing one another across a mean street. As he turned away he said to his friend: "These women will never agree because they argue from different premis(s)es". Storr[23] has drawn attention to the different backgrounds of Freud and Jung, their different class of patients and modes of working, their different academic interests and the like. Yes, they do come from different premis(s)es! We speak of two streams in the Association, but it would be better if we compared the two systems to (1) a vigorous main stream and (2) a lake.

The result of Freud's work has been such that 95% of all psychotherapeutic training ultimately comes from Freudian sources. His original work has been modified, contradicted and corrected time and again, and other schools have been set up, all of which would admit that their original source was ultimately Freud.

Jung after the break worked away on his own, not relating any of his work to the rest of psychoanalytical studies, which were going on elsewhere. Rather than a stream or flowing river, Jung created a beautiful lake in which all kinds of exotic flora bloomed. He lived by Lake Zurich—was there a principle of "syntopicity" here? (Syncronicity uses "Chronos" (time); I use "Topos" (place)). Now Jung's disciples today are doing what their Master failed to do, and are building channels between the lake and certain neo-Freudian streams and showing correspondences between them, as there must be as both systems are based on data from the same empirical sources. This work is to be greatly encouraged, as it is undoing Jung's going-it-alone which is no doubt responsible for the fact that Freudians do not give much time to Jung's works, and there is no Jungian reading on our Freudian reading lists.

Storr, on whom I rely considerably, points out that if Jung had carried through a suggestion he made that archetypal images take their origin from early infantile experience, rather than base them on inherited predispositions, he would have gained wider acceptance for his psychology.[24] This would have been a correspondence between the systems. The images or Archetypes are closely similar to the sort of figures in infantile fantasy to which Freud, Klein, Fairbairn and others draw our attention. It would be much easier to continue speaking of Archetypes or the Unconscious as though they were irreducible concepts, as termini beyond which one cannot go but which require to be united in the subsequent process of Individuation.[25]

If reductive treatment can elucidate the Archetypes, it can make nonsense of creativity and artistic production. The "nothing else than" or "nothing but" type of reductive reasoning which Freud took over from Feuerbach fails when it claims that

works of art are nothing but infantile wish-fulfilment. Jung's idea that creative work may be a fulfilment of the personality and that the origin of such work lies in the unconscious although the actual execution of the work is a conscious effort, has more to commend it, and agrees incidentally with the view of Charles Lamb writing at the beginning of the last century.[26]

IV

I would return to the question of the logical status of our psycho-dynamic theories. There is a danger of regarding these as though they were scriptures and revered writing to which we must ever return for illumination. When theories are treated as Holy Scriptures, a fundamentalist approach can take over and Revelation in the religious sense appears. It is then that psychodynamics can find itself up against the same kind of difficulties which have overtaken the Church and theology in the last century and this one. The writings become operative and fundamental; the only way ahead then is by faithfulness to the Revealed Word, and deductive approaches take over. Nowadays the need for empirical fit in matters of theology, rather than a deductive approach, is at last winning the ground. There is even less reason for us, by perpetuating the same mistakes as did the Church, to find ourselves in a similar impasse, for there is no logical reason for our regarding our theories as the final work of God.

There may, however, by psychological ones. Omnipotence, I have suggested, happens in the theological world when adherents identify themselves with revelation. In all spheres, omnipotence is the most difficult thing to surrender—in education, politics, the church. We psychotherapists can understand and explain the motives of other groups and individuals so clearly; can we see our own potential dangers, and surrender vested interests in the cause of the unified discipline of psychodynamics?

It is to be hoped that contact with the same empirical data from which the theories took their origin will prevent us from hardening into either a deductive use of our chosen theory, or a defensive attitude towards any criticisms. We may not find it easy to abandon ways which we have found to work in the past; but if they are inappropriate for the present and future . . . well, is this not what psychotherapy is all about?

V

One of the reasons for the streams merging is that if we are sensitive to current trends, we will need to have a third stream, alongside the other two, namely an Existentialist one, for this school is gaining very much in strength and has many well-known adherents. The older " daseinsanalysts " like Binswanger and Boss

rejected Freud's theoretical constructions, asserting that man and his true nature cannot be contained within such confines.[27] They argued that the placing of data about persons within metapsychological constructs which claim to be universal, causes the unique quality of the phenomena to be lost, for man's true nature will always be destroyed when fitted into categories. They therefore turned to the phenomenological approach of Husserl, which stands for the complete abandonment of all metaphysics, including metapsychology. To this they added the Existentialist language of Heidegger, the "Existentalia", the first of which is *Dasein,* elaborated as *Being-in-the-World,* the world being the meaningful structure of relationships in which a person exists, together with the design in which he participates.[28] In mental indisposition, therefore, we study not an illness, but those whose relationships are disturbed.

Existentialists claim that their approach is presuppositionless, apart from the given structure of *Dasein.* They would dispense with anything which goes beyond immediately observed phenomena, such as the unconscious, the instincts and Freud's threefold structure of the mind. By contrast, they claim to confine themselves to what is immediately experienced.

At first sight this looks like a movement which strikes at the very roots of psychodynamics if not psychotherapy. A recent article by Roy Schafer[29] claims that it is time that all metapsychological language be dropped and psychoanalysis conducted without psychodynamics. In its place, he would suggest that a new language be developed based on a combination of existentialist and phenomenological concepts, together with those employed by philosophers of mind like Ryle, to which he gives the name of *action-language.* A long history lies behind Schafer's article, and it will be remembered that R. D. Laing[30] in *The Divided Self* raised an objection to psychoanalytical language in that a theory of man loses its way if it falls into an account of man as an organistic system of "It" processes.

There is much that is attractive here. Following on Buber,[31] we would all prefer "I-Thou" to "I-It" language and procedure when dealing with individuals. However, I cannot agree that categorisation depersonalizes because the patient is treated as an "It" when he should be treated as a "Thou". The therapist who understands the patient in terms of categories may be doing so in order to understand him better as a "Thou". As long as classification is used only as a means to an end, the end being the better understanding of the patient, then the application of categories is completely justified. A patient who is exceedingly difficult to help, may be assisted much better once the therapist has made a classification: i.e., that the man is paranoid, OR is displaying oedipal difficulties, OR has a harsh super-ego, OR is dis-

playing a " false-self ". It would not be necessary for the therapist to tell the patient this; he will keep the concepts to himself as sustaining facts, but having made the " It " evaluation, the therapist can then return to the patient with renewed resources and widened understanding.

The value of the Existentialist protest lies in the demand for a clearer and more immediate language than that which Freud and Jung employed, and its effect is being felt in the psychotherapeutic movement in such books as Peter Lomas *True and False Experience,* a book which uses terms closer to human experience than either Freud or the Existentialists themselves do.[32] It points the way to what could develop as a true language for a united discipline.

Another kind of approach to be recommended is that in John Bowlby's trilogy *Attachment and Loss,* particularly *Part 2, Separation,* where the claims of psychoanalysis are set side by side with research projects and experimental psychology, with the result that some have to be rejected.[33] Bowlby even psychoanalyses " Little Hans " most convincingly; I am sure that Freud would have approved. One feels that here is a book which is working for true unity, not only in psychodynamics, but in the whole of psychology.

To have a common language for our united discipline, we cannot just engage in a form of psychological carpentry using bits and pieces from the traditional terms of Freud, Jung and the Existentialists together; this would result in a kind of Esperanto which none would espouse. What we hope will emerge, however, will be a common language which will constantly be developing and changing to meet the needs of empirical data—a living language rather than a dead one.

An example of this came from a psychiatrist of the Jungian persuasion who runs a psychotherapeutic unit in a large mental hospital who told me that not only is the word " unconscious " seldom if ever heard in the unit, but that the concept behind the word is seldom employed. Of course, a change of method from individual psychotherapy to group psychotherapy can cause differences. And in this connection we recall that Laing[34] once said that the theories of Freud lack concepts to deal with how two human beings meet, and is unable to take account of more than one person at a time. Storr[35] likewise has said that Jung was not concerned with interpersonal relationships, but with " the growth and development of personality seen as taking place within the charmed circle of the individual psyche."

One could continue indefinitely dealing with criticism made between the various schools and from the outside as well. We must, however, call a halt. We belong to an ever-moving discipline where new ideas are emerging which modify and correct

former ideas. This is part of the excitement. I have indicated some of the ways in which encounter takes place; there are countless others. All serious students of a discipline must engage in such an encounter, and to protect them from the cross-fertilisation of ideas which can occur, by keeping them largely segregated in two charmed circles is to desprive them of valuable learning experiences. Not only in these days do we need to avoid unnecessary duplication of teaching, but we waste learning potential as well.

So I hope that the day will soon come when a basic curriculum for all our students is worked out; it could be constructed on a modular basis, some of which would be obligatory to all students: others, could be selected by the students in the school of their choice; and one can always express one's preference by the choice of analyst and supervisors.

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MOTIVES AND REASONS FOR SUICIDE IN AN ADOLESCENT GIRL*

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Suicide is one of the major causes of death among young people in industrialised countries, generally surpassed only by death through accident or cancer. In addition there are large numbers of young people who attempt suicide. Yet child suicide, while it does occur, is still exceptional.

We have still to clarify what it is about the adolescent process that makes suicide possible. Recently there have been a number of valuable contributions. (16, 17, 23, 35, 37, 38). I hope that Jessie, the case I am presenting here, can help us towards further clarification in regard to one type of suicidal adolescent. For Jessie threatened to kill herself from latency onwards, but did not try to do so until shortly after her sixteenth birthday. She was in intensive treatment for five years, from the time of her attempt until just before her 21st birthday. For the first three years the possibility of a further attempt was an active one, and there was a resurgence of suicidal wishes during the termination phase. It is on the various motives and causes for her suicidal wishes and threats as they emerged within the transference, and on the meaning of her ambition to be dead, that I shall focus in the main part of this paper. Some comparison of these findings with those reported in the literature, may be found in the notes.

Jessie was the younger daughter of elderly Jewish parents. The extended family was highly disturbed, and mother had been hospitalised for "nervous breakdowns". She was an intensely hypochondriacal woman, whose "illnesses" included such unorthodox complaints as "disseminated spina bifida". In addition she had throughout Jessie's life suffered a number of serious illnesses necessitating hospitalisation, including cancer of the breast. During Jessie's pre-school years she had a miscarriage and, when Jessie was nine, an abortion and hysterectomy. Nevertheless she was in many ways the strong one of the family, dominating her husband and children. Towards Jessie she was highly intrusive, controlling, guilt-provoking and infantilising. In treatment Jessie gradually came to express her awareness that mother could not perceive her except in terms of her own needs, could not allow her to have feelings of her own. As Jessie once put it, speaking of her babyhood, "she probably picked me up if I was crying, but she would not see if I was hungry and needed my

nappy changing: she probably just grippled me and put me down again."

Mother's need to overprotect and infantilise sprang partly from her unusually marked hostility. Her death wishes were clear in the way she would leave tablets in Jessie's way, or give them to her, at a time when the GP had asked her not to. She would frequently shout at Jessie to get out, or she would threaten to leave herself. At times she would threaten suicide. She openly blamed Jessie for all her illnesses and frequently described how she had been "sick every day for nine months" while carrying her. Another theme was how much Jessie's teeth had hurt during feeding. Such comments would usually be followed by reactive overtures of love in which mother would assure her, "You'll always be my little girl."

Mother had named her elder daughter after her own elder sister, and it was clear that she herself identified with Jessie. As Jessie did begin to separate from her, and to go out with boys, mother gained considerable vicarious gratification from living Jessie's life at one remove. At times their closeness seemed almost uncanny. For instance, on the evening Jessie returned home after first having sexual intercourse, mother greeter her with "Tell me all about it, darling, let me clutch you to my bosom".

Mother's often florid sexual talk covered her marked conflicts around feminity. She openly regretted the fact that she was not a man. While Jessie too longed to be a boy it was a long time before she could recognise her awareness that mother had wanted a boy. When she was able to see her parents with some accuracy she sadly described them as being like people in the cartoon: the big strong woman and the weak little man. Father, she said, survived his wife's nagging and shouting by going to sleep. He was generally despised in the family because he had not made money: he had lost the family business when Jessie was three, and then had to work in a shop.

But withdrawn and despised as father was, he had been for Jessie a masculine, exciting and at time very frightening figure. As a child Jessie had taken baths with him and scrubbed his back. He would take her for rides in his van, and he taught her to box. At other times he would ignore her, or explode into violent temper, beating her and threatening to break every bone in her body. These explosions seem to have increased when Jessie began to go out with boys. Once when she came in late from a date he shouted that he would murder her, and added that no one would blame him because everyone could see how terrible she was.

Indeed, both he and mother constantly denigrated Jessie, telling her she was too stupid to think, too ignorant to know things, and too mad to manage her life.

It was against this background that Jessie had developed into a plump, stocky sixteen-year-old who viewed herself as almost totally worthless: dirty, broken and vicious; stupid, bad and mad. Generally these feelings were hidden from the world by a bright social smile plastered across her face, and she attempted to hide them from herself by a whirl of activity. At work she would spend the day giggling with her current girl friend, in the evenings she went regularly to night clubs until two or three in the morning, flirting, drinking, swearing and screaming with laughter. She would work up romantic dramas about boy after boy, and try to think of these when alone, so as to keep the sadness at bay. Or she would masturbate repeatedly, using the physical sensation to block out misery.

Nevertheless what she called the "pain in the mind" broke through with increasing frequency during the year after she left school. At such times she seemed hardly able to move, and she dressed entirely in black. She would find that she was crying without noticing when she began. She once rang the Samaritans, but put the phone down laughing. When tablets from her GP did not stop the tears she referred herself to the Centre.

She had been in difficulties from babyhood on. She suffered from infantile eczema so severe that learning to walk was delayed: she would shuffle around on her bottom because her legs and feet were so painful. Eczema continued intermittently until treatment began, and thereafter she suffered from various skin irritations and eruptions at times of maximum stress. Weaned at $7\frac{1}{2}$ months, she refused the bottle and went straight to a cup. Thereafter she rejected all milk foods and developed various fads. From the time she was toilet trained (and training began at birth) she was severely constipated. At three she had a tonsillectomy, and throughout childhood she had numerous feverish colds and painful middle ear infections. She had frequent tummy aches, and at nine was investigated for appendicitis. She vividly remembered her mother holding her legs apart while the doctor poked things up her. At 13 she had glandular fever which left her very depressed. (c).

Painful as were many of her illnesses, they also provided the gain of staying home with mother. For throughout her childhood Jessie was terrified that something would happen to mother, and felt she had either to be with her or to think about her all the time in order to preserve her. When she was not ill she often pretended to be in order to stay home. Mother's agreement that she do so, prevented the recognition of her near school phobia. Not surprisingly she did not do well at school. At school, as later at work, she usually had one close girl friend with whom she repeated many of the elements of her relationship with mother. Otherwise she was virtually friendless.

She had a violent temper, and would fly at anyone who disparaged her, kicking, hitting and sometimes biting. At home, although she sometimes shouted at mother to " drop dead ", she never attacked mother physically, having been told that any kind of blow would kill her. After rows with her parents Jessie would be overcome with guilt, and it was at such times that, as a child, she threatened to kill herself. But at that stage mother always told her not to. Earlier, from around six months until at least the age of four she used to bang her head, at first in her cot, and later in the road or wherever she happened to be. (d). Among the motives for her headbanging as she remembered it were many but not all of the motives for her later suicide wishes. By it she protected her mother, deflecting the aggression onto herself, and she attacked mother, trying to make her feel guilty and to show her up and embarras her in front of others. Most important of all she tried to see if mother cared enough to stop her. But the trouble was, as she later put it, it was never any good because she was never sure, and so she had to try again.

The wish to see whether I cared, and whether I cared enough to protect her, was present in the transference from the first interview. Behind it lay the terror of being abandoned and left a prey to the dangers of her own explosive impulses.

Jessie was uncertain as to whether she wanted treatment. She had told the psychiatrist at the Centre of her depression, saying that it followed the breaking up of her friendship with a girl, but while she mentioned that her mother had recently threatened suicide, she did not speak of her own suicide threats. Her first session with me was delayed because an uncle died the night before. When she did come, she was very afraid of the idea of treatment: to admit that she needed help confirmed her view that there was something wrong with her, and her guilt about having damaged herself and others. She presented a bright chatty front, and although her underlying view of herself as not fit for anyone to accept or stay with was clear, she insisted that everyone said she did not need help. She indicated her guilt over hostility to mother by assuring me, " My mother is very good to me; I respect my parents ", each time she tacitly complained about mother.

In the second session Jessie asked what I thought about her having treatment. Here, in addition to taking up some of her initial anxieties, I said that I thought she did need help, but that the decision as to coming had to be hers. This was a mistake, for Jessie construed it as a total rejection. Some time later she told how she had walked away down the road thinking, " what's the use? She doesn't care either ".

That evening, after rows with her boy friend and her parents she tried to kill herself. (e). Full details of the attempt emerged

only gradually over the first eighteen months of treatment, and the full meaning of those details over the course of the analysis.

When Jessie got home from her session mother "asked and asked" about treatment, and whether she liked me. Then at the Club her boy friend questioned her. She "couldn't bear" this, and had a row with him. She went home with another girl, "for protection" asking her in for coffee. But Auntie Esther was visiting, and as soon as she saw the friend she "started on", "What's she doing here?—Send her home!" Jessie was furious. She had a blazing row with Aunt Esther, saying "dreadful things", like that Auntie was just like father's sister (who had supposedly murdured his mother). The parents now joined in, shouting how wicked Jessie was, and hitting her "all over". Jessie said that she would kill herself, and this time, instead of telling her not to, mother said, "Good, I will too". Jessie went off and took twenty or thirty of her mother's Tryptazol.

Later, when asked if she wanted to die, she said, "I didn't want to live without my Mum . . . I wanted to be with my Mum".

Having taken the tablets she went down to the kitchen and told her cousin, but he just told her not to be stupid (f), and she went to bed, not thinking particularly about dying. Mother came to her room, probably, she thought, to make up. But Aunt Esther came too, and they stood outside the door talking about how Jessie had made her mother ill and did not care. Mother said, "Look, I am paralysed," and Aunt rejoined, "Don't take any notice of her, she's just a stupid girl." Then, Jessie said, "I went shaking and sort of blank, and then I was swallowing and swallowing." (g). She did not know how many tablets she took this second time, but she thought about forty of fifty of the various pills her mother had. She went to bed and lay there until she passed out, thinking sadly of how she would never again see Mother or Doodoo (her still-retained transitional object) or Rachel. She was hospitalised, and remained in a coma for 48 hours. Her parents were furiously angry, telling her how wicked she was. "How could you do this to me?" asked mother, while father said she was old enough to make up her own mind.

I wrote Jessie a brief note, which she received in hospital, and on her return home she rang me. When I took her act as partly a message to me she immediately agreed. Although still very afraid, she now wanted to come. As she left her next session she said, "It's a help talking; it's ever so much better than my tablets." When her parents withdrew their promised financial contribution, asking why the psychiatrist could not "finish her off in three weeks", Jessie went back to work in order to pay for one session herself.

Only at termination did it become clear how far she had seen her act as effecting a change in my attitude. She had very mixed

feelings about ending, being pleased to be independent as well as very sad to go. She became frightened that she might leave and then go to the nearest cupboard and take everything in it. But this fear quickly vanished when I took up her wish to make me so concerned that I would keep her on: it was then she said that it was *after* she had tried to kill herself that I had said she needed treatment. It seems that when I first spoke of her need for help Jessie heard only that she had to make the decision. For to her this meant to manage on her own, with no one to hold her hand, and at this stage she was far from ready to take responsibility for herself (h).

Thus an important motive for Jessie's suicide act, and for later suicidal wishes during treatment, was her wish to win the object's care and protection. This was evident at the time of the act both immediately in relation to the mother (who had always previously told her not to take tablets) and in displacement, in relation to me.

This wish was at first strenuously warded off. Jessie would assure me that she had not done it " to get attention ". It was for some time particularly strongly denied within the transference, since to admit it involved both shame and the danger of rejection. Jessie once rang when she was feeling suicidal, saying she wanted someone to tell her to stop, *but not me.* While she had to defend in this way she could only act out her longing for protection both from outside world and from her own impulses. Often, and particularly at holiday breaks, she would get herself into dangerous situations. As we analysed the wish for protection she gradually became able to *plan* to get into danger or to kill herself (i.e. to elaborate her impulse in thought rather than act it out) and from the fact of my analysing the reason for these plans she took a token of concern which reinforced the effect of the interpretations. She became able to plan not to " get into a mess " in holidays, and, eventually, to plan to enjoy them.

Her feeling of unprotectedness was in part displaced from the current relationship with mother, and for a long time she tested out how far I resembled her mother in willingness to let her be exposed to danger. Once she asked me to lie for her: to write a certificate saying she was 18 so that she could go to a very unsuitable club. The next day she told me triumphantly that mother had helped her to forge a certificate so that she could get in. But in fact she was relieved I had not lied, and later in the same session she spoke of how I had become " a protective shield ", adding sadly " —what my Mum should have been but never was."

And indeed she had felt unprotected all her life (i). She brought many memories which related to the times when mother had been at home as well as to mother's frequent absences. A recurring theme was how she was not sent to bed, but left to go when she

wanted. She would fall asleep on the sofa with people talking all round her, and wake alone in the dark, " cold, with all the warmth of the people gone."

The feeling of unprotectedness also seemed to me to stem from the earliest months of the relationship with mother when, exposed to much pain and much excitement, she had really needed a protective shield, a mother who could act as a stimulus barrier. Jessie had a horror of any impingement: she was disrupted and startled by noise and longed for quiet; she reacted intensely to heat and cold. She had an almost physical rawness to stimuli, and at times reminded me of a baby's juddering when his vest is removed. Mother, far from being experienced as a protective barrier, was largely experienced as the agent of unending pain (as I often was in the analysis). Far from being experienced as a holder, she was experienced as the agent of unbounded excitement: Jessie remembered how if she cried as a small child mother would blow on her tummy and tickle her into paroxysms.

To her basic fear of being exposed and unprotected, abandoned to inner and outer danger, had accrued the various forms taken by the fear of loss of the object and of the object's love at all levels of development. *Defensive manoeuvres aimed at avoiding the pain of abandonment were important factors in her suicidal wishes arising in the analysis, and in her suicide attempt* (j).

Jessie's ongoing terror of abandonment was a running theme of her analysis. It had been heavily reinforced by mother's frequent absences and threats. At first Jessie did not expect me to be there for the next session, let alone after weekends and holidays, although she denied the full extent of her fears: once she said, " When you are not here I know that you are dead—oops! I mean *not* dead." This fear of my death was by no means only based upon her view of her aggression as omnipotent; it was also a natural expectation in view of her experiences.

She felt too that she was bound to be deserted because she herself was so horrible. Her self-disgust and self-condemnation covered virtually all aspects of her body and mind: having internalised the condemning belittling aspects of the parents she saw herself as stupid, crazy and dangerous; bad, dirty and ugly. (k) She felt that I got rid of her with relief at the end of every session, just as she used to feel mother had done when mother was away.

Jessie brought a cover memory of the time when she was four and mother was hospitalised. Rachel was allowed to stay with Father, but Jessie had to go to an aunt. Thus she lost both her physical home and all her immediate family. Then, she said, she " really knew " that nobody cared about her, and decided she was not going to care about them. It was then she first " turned her back " on mother.

By 16 Jessie was trying "not to care" in all her relationships, always rejecting before she could be rejected. In the analysis in particular she would plan to desert me: regularly every holiday for the first three years she would decide to terminate, at first rationalising that there was nothing wrong with her, and later announcing that I could torture someone else. Each time this passive into active manoeuvre would quickly give way to interpretation. It was in any case fairly ineffective in that even when Jessie did reject someone she generally reacted as though they had rejected her, or were glad that she had gone. *Suicide appeared to be a more effective way of leaving before she could be left,* (l) and, hopefully of ensuring the object's grief. Jessie fantasized that if she killed herself I would not even come to the funeral, but behind this was the fantasy of my weeping at her grave. Quite early on I decided to clarify reality with her, saying openly that while I did not want her to die, I could not omnipotently prevent her suicide. I added that while I would be sad if she killed herself, I would not be sad for ever.(m) Jessie appears to have taken in this information: after her first long summer break, as we again analysed her wish to leave, she commented miserably that even killing herself wouldn't be any good, "Because people get over the pain of losing someone in death".

At times when Jessie was feeling particularly low, either because of the ongoing work, or because of outside events, she longed not so much to be able to leave before she was left, as simply to withdraw, and not to suffer the pain of hope or of caring. At such times she wanted only to be alone and in peace. In her third year, just after the Christmas break, at a time when her father was seriously ill and her boy friend had gone abroad, she again wanted to terminate. She said wearily, "I don't give a damn, I just want out, no-one gives a damn", but then she added, "The trouble is I don't want to". At other times she would rage at me for not chucking her out as she tried so hard to make me do. *Suicide represented the last step on the continuum of withdrawal.* In holiday breaks Jessie would sometimes write down her thoughts, partly as a way of expressing impulses without destroying herself, and partly as a way of keeping in touch with me. The swing between pain-hope and withdrawal with its final threat of death, was often evident at those times when she was feeling at a great distance from me. Once she wrote:

> "I feel like I was left . . . never to find my way again . . . it brings pain . . . I felt such pain many times before . . . I wish it was physical pain, it's just not, help, help me please. I want so much to get away, I wish I was on my own, always in peace."

At times death represented an active way of abolishing pain which seemed to Jessie to be always beside her, ready to flood her at any moment. We were eventually to relate the extent of this pain to early times when physical and mental pain were not yet differentiated, and when there were no time boundaries to her experience, but it was my feeling that this particular intervention served largely to give Jessie the feeling that the pain was not an alien visitation which would always be beyond the range of her understanding or of human help. Moreover, by the time she was 16 the effect of pain was highly complex. It contained elements of sadness, loneliness and worthlessness. An important component was a feeling of lostness, " like being alone in the middle of the road, like being lost with all the cars and people going by." The feeling of coldness was always present, often literally as well as physically. It is perhaps not surprising that Jessie once spoke of killing herself in order to " kill the pain ". Towards the end of her third year of treatment, no longer actively wishing to kill herself, Jessie explained to me why a girl at work had done so. It was not because of any one thing, she said—if you were lonely you could go home, if you were pregnant there was something you could do. It was only when you could not do anything that you killed yourself: when you were in pain and there was no way out.

In sum, for Jessie, suicide served as a defence against the pain of abandonment in that death represented an active way of leaving the object, and a means of withdrawal and of obliterating pain.(n)

In spite of her terror of unprotectedness and abandonment, for Jessie to have developed at all there must have been some experiences of satisfaction in infancy, some islands of safety. These seemed to me to be reflected in the transference at times when Jessie would regress to a state close to merging. At one level I represented an ideal mother created by Jessie, part of her and yet not part of her: a kind of transitional object.[46] Curled up on her side she would speak of how I had a " lovely Mummy voice " and of how quiet it was, like being in bed with Doodoo. We came to speak of her wish for us to be " part of one another, like twins ", as reflecting both current and early wishes not to be exposed to the coldness and dangers of separateness. *We also understood her longing for death in part as a longing to achieve this state.* Thus while her feelings at the time of the attempt that she wanted to be with her Mum was precipitated by her belief at one level that mother really had taken tablets, was paralysed and would die, it covered her more basic longing to return to a state where united with, and yet partially distinct from and held by the object, she could not be threatened with its loss.(o) Thus at one level Jessie, far from viewing death as

involving her own non-existence, viewed it as fulfilling a fantasy. (Hendin[18] has suggested that the danger of suicide is particularly marked in cases where death represents a fantasied gratification. I felt that this was certainly so in Jessie's case, and at several points I introduced reality to counterpoise her fantasy, noting that if she killed herself she would not actually achieve the state she sought, but would in fact be dead.)

Although Jessie's wish for togetherness and protection predominated in the earlier part of the analysis, there were for her grave dangers in closeness, and the wish for separateness was to emerge as equally important. *In fantasy Jessie's suicide attempt had represented a means of individuation, and for some time suicide continued to appear to be a way of achieving independence.*(p) Once, when we were speaking of her longing for closeness Jessie said, "I think that must be what I do with everybody really—and then I get angry because I am scared of it." With her mother she fought a constant battle for her own individuality. She was enraged by her mother's attempts to tell what she thought and liked. Although in the early days she would always succumb she became increasingly able to differentiate herself openly from mother. She began to allow herself her own thoughts, and to wonder whether everything mother said was true. She increasingly took over the ownership of her own body, telling mother one day that it was *her* body that was wearing her clothes, and she would make her own mistakes in dressing.

Not surprisingly analysis often appeared to her as an attempt to take her over and make her over, body and mind. And closeness in the transference appeared to involve dangers of being gripped, swamped, smothered and never let go. When I took up the fear and rage with which she reacted to what she saw as the danger of my "grippling" her Jessie said, "That's why I had to kill myself: to show I was a separate person." The threat of being taken over in the transference, frequently precipitated suicidal thoughts. It was termination which provided for Jessie the ultimate proof that she could be a person in her own right. Only a few weeks before finishing, when she was speaking of her pleasure in independence, she said, "I want to make my own mistakes."

Thus we can see how in fantasy suicide was to gratify two opposing fantasies: that of a partial, narcissistic union with the object, and that of individuation/separation from the object.

While both the threat of abandonment and the threat of closeness percipitated suicidal thoughts, they could not have given rise to an act of suicide had they not also precipitated in Jessie a gargantuan rage, an hostility towards the longed for and dreaded object which she found quite intolerable.

I have previously described some elements in Jessie's experiences of pain as we understood it at the time when she viewed it as something visited on her. To see it in this way left her relatively guilt free. In fact, the state of pain also involved the near-conscious and certainly preconscious awareness of her aggressive wishes. This contributed to the cold feeling, which she came to describe as "cold with hate". At times during treatment she was to be flooded with hate to an extent that terrified her. Once, in the third year, she was desperate and angry at me because I could not change her times. For the first time in her analysis she reacted with a lengthy silence. The next day she brought a letter containing the things she wished she had been able to say:

> "I have got desperate again and I just don't want to be. . . . I am scared, real scared like I am lost in one big giant pool of water and can't swim yet I know how to. . . . I feel low and bad. I don't understand why it has hit home so suddenly. . . . I wish it all could go away from me for ever I hate it so much. I think it hurt most being a prisoner of time, kept in a space, told when to come, when to go. I get so angry and cut up about it all that I take it out on myself, but I don't, because I am not going to let it get a hold of me ever. . . . I just can't lose those feelings—I hate so strongly at the moment. . . . It gives me the creeps inside of me, real bad it does, real bad. If I keep telling myself I must fight it I will. I just hope I can, I really hope so."

I have described elsewhere the overwhelming, unintegrated nature of Jessie's rage, suggesting that the origin of this type of aggression may lie in the oral phase, with a crucial period around the eighth month. (See note (g)). I cannot describe here in detail how her aggression took on the colouring of the various phases through which she passed, but I should briefly note the anal quality of anger which arose in response to anything felt as a control or demand. She would lie raging and swearing, wanting to mess and smash the consulting room because she was asked to come and go at specific times, and because she was asked to pay. Equally vivid was her intense rage at being deprived of the phallus, which she saw as the embodiment of strength and power, as well as a means of ensuring the object's love. Her phallic stance was in part adopted in retreat from oedipal functioning with its concomitant increase in hostility towards mother. At all levels of development it had been mother whom Jessie saw as the cause of her difficulties: mother, the deserter or smotherer; mother, the controller and the depriver of faeces, penis, baby and father. All these reasons for anger are common in girls. What was unusual in Jessie was the extent to which they were

still currently alive, and the intensity with which they were expressed within the transference.

But when Jessie first came she could express no anger to me. In spite of the fact that breakthroughs of aggression towards mother had been fairy frequent, her aggression was intolerable to her. She had no adequate defences through which it could be qualitatively transmuted, but was able only to change the direction in which it flowed: i.e. to deflect it towards other people or back upon herself. Only a small stimulus from the original object was needed for her aggression to flow back into its original channel and she was terrified of losing control whenever this happened. In addition, she viewed all her fantasy as omnipotent, and was constantly guilty over what she felt she had done and was doing. This fear and this guilt were important motivators of her attempt and of suicidal wishes arising in the analysis.

When she first told of the attempt it was her anger towards her Aunt Esther which she stressed, saying, " If I had not killed myself I would have killed Auntie ". She frequently warned me of her terrible temper, longing for me to be able to withstand it, and to help her to control it. She remembered when she had taken a knife to her sister, and had been held back from killing her by force. But it was nearly a year before she dared actually to lose her temper in sessions. At first she defended against anger towards me by displacement, for instance onto older women at work, and sometimes onto the mother herself. Alternatively she protected me by turning the aggression directly upon herself, in misery and thoughts of suicide. Once she raged at me for leaving her to go on holiday, and at her boy friend for going abroad. She hoped we both got run over. The next day she came saying her foot had been run over by a motorbike, and was surprised when I recalled her hopes. When she did lose her temper and found that we both survived, she was enormously relieved.

In regard to mother, she was to comment spontaneously, " I would have killed my mother if I had not killed myself ". But at first mother too was protected during the analysis, as she had been in the attempt, by Jessie's deflecting her aggression. She had to maintain this defence because she dared not risk the destruction of the object she needed. She put this particularly clearly after a nightmare about finding mother's body cut up in pieces. When I eventually touched upon the childhood wish element in the dream Jessie said, " Oh no, I couldn't have, because I needed her for the warmth! ", although a little later she was speaking directly of how she would like to chop her mother into pieces.

Thus both in her attempt and in later thoughts of suicide, Jessie turned to suicide as the answer to her dread of losing control. When her aggression broke through, to turn it against herself was the only available way of protecting the object she needed.(q)

Although she desperately sought outer control through me, Jessie's inner condemnation of aggression was extreme. She had to defend against aggression not merely lest she lose control, but also because of her omnipotence and her guilt—a guilt so great that she felt death to be simply what she deserved, and that it would have been better if she had never been born.

Jessie's belief in the omnipotence of thought was no unconscious survivor of an earlier mode of functioning: it was a consciously held view, one she felt at first to be entirely rational. " If somebody dies, somebody did it "—and that ' somebody ' was almost always her. Her fixation at this stage of thought had been facilitated by the fact that it was the family mode of thought: nearly all the deaths in the family were blamed on another family member, and some were spoken of as real murder. It was reinforced by the death of her grandfather when she was four, by the number and extent of mother's illnesses (real and imaginary) for which Jessie was always blamed, and very importantly, by the miscarriage or abortion of the babies who would have become her rivals. Fairly late in her analysis Jessie clung to her omnipotence because it gave her at least some illusion of control over dreaded losses and disappearances. But when she first came she simply believed herself to be a murderess who had made her mother ill and killed her rabbit, her grandparents and her potential rivals.

At the time of her attempt this view had received acute reinforcement from her uncle's death, and mother re-confirmed it by speaking of how Jessie had made her ill and paralysed. For such crimes, and at root, *for the ongoing crime of her hatred and death wishes towards mother, she felt she deserved execution, and she carried out this sentence in her attempt.*(r) In the first session after her attempt, she said, " It would be dreadful to hate someone—I'd rather be dead than that ". By the seventh week she was able to tell me how at times she felt like killing mother, and then asked, " You don't think anyone else could be so wicked as to want to kill? " For a considerable period the revival within the transference of different aspects of Jessie's hostility towards mother would precipitate thoughts of suicide as a means of punishment. But she was to progress through the stage where when someone died she would say, " But I know I didn't do it ", to the stage where the thought of her own responsibility did not occur, even in negative form, and where she could cheerfully say, " If I catch mumps off Mick I'll murder him."

I have stressed the defensive aspects of suicide in regard to aggression. However, in fantasy suicide also represented a means of gratifying aggressive wishes. *By killing herself Jessie hoped to punish and attack the object* (s), although this aspect was less conscious at the beginning, for she was at first very ashamed about wanting to make her parents feel guilty and unhappy, and wanting to make me feel dreadful. Later she was able to speak of how she would love to be a ghost so as to see us all grovelling. She fantasied hopefully about how we would all beat our breasts and say it was our fault. Important in our punishment was to be the public shame which we would suffer. Just as she had once embarrassed her mother by her head-banging, she now planned how all the neighbours would speak of what bad parents she had had. As for me, mother would write to the newspapers, everyone would know what a bad analyst I was, and perhaps I would not even be allowed to practise any more.

Along with the acceptance of her own aggression came the gradual recognition and acceptance of her parents' hostility towards her. If she could hate them without actually killing them, then they too could hate without killing. If she could love at the same time as hating, then they too could have mixed feelings.(t) At first she tried to ward off her terror of them both, and particularly of her mother, but she would make slips, describing her home as a "gas chamber". And in the transference her fear was clear as she spoke of how I might have been "a murderess on the loose" before I became an analyst. Such material contained not only Jessie's externalisation of her view of herself, and the projection of her impulses, but also the displacement of her view of her parents. She was eventually able to tell me of how mother's anger always seemed more dangerous than father's, because she looked at you "with such hate in her eyes", and she remembered how at nine she had thought that if mother could murder one baby then she could murder another. Once when telling me of one of father's attacks, in which he shouted that he would murder her, while mother "danced around and laughed", Jessie added that she had stood there thinking "You needn't bother, I'll do it for myself". This aspect was not analysed, but I have wondered how far Jessie's suicide attempt, which did occur after she had been physically attacked by both parents, was determined by a kind of passive into active attempt to control her own murder by being the agent of it, i.e., by an immediate identification with the aggressor.(u)

It is worth noting that all the factors described so far stem from childhood, although the conflicts around separation from and closeness to mother were exacerbated by the adolescent process—by the increased need to become and increased fear of becoming a separate person. Further, Jessie was 16 when she

made her attempt, an adolescent with a physically mature body. Her sexual needs were the final factor in determining her attempt: *she had to avoid sexual fulfilment, or punish herself for it, because of the intimate link between her sexuality and her aggression towards her mother.*

At the beginning of her analysis, however, it was Jessie's *defensive* use of sexuality which stood out. To work up physical excitement, either through masturbation or in petting with boys, was one way of temporarily obliterating pain. Jessie was intensely ashamed of her masturbatory activity, and it was only after several months that she described how she had masturbated compulsorily for as long as she could remember, because it was " the only way of keeping away the sad ". It left her feeling totally unacceptable, and for a long time she believed that she was the only girl who behaved in this way. She began menstruating at 13, and while this confirmed her feeling of dirtiness it also provided great conscious relief, for Jessie felt that at least she was now a woman, and not " a complete freak, neither man nor woman ". At 13 too she began petting and mutual masturbation with boys. At a conscious level this seemed slightly less bad than touching herself. It also provided some relief of her fears of being wrongly made, since if the boy did not comment in disgust there could not be anything too badly wrong. During the first year of analysis she would often turn to boys when she felt threatened with abandonment by me, and holidays were occasions for wild and sometimes dangerous sexual acting out, although this would stop short of intercourse.

Her fantasy of the primal scene, reflecting both her own urges and her image of violent parents, was one in which both partners were hurt, but the woman in particular was ripped, stabbed and torn. Thus intercourse was in part a self-destructive act, and when Jessie first had intercourse she did so quite consciously as an alternative to killing herself. Shortly before the first long summer break Jessie was feeling particularly afraid of being dependent on me, and terrified of the feeings of loss and desolation that threatened her. She tried to fill her time with night club adventures, and her sessions with busy chat. But she could not maintain this, and warned me that she thought she would have to have one more try at killing herself. The idea of intercourse, and in particular the idea of becoming pregnant and having an abortion, was also in her mind, and here she wanted me to protect and stop her just as she did in regard to suicide. She left one session saying at the door, " I'm scared, I'm going to meet Stavros tonight ". And she did have intercourse, with a boy who cared little about her, telling me the next day that, " Anything was better than talking about the sad ". She described how:

" I felt awful, and I didn't feel anything except that it hurt, and all the time I was just hating him, and we couldn't talk to one another, and I felt as if he was stabbing me and I was so scared, and I just didn't stop him . . . and afterwards he asked if I wanted to kill him, and I said no. I knew what I would do." (meaning commit suicide).

When I took her act as an alternative means of self-destruction, Jessie said, " That's why I thought ' now I must do it '—because it didn't work ". (i.e. did not kill her.) And like the suicide attempt, the act of intercourse also contained an attack on me: an attempt to hurt and punish me for planning to leave. Episodes of sexual acting out lessened considerably thereafter, but Jessie was often tempted towards promiscuity, and here both the analysis of her wish to hurt and her growing appreciation of reality were important in holding her back. She once warned me, " If I really wanted to kick myself in the mouth I would sleep with lots of boys ". But she ruefully agreed that the trouble was it would not hurt *me* enough, adding that in the end it was really true that this sort of behaviour hurt yourself most.

Thus sexual activity served many of the functions of a suicide attempt: it gratified similar fantasies, and was built upon similar defences. It served temporarily to obliterate pain. Guilty, dirty and angry as it left Jessie feeling, it nevertheless represented a less final alternative to suicide.(v) This raises the question as to how far suicide may have represented a regressive or disguised gratification of oedipal wishes. Jessie's masturbation fantasy was a highly masochistic one, involving both hurt and degradation, and it would seem probable that in the act of suicide she became both the potent attacker and the passive victim submitting to the violent sexual father. Moreover, the concepts of death and of orgasm were linked, although not necessarily equated. However, Jessie's attempt to kill herself was not seen in the analysis as a gratification of oedipal wishes, and the possibility that such a link existed must therefore remain an open question.(w)

In spite of the extent to which Jessie turned to sexuality as a defence, and whatever the gratification involved in suicide, an act of suicide finally came to seem necessary because, for Jessie, genital sexuality inevitably involved the death of her mother, so enmeshed was she in oedipal conflict.

Her oedipal rivalry was intense. It had been exacerbated both by her father's seductiveness and, it was my impression, by her mother's responding rivalry. She was passionately attached to her Dad. Her warmest memories were of going for rides with him, and of his burying her baby animals; her most excited were of those times she fought or shared the bath with him. Quite late on she remembered how once when mother went to

hospital *she* had been left alone with father, and had been very happy being " the little lady of the house ". But each time with Dad ended with his faithlessness in returning to mother. And mother told him how horrible she was, and disapproved of his presents, holding the rabbit as if to strangle it, and having the cat put down.

Until adolescence Jessie's hatred of her mother as a rival had served largely to reinforce her already existing hostility and thus to intensify her fear and guilt. Throughout latency her masturbation fantasy was of " worrying about mother ". We analysed how the wish behind this worry had often seemed to be fulfilled when mother went away to hospital. But in childhood it could never be fulfilled completely. Physical maturity appeared to bring the possibity of fulfilment, for Jessie's defences against oedipal wishes were nearly as inadequate as those against aggressive wishes. She was barely able to displace her sexual wishes, each boy that she went out with being selected on the basis of his resemblance to her father. Often she tried to provoke father directly, through her adventures with boys, or by wandering around at home in bra and pants. Indeed, it was not the libidinal aspect of the oedipal conflict which made her feel guilty, but the aggressive one: i.e. to fulfil libidinal wishes was dangerous because this meant that aggressive wishes must also be fulfilled.

What she saw as the inevitable link between sexual activity and death began to emerge when maternal grandmother was taken to hospital. Jessie was consumed with guilt because she had spent the night with a boy friend. She remembered how, after her first date with a boy, she had come in to hear that great-grandmother and another uncle had died. Somehow she had felt to blame: " Because I had sex, they died ". She remembered how she had been going out with Bill just before her suicide attempt, and then her uncle had died, and she had felt to blame for that too. *Thus the self-punishment in her suicide attempt had been in part a response to her guilt about the destructiveness which she felt to be involved in her sexuality.* (x) " Every time I go with someone, something happens to someone." (There were so many deaths occurring in the extended family that this was virtually true.)

As we approached oedipal material she would react by avoiding boys, clinging to mother and trying to be again her little girl. She insisted that she *must* die because she could not bear to live without her parents. She hated the idea of growing up. Once she said that she thought her parents hated her much more since she became adolescent: " What they can't bear is me growing up, because it makes them older ". But the externalisation of her own view that there could be only one sexual woman was clear when she added that, although she would see

no point in living if her parents died, a friend of hers had "come to life" when her mother died. Immediately she wished again that she herself was dead. We were repeatedly to work though her fear of having a relationship with a boy lest it prove fatal to her family. Jessie once produced a flurry of denials that she could still think anything like this, and then said, "If Mum and Dad died because I was in love I would give him up. . . . I couldn't bear Mum to die, because Dad would be so lonely". Eventually Jessie was able to begin to relate to boys on a more long term basis, and to face the probability that her parents would die before her with appropriate sadness. She recognised that she would find it difficult, and that probably she would have to guard against her old tendency to feel guilty.

I have described puberty as the final factor determining Jessie's suicide attempt. We can now see that suicide often seemed imperative if she was to avoid the attack on her mother which she felt her sexuality involved. So inadequate were her defences against both libidinal and aggressive wishes, so limited her reality testing in this area, and so persistent her omnipotence of thought, that *the reality of her sexual maturity became a crucial factor in that to grow up and become a woman appeared to Jessie to involve the actual death of her mother. She dared not, therefore, become a woman. But nor could she remain a child. The "only way out" was to protect her mother by turning her aggression upon herself in her suicide attempt and in thoughts about suicide.*(y)

Jessie's need to become a woman was determined not only by physical change and inner pressures, but also by her longing to be acceptable and "normal"; not a freak, broken, mad or defective. At the beginning of her analysis, when someone asked what her ambition was, she had replied, "My ambition is to be dead". At the time I was struck by the hopelessness of this, and missed the restoration of self-esteem involved in her ambition. By the time she finished analysis her narcissism was considerably restored. She had accepted the fact that she was not merely a woman, but an attractive one. She had a regular boy friend, and was fantasizing about being married, furnishing a home and having children. She was partially able to sublimate her intense penis envy through promotions at work, and in furthering her education at evening classes. Although still vulnerable, she was determined to succeed. Shortly before termination she wrote for her English class an essay about a successful suicide. Through it she showed me *that suicide had also represented for her a way of becoming what otherwise she felt she could never be—successful, competent and phallic.*(z)

The essay opens in a hospital ward. Jessie describes the nurse shaking the semi-conscious body, then continues,

"Night passes, the eyes of the body open, sobbing softly . . . suffering, estranged, needing desperately a reason to survive, 'Hold me, keep me warm', the body screams. It's cold, wet, and the body aches all over, teeth chatter to show the lack of warmth. It's cold. The tears begin to flow again. They stop, the eyelids close, the pulse slows down, the want to go on comes to an end. The heart stops. The final choice to succeed in something has taken place."

SUMMARY

Most of the elements in Jessie's suicide behaviour (wishes and attempt) stemmed from childhood, and had played a role in her latency suicide threats.

Through suicide behaviour she tried to gratify her longing for care and protection. She sought to defend against the pain of abandonment by actively leaving rather than passively being left, by withdrawing, and by obliterating her pain.

In fantasy death represented a gratification both of her longing for closeness and partial union with an ideal object and of her need to separate and individuate.

Through the mechanism of turning aggression against the self she protected the needed object. By the same mechanism she punished herself for this aggression. But aggression towards the object was not only defended against in her suicide behaviour: it was also expressed in the hope that others would suffer both guilt and shame.

In both childhood and adolescence masturbatory activity was an alternative to suicide. But the onset of physical maturity was crucial in that, in the context of oedipal conflict, the threat to the mother attained a high degree of subjective reality. Suicide then became a subjective necessity, rather than a possibility, because of Jessie's need to avoid sexual activity in order to preserve her mother. It was also a means of punishing herself for sexual activity, again because of the associated aggression. It may be that suicide additionally represented a disguised gratification of positive oedipal wishes, but such was not shown in the analysis.

Finally, suicide appeared to Jessie to be a means of achieving an identity and of restoring her self-esteem.

NOTES

(a) There is little agreement in psychiatric literature as to the degree or type of illness involved in adolescent suicide. White, for instance, found no psychiatric disorder, or at the most "what could loosely be called an adolescent crisis" in 40 per cent of the cases he studied.[4] Balsur and Masterson, in contrast, found a very strong relationship between suicide attempts and schizophrenic, rather than depressive, reactions.[2] This finding differs from those generally obtained in studies

of adult suicide, where the role of depressive illness and alcoholism is virtually unquestioned (e.g. 3).

(b) A number of authors have commented upon the role of parental hostility in child and adolescent suicide.[4 15 16 17 36 38 39 42] This hostility is often conscious or unusually close to consciousness, and expressed in direct as well as subtle ways. I fully agree with Stone[42] that "Prognostic statements about suicidal adolescents . . . are meaningless without inclusion of the parental factor."
In much of the literature, however, parental hostility is scarcely mentioned. Some therapists appear to feel that recognition of outer reality involves the danger of neglect of inner reality. Further, where there is a chance that hostility may be acted upon, it appears more difficult for therapists to recognise it in parents than in children. Havens[17] expands upon therapists' denials of "really murderous" wishes.

(c) Clinically it is my experience that young people who attempt suicide very frequently suffer from asthma or eczema, and such illnesses are often mentioned in studies of children and adolescents e.f. [1 8 16 23 37]. Frankl notes that in accident prone children there is a tendency to express mental conflict in bodily terms during the pre-oedipal phase, and that this may be followed by a tendency to express in action rather than fantasy.[8] One of the cases she describes later killed himself during adolescence. Schneer and Kay[37] describe the frequency of illness and operations, as well as of accidents, in the histories of suicidal adolescents.
The presence of psychosomatic illness would suggest that the roots of the disturbance in such cases reach back to the time prior to full differentiation of psyche and soma. Secondarily, such illnesses would assist in the establishment of a masochistic pattern of relationships, and thus contribute indirectly to later accident proneness and suicide attempts.

(d) Similarly, temper tantrums and explosive rages are frequently mentioned in clinical histories.[1 23 33 37 42] Head-banging is mentioned only very rarely, but by adolescence such details are not usually remembered or available.

(e) Surprisingly little has been written on counter-transference responses to suicide attempts in patients. There is one excellent study of therapists' responses to successful suicides by Robert Litman.[28] In some respects his findings apply to therapists responses to suicide attempts. He describes the various maladaptive defences to which therapists may resort, and suggests that consultation with colleagues may be more adaptive.

(f) Most writers now recognize the appeal inherent in suicide warning and suicide act, e.g. [5 15 21 24 27 31 32 34 35 40 41 43]. The "success" of an attempt depends very much on chance factors, and upon the extent to which an appeal is recognised. Of course recognition of an appeal will depend both upon the nature of the appeal and of the person to whom it is made. Jenson and Petty[21] point out that rescue is more likely where the wish to be saved is partially or almost wholly conscious.
Shneidman[40] counsels against regarding any suicidal behaviour as other than "a genuine psychiatric crisis", warning that ". . . a cry for help should never be disregarded, not only for humanitarian reasons, but also because we know that the unattended cries tend to become more shrill, and the movement of the lethality scale from cry to cry is, unfortunately, in the lethal direction". This warning is borne out by numerous statistical studies. Kiev[9] in a follow-up study of 300 suicide attempters, even found that those who subsequently made successful attempts had initially made attempts which were *least* likely to be judged serious. i.e. ". . . they had by and large used reversible means, were not far from others, and had sought help".

Even those writers who regard suicide and suicide attemps as separate phenomena tend to find that they are related and recognise the danger that second or later attempts may be fatal. Kennedy *et al.*, for instance, found that, " One per cent of detected parasuicides committed suicide within the year of study. Forty-one per cent of detected cases of suicide had a history of parasuicide ".[22]

(g) It is worth noting that Jessie's description of this renewed attempt (" and then I was swallowing and swallowing ") is in words implying that no secondary process choice intervened between the suicidal impulse and the act. This is reminiscent of Dublin's description of how the ego may be traumatically overwhelmed and provoked to impulsive suicide: in states amounting to panic or hysterical blankness, " the victim may go through the act of self-destruction as though he were an automaton ". There is considerable agreement as to the impulse driven nature of many suicide attempts, e.g. [14 16 27 38 46].

A particular type of ego structure is required for such an act to be possible. Many writers mention the weakness of the ego and the poverty of the defensive structure. Both Haim[16] and Schneer[38] are particularly helpful in discussing the possible origins of the ego's inability fully to integrate aggression. Schneer notes the importance of experiences of separation and loss and points out that initially the infant cannot redirect or displace aggression. He suggests that " narcissism is linked with aggression when teeth emerge and there is a growing awareness of the capacity to destroy food ". This link, he suggests, may form the anlage for suicide. Haim believes that it is after the eighth month that anxiety becomes organised in relation to object loss. It is at this point, he says, that " The wrong integration of the thanatogenic tendency into the impulse organisation gives it an autonomy that facilitates direct expression ".

Jessie's aggression, as it emerged during the analysis, was of just the autonomous, unintegrated nature described. With her, muted aggression did not exist. Rather, each experience of anger had something of a force and quality of very early states of pain and rage occurring prior to full differentiation of self and object. The earliest memory of aggressive feelings which Jessie recovered during the analysis was of her hatred of mother when she had eczema and mother washed her feet and hurt her. While this memory is of a time when anger was already object directed it seems probable that prior to this stage experiences of pain gave rise to an unfocussed aggression which Jessie had no means of dealing with, other than through diffuse bodily expression in her eczema. The eczema itself, in creating further pain, would increase the aggressive response. We do not know whether her head-banging represented the further expression of diffuse aggression, or whether from the start it also represented the turning against the self of aggression which she was already capable to some extent of directing towards the object. But certainly the occurrence of weaning as a response to her teething at 7½ months would either confirm or initiate the turning of aggression against herself. You will remember that she refused a bottle and was weaned straight onto a cup. During the termination phase of her analysis we reconstructed the experience of weaning and her feeling that she destroyed the breast/mother as an important factor in her need to turn away from the object and turn her aggression upon herself. Thereafter this response was certainly reinforced by mother's continuing refusal to accept Jessie's aggression. It is the ego which directs the aggression upon the self. If it does so in the automatous way described, this is most often where there has been a conscious intent or ' plan ' to commit suicide. Litman and Tabachnick[27] ascribe particular importance to the previous intent. They describe how the " suicidal attitude and plan " is often based upon

identification with someone in the past who was suicidal. Gradually the plan "acquires an autonomous structure within the ego, more or less dissociated from the rest of the self and tolerated as ego-syntonic. . . . Although further elaboration may be suspended for days or months, the suicide plan has acquired some of the qualities of an incomplete or on-going act. Such interrupted acts have an autonomous momentum towards completion".

Jessie's suicidal attitude was certainly based in part upon her identification with her mother. I do not think that her act would have been possible had she not previously had the intention of killing herself. However, I have no evidence from the analysis that her suicide "plan" had acquired a momentum of its own, as distinct from the pressure of her aggressive impulses and the ego's response to these.

(h) The importance of the need to make a conscious choice as a factor precipitating suicide attempts is rarely mentioned in the literature although Haim[16] does discuss the feeling of loss of identity involved in the renunciation which any positive choice also imposes. Suicidal adolescents often react to the need to choose with thoughts of killing themselves, not only because of the factors Haim mentions, but more importantly because the very act of making a decision implies that they have become independent.

(i) Frankl is helpful in describing how self-preservation normally develops gradually in the pre-oedipal and oedipal phases, the child taking over the self-protective function from his parents.[6]

(j) The loss of a loved person through death or rejection has long been recognised as a precipitating factor in suicide attempts. Recent literature links this response to loss both to the dependant or narcissistic nature of the previous relationship, and to the narcissistic wound which loss involves.[27 18 37]

(k) Most authors agree as to the feelings of extreme worthlessness experienced by suicidal adolescents. Typically, Hendin[18] describes the group he studied as feeling "worthless, no good, afraid, deserving of punishment and filled with self-hatred for their failures, fear and incapacities". Such feelings are related to deformities of the superego, which Litman and Tabachnik[27] describe as "due to cruel parents, dead parents, parents who hated the child, or possibly to some constitutional inherited trait of exceptional destructiveness in the superego".

Many patients have cruel or sadistic elements in the superego. What seems to me remarkable in very many suicidal adolescents, and certainly in Jessie, is the extreme lack of benevolent elements which might balance the sadistic ones. Having no inner support, these adolescents require constant outer support if they are to survive. As Fenichel put it, "To have a desire to live evidently means to feel a certain self-esteem, to feel supported by the positive forces of a superego. When this feeling vanishes, the original annihilation of the deserted hungry baby re-appears".

(l) Surprisingly, this view of suicide is seldom mentioned in the literature, although, as so often, Hendin[18] has a contribution to make:

> "I should like to emphasize . . . that death often has the unconscious meaning of abandonment. The patient views his suicide or threat of death as a retaliatory abandonment. He says in effect 'I will abandon you as you have abandoned me', or 'I will abandon you first, so of there is any abandoning to be done, I will do it'."

(m) It could be argued that such a comment must involve a contamination of the transference, but the suicidal adolescent's self-condemnation and expectation of rejection is so extreme that any contamination is minimal. It is fortunate when he can retain some reality awareness of the therapist as therapist alongside his transference conviction of rejection. Where patients have had a lifelong experience of being

hated an attitude of total therapeutic passivity is often seen as a confirmation of the reality of transference fears likely to result, at the least, in a breaking off of treatment. This does not mean, of course, that I am advocating the haphazard giving of information. Commitment to the suicidal patient must be a real one, and most writers who consider the topic of counter-transference also take this view. Haim[18] states that the quality of the counter-transference dominates the therapy of suicidal adolescents, and that "A real and not a pretended availability is an absolute condition".

(n) These defensive elements in the wish to kill oneself, where death is seen as a means of withdrawal from involvement with objects and as a means of obliterating pain, are discussed comparatively rarely, perhaps because most writers focus on the regressive fantasy of union which is often present at the same time. (see note (o)). Of the two, the wish to escape mental pain has received more attention[27 31 41] and in Jungian thinking there is considerable emphasis on suicide as a response to unbearable mental anguish".[25]

(o) Many analysts have seen the wish to unite with a lost object and/or to merge with the love object as motivating suicide.[7 16 18 27 31 37 38 41] Most often this is described in terms of the "oceanic longing for union with mother"[7], i.e. in terms of "fusion" of self and object. While fusion may have been what death ultimately represented for Jessie, this was not apparent during her analysis. Rather it appeared that it was a narcissistic union which she sought: that she longed to return to (and was even partially fixated at) the stage where the object is both "me" and "not me". Winnicott[45] suggests that this stage begins to show "at about four to six to eight to twelve months". Jessie retained her transitional object until she was 17, and it may be that she longed to regress completely to the stage of transitional phenomena partially because any illusion of omnipotent control over the breast was shattered by her weaning at 7½ months, rather than allowed gradually to dissipate through a lessening in the mother's active adaptation to her needs.

(p) I have found little acknowledgement of this motive for suicide, except in Haim[16] where it is acknowledged by implication. It is in writing of the normal adolescent that Haim says, "He . . . braves those close to him in thinking that he can bring death upon himself, and confirms himself in his independence of them. However much they may wish to see him go on living, he can deprive them forever of his presence without their consent. His death depends solely on himself and if he goes on living it is because he wishes to".

(q) In 1917 Freud spelt out the turning of aggression against the self involved in suicide[10]:

> "... no neurotic harbours thoughts of suicide which he has not turned back upon himself from murderous impulses against others, but we have never been able to explain what interplay of forces can carry such a purpose through to execution. The analysis of melancholia now shows that the ego can kill itself only if, owing to the return of the object cathexes, it can treat itself as an object—if it is able to direct against itself the hostility which relates to an object and which represents the ego's original reaction to objects in the external world."

He further explored the theme of the inner or outer directedness of aggression in 1924[12]; by this time he had adopted the theory of the death instinct. Although the death instinct remains a matter of debate, the view of suicide as an act of murder turned back upon the self is now almost universally accepted. (See, for instance, almost all references.) Oddly enough there is comparatively little reference to the fear of losing control in suicidal adolescent patients. This fear is a common enough one among adolescent patients in general, and while

I do not think that it necessarily enters into all suicide attempts in adolescence, it may be that it does so more commonly than current literature would suggest.

(r) As early as 1910, in the discussions of the Vienna Society, Stekel pointed to the importance of the Talion principle, adding, "No one kills himself who has not wanted to kill another or at least wished the death of another". Freud who had already touched upon this subject in "The Psychopathology of Everyday Life"[29] spelt out the mechanism involved in 1917.[10] (See note (q).) In 1920 he described the suicide of an adolescent girl as representing, in part, a self punishment for death wishes towards her parents, most probably her father.[11]
Many later writers have also viewed suicide as in part a response to guilt over aggressive wishes describing it as an "expiation" or self-punishment. (See, for instance, [5 7 18 27 31 41 43])

(s) Stekel also noted the adolescent suicide's wish to punish the object, to say to his parents, "You will see where your hard-heartedness, your lack of love, has driven me".[13] This motive is now almost universally recognised.[4 5 7 27 31 39 41 43]

(t) It is not possible to describe here the lengthy work on interacting family defences needed in this case.[20] It was necessary in particular to focus on the interacting mother/daughter/grandmother identifications, and on Jessie's need to accept the externalisations of those aspects the parents could not tolerate in themselves.

(u) Although the role of an ongoing identification with the hating parents is recognised in the literature (cf note b), I have not found any instances of this kind of passive into active response to an immediate threat of murder. The role of suicide as a passive into active response to a more ongoing fear of death, and as a kind of counterphobic attempt to triumph over death, is, however, recognised by several authors.[5 16 31 41]

(v) cf. Rice (1973):

> ". . . masturbation and suicide are *related* attempts, in fantasy and/or action, to deal with the same or similar basic needs. The feeling of abandonment by external and internalised objects, narcissistic mortification, increasing anxiety, incessant demands for instinctual drive gratification—all these necessitate drastic defensive maneuvres. Masturbation, the beating fantasy, and suicide can be considered to be in this regressive continuum of defensive adaptation."[35]

(w) A number of authors have described suicide as possibly involving a fantasy of masochistic surrender (e.g. [27]), or have referred to the equation between death and orgasm (e.g. [7]). Zilborg is among the more definite, defining suicide at or following puberty as "the primitive and impulsive semi-ceremonial outcome of frustrated genital wishes".[46] Rice[35 36] whose work on the relationship between fantasy, masturbation and suicide is notable for its clarity, tends to the view that suicide is a regressive version of oedipal masturbation, but he makes this statement only tentatively, feeling that further study is needed.
Many of the cases reported in the literature appear to support the views of Zilborg and Rice. Freud, for instance, described the suicide of an adolescent girl as being partially the fulfilment of a wish: "namely, the wish to have a child by her father, for she 'fell' through her father's fault".[11] Oberndorf[23] describes a young man who drowned himself after his sister had suggested that they "slip in together". Marcowitz[20] spells out the various sexual roles adopted in fantasy by a young soldier who shot himself.

(x) Suicide is occasionally described as a punishment for the fantasied fulfilment of oedipal wishes.[20 33] Those who so describe it do not spell out which aspect of the oedipal wishes precipitates the guilt, and I think it must remain questionable whether the libidinal wishes could

do so other than indirectly via the rivalrous hostile wishes to which they are attached.

(y) Jessie's case, and a study of clinical reports on suicidal adolescents suggest that, in both suicidal boys[29-33] and suicidal girls[21-26], oedipal wishes are considerably less well defended than in most non-suicidal adolescents. There is often an ongoing awareness of the object of libidinal wishes, rather than an occasional breakthrough, or even a series of breakthroughs. I would tentatively suggest that in the case of suicidal adolescents the apparent reality of the oedipal threat may also be more marked than in other adolescents. It may be that in boys an act of suicide appears as the way out in the face of a 'real' castration threat. In girls, an apparently real threat to the mother may make it impossible for them to be women, and so leave suicide, in the context of the factors previously discussed, as the only solution.

Certainly the choice between childhood and adulthood is an intolerable one for many suicidal adolescents. At times this is consciously because of oedipal conflict. Kernberg's patient, for instance, said "Right now every boy represents my dad, which is why I cannot marry or date—the only solution is to die".[29]

But if the subjective "reality" of the oedipal situation in adolescence is the crucial factor opening the way to real rather than fantasied suicide, how is it that children commit suicide at all? Unfortunately published clinical accounts of suicidal children are very rare indeed, and we cannot as yet even begin to answer this question. It may be that different factors are involved, that the role of identification with suicidal adults is particularly important, or that the weighting of the various factors is different. However, experience with accident prone children, and study of Aleksandrowicz's account[1] of the treatment of a seven-and-a-half year old girl who attempted suicide*, suggests that one avenue of exploration might be the extent to which the oedipal situation appears in a "realistic" context prematurely because of direct seductiveness on the part of the parents, because of more disguised expectations and use of the child as a sexual object, or because of accidental factors, such as a death or divorce which leaves the child with the parent of the opposite sex.

* I should note that Aleksandrowicz herself does not interpret the suicide attempt in her case as related to oedipal conflict.

(z) Many writers have discussed the extreme narcissistic vulnerability of those who attempt suicide (e.g. [6 7 13 16 18 19 27]). A number have also pointed to the attempt to restore self-esteem and to the "search for glory" involved in the suicidal attempt.[3 19] Further, where the normal identity choices are closed to the adolescent, to be a suicide, as Erikson points out, "although it is a negative identity, is, nevertheless, an identity choice in itself".[6]

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HOW MUCH OF A REAL PERSON DOES THE THERAPIST NEED TO BE IN THE EYES OF THE PATIENT?

Sheila Chesser

"We see nothing until we understand it."
—John Constable, Landscape Painter.

In this paper I shall discuss how the patient perceives the therapist, and I shall try to evaluate some methods within the psychotherapeutic process, by which the therapist's view of the patient, and the patient's view of the therapist can be enlarged and intensified.

The psychotherapist seeks to know each patient as an individual; each psychotherapeutic treatment has to be adapted to suit the individual. Although we need a technique relating to a theoretical model and providing structure and limits, this does not invalidate the use of flexibility of method, impromptu inspiration, or hunches.

Many therapists are aware of the need, both for patient and for psychotherapist to use intuition while searching for ways to withdraw some of the defences which obscure the patient's ability to see us as real people.

There is a meeting between two people, not because they are friends, but because they have needs which the other fulfils. The patient needs the therapist to bring his knowledge to consciousness; the therapist needs the patient to help him crystallize his own thoughts, and also foster his own growth with the help of his patient. The common interest is to understand what happens between them. This is like Winnicott's view that " *Psychotherapy takes place in the overlap of two areas of play, that of the patient and that of the therapist. Psychotherapy has to do with two people playing together. The corollary of this is that where playing is not possible, then the work done by the therapist is directed towards bringing the patient from a state of not being able to play into a state of being able to play.*"

Psychotherapist and patient play together and thereby hope to fix in the mind's eye of both partners a real being rather than a mirage, a meaningful image rather than a confused vision. By " play " I mean an activity where fantasy is expressed, and imagination is engaged in for its own sake. Inhibition and guilt are in partial abeyance. (Rycroft, 1968.)

The patient will be able to develop his observing ego through the way in which the therapist behaves. The therapist attempts to gain the patient's confidence, and to remain a constant person throughout acting-out, and during projective and introjective processes. While establishing contact there is an interaction be-

tween the patient and his regression on the one hand, and the personality of the therapist on the other.

During the time that the patient and therapist play together, the patient learns to recognize through repetitions of the past, curious primitive patterns, and thereby overcomes the fear of looking at the therapist; reality testing corrects subjective impressions of what is real by reference to external facts. The therapist helps the patient to understand and remove blocks to seeing himself and the therapist, and helps him to believe what he sees. They both tease away at anything and everything lying between them, until they develop a growing conviction that there can be a new reality.

Not all reactions between patient and therapist are transference; reality elements are retained and make possible the progression, evolution and resolution of transference.

At the beginning of every treatment the patient has a reality attitude to the therapist; there is a healthy, rational, reasonable part of the patient which contributes to the formation of the working alliance. The real relationship differs from the transference in that it has less distortion. Psychotherapy usually includes confrontation, clarification, interpretation, and working through. The therapist uses direct and open interventions which provides soil for the development of transference. In the course of this process the past of the patient emerges into the present. We give the patient a second chance as it were, and the patient by freeing himself from the transference image of the therapist may find better ways of handling problems than those provided by earlier " solutions ". The patient's world will be given new meaning. Southwood says " . . . the main work of analysis is involved with unpicking the patient's identification—*who he thinks he is*—and his transference—*who he thinks the analyst is* —as they arise in the course of the developing communicative relationship, as they are brought into the analysis ".

It is essential to nurture the non-transference reaction between patient and therapist, but equally important is the experience of both the positive and the negative transference: the breadth and depth of this experience is essential for the decrease of the patient's distortions of the self and object images. Constancy in the structure of the therapeutic relationship allows the patient to be both hostile and loving in safety.

Feelings, e.g. of hostility in the transference can be acted rather than worked through. The experiencing of affect is not curative in itself. The connection with an event from the patient's past which caused the effect, must be re-established. The limits put on the therapeutic relationship allows for such connection.

A patient talked of the hostility she thought she saw in her mother's eyes, and how she had to hide from her mother with

the hope of escaping from what she felt as rage, indifference or disinterest. She moved from the couch to the chair in order to see me face to face. But in countless other ways, she had to hide from what she supposed was in my eyes. On moving back to the couch she admitted that the re-assurance of being able to see my eyes did not help her. She had to live through and experience the fear of her mother, within the structure, limits and privacy of my room, in order to be able to be hostile in safety with me.

This patient sought and found her hostility towards a transference object in the form of the therapist. She abandoned the couch for the chair, but agreed to return to the couch where the " real work " took place. Her need to keep an eye on the therapist while sitting facing me, was acting rather than remembering, the move relieved inner tension, and may have contributed to remembering the feeling of her own hostility towards her mother, but this was something different from verbalizing without action, which took place when she returned to the couch.

In his paper on acting out, Kernberg gives an illustration of hostility towards the analyst, which in fact gratified the patient's aggressive needs far beyond any source available outside treatment, and functioned as a resistance to seeing the therapist as a real person. The patient acted towards the analyst with hostility, rather than reflecting on his feelings of hostility towards him.

The effect of counter-transference when trying to understand the patient's love and hate can be insidious. I am here referring to that aspect of the counter-transference in which the therapist's unconscious attitudes to the patient, hitherto unanalysed in the therapist himself, attach themselves to the patient in the same way as the patient transfers to the therapist affects belonging to his past.

Of course the therapist has to be prepared for some regression within himself, while allowing his free-floating attention to centre on the patient. It is necessary to try to understand, control and utilize conscious counter-transference feelings in order to gain better understanding of our patient. The patient's love, devotion or hostility may undermine the therapist's self-esteem; the therapist may then struggle with an upsurge of primitive impulses in himself, and he will feel the need to control the patient as part of the effort to control his own impulses. On the other hand there may be a temptation to submit to the patient's efforts to control his therapist.

When the patient or the therapist block primitive transference patterns, or the therapist responds to excessive demands, including gratification of unreasonable needs, there is little development of a real personal relationship. If the therapist opens up his own life to the patient, expresses his own values, interests, or

emotions, this can augment transference distortions and promote imitation. Defensive organizations are reinforced, and a feeling of emptiness in the therapeutic relationship can follow the therapist's over-adaptation. Shallowness in the treatment leads to a stalemate rather than the turbulent relationship of an ongoing working through and seeing through.

There is an overlap between the transference, non-transference, and "real" relationships: all real relationships have some transference elements and all transference contains some reality.

With one patient, a college student, I was aware of apprehension before each session. She reacted with distance to the fact that I would be away for a week, withdrew, and talked about an incident at college. The break and its transference implications, although relating to separation anxiety, might have been less important than the incident at college which was contemporary, realistic and appropriate. I was conscious of the need to care for the total patient; it was up to me to help the patient to distinguish what was real, appropriate, distorted, correct or false. The holiday break involved our real relationship as well as transference. I felt threatened by her, and therefore over-adapted to what I saw as her needs. When I offered her an extra appointment, she thanked me and declined. At a later date, she said her parents had always been afraid of her, and had given in to big and small issues. She did indeed feel powerful and was seeing me as a frightened and uncertain parent.

A patient came to each session, lay down on the couch and cried; this continued for some months, it served the purpose of feeling affect and was meaningful on that level. In the real relationship she felt free to use her sessions in this way. Then, by intervention and interpretation, I put a limit on her behaviour, and suggested that we looked for links with the past. Following this work, she was able to cry with sadness, hostility, joy and rage. I think there was considerable emphasis on the real relationship in this patient's therapy.

Another patient assured me with fervour that she did not feel rejected when I told her about my holiday dates; she shouted that rejection was meaningless, then added I should feel sorry I had upset her. I treated these remarks as free-associations and clinical data to be analysed, rather than reproaches. I was not in tune with what the patient had been feeling about the break. There was no doubt about the session being turbulent, yet it was not a satisfactory interchange. She asked for an extra session, I said, in a grudging tone, that all I could offer her was an evening session on Friday; she made the appointment but did not keep it. At a later session she said she saw me as too upset to deal with her down-to-earth manner, she felt she was powerful

enough to injure me with her anger, therefore did not keep the appointment.

A teacher had asked me to increase his appointments from three to four a week. He came to his session in a recalcitrant mood, and told me in detail how, as well as his school work, he had promised to lecture once a week, and also visit a charity organisation—he added he could get no help and support from the head of the school. I intervened to say that he seemed to take part in all these activities in order to separate himself from his own problems. The patient replied he did not think that was so, and then persisted with his tale of woe. I felt that he would probably have sustained this attitude of self-pity until the end of the session had I not interrupted the indirect diatribe against me. I postulated that I was the head from whom he could not get help; after all, his mother had always been too busy with her charity work to be at home with him when he was young—I added that he wanted to tell me that he was too busy to accept an extra session in case I should not offer one. Two minutes before the end of the hour, he said he had been trying to pluck up courage to tell me how angry he was that I had interrupted him to talk of his mother when he wanted to keep our (real) relationship good and reliable, and not to have to look at attitudes which might remind him of his mother.

I had the alternative of allowing this patient to continue in his morass of misery or making interventions. Although the patient shunned my first interpretation, the intervention relating to his busy mother seemed to change the climate of the session from despair to anger, and the end of the hour helped him to feel I would not give in too readily to his demands, yet at the same time I had helped him to know that, through our relationship, I cared about his predicament.

Freud in his early writings recognised that the anonymity and neutral objectivity of the therapist could never be achieved, and in "*Analysis Terminable and Interminable*" he reports a patient as saying that not every good relationship between therapist and patient was to be recognised as transference, there were also friendly relationships which were based on reality. I presume he was reflecting his own views in this example.

Certain facts about the therapist cannot be concealed. Patients come to know a great deal about their therapists: everything we do or say reveals something about our real selves. Our surroundings, the consulting-room furniture, our age, sex, voice, dress, mannerisms all contribute to the patient's knowledge. However, it may be difficult to bring the patient's knowledge to consciousness, and to "give the patient permission" to talk about us. They do not know they have the information, and it is part of our task to bring the knowledge to awareness. Each time we make a change

in the consulting room, for example, re-arrange the books, or have a new plant, some patients will volunteer inferences on the change, disclosing their depth of feeling about us; others will ignore changes about which they know; some others will not notice until their attention is drawn, for example, to a new picture.

The following is an example of a patient who has to know everything, thereby masking her fear of learning. With regularity and in different contexts, she brought up the fact that she thought I must be divorced or estranged from my husband. Eventually I asked her whether she could think of any other ideas on this topic. Her mind, she said, was blank, and she could think of no alternatives. I told her my husband was dead, whereupon she asked when he had died, and on being told, she complained bitterly that her therapy had commenced only one month after his death. The patient said this proved that I could not have cared about him: if her man-friend died she would " fall apart ", " be paralysed ". I said that she saw her therapist as someone who could only care about one person at a time: to justify my action she had to think I did not care about my husband. The patient said she could now see it was possible to care about more than one person, and draw sustenance from many. She added that she no longer felt bound to be paralysed by separation.

The above vignette might be seen as the therapist opening up her own life to the patient. I see it as an example of the patient and therapist working together in order to authenticate the patient's lack of reality-testing, lack of curiosity, fear of making important discoveries, fear of exploration. I had to make an effort to allow her to see me as someone who could care for her at the same time as others, and to help her to liberate her use of inquisitiveness in order to find evidence of our relatively transference-free relationship.

This example might also be seen as a therapist showing herself as someone to be imitated. In fact, the patient, as a result of the disclosure about the therapist's life, could touch on deeper sources of her own experience, and at the same time, she was able to correct distortions in her image of the therapist.

Insight is a combination of the intellectual and the emotional understanding of deeper sources of psychic experience, accompanied by concern for and an urge to change the pathological aspects of that experience. A male patient said he found he had little opportunity to be angry with me because I attended to his every need; he was feeling depressed because, on the way in, he met another patient who was looking happy. He then hastened to tell me he had lost his temper the previous night. He and his wife were to entertain a woman friend, and the patient had answered the telephone to discover that she had arranged for a fourth person to be present, a man. He rebuked her for her deceit: she

had invited the man not disclosing the fact, the arrangement had been made in an underhand manner. He often felt like a pawn in her hands, a victim of her independence. I enquired what he thought was her motive for this " deceit ". He replied that she had made the date to evoke his jealousy, and added that it made him think of the day when his mother arrived back from hospital having given birth to his younger brother.

The patient sensed the primitive feeling link between the events, he was able to stand back and observe that I seemed to be the faithless parent who replaced him with another child (the happy patient). He said that although he looked back on his brother's birth as being without hurt or pain, he was sure he must have felt anger and jealousy. It dawned on him that the anger he felt the previous night also applied to me, I was independent and " deceived " him by making the other patient happy, he felt helpless about my relationship with other people. But co-existing with transference-reactions, there was a more accurate perception of me based on trust and observations made over a period of three years. He saw that this anger did not destroy our relationship, and that he could develop a flexible relationship with people in spite of his own and their changing moods.

I have been writing about the therapist as a " real " person as seen by patients with character-neuroses or character-disorders. For these patients the therapist appears as a good forgiving parent, understanding and tolerant, who loves the patient in spite of his " badness ", and with whom the patient can experience his love and hate, feeling the simultaneous presence of both strong feelings at the same time. As the transference experience moves from the stage when the adult is the need-satisfying object (characterised by fear of loss) to super-ego conflicts and fear of punishment (although not necessarily in that order), we can hope for a gradual development towards the therapist being seen as a " real " equal adult. There is then respect for the entire person; the therapist is " reduced " to his true status.

A young male patient told me he had felt lonely at the weekend, and had mooned about in the district where I live; he found himself wishing that he could catch a glimpse of me, yet feared that I should see him and want to punish him for his behaviour. He was aware of his adolescent yearnings, and also saw me as a transference-object who could satisfy a need. Anna Freud said she had wondered frequently what it was that facilitated the transition from loving the satisfaction, to loving the person by whom the satisfaction is provided.

Work with narcissistic, borderline, and psychotic patients highlights the importance of the real relationship, and I believe we can learn much that has relevance to our work with neurotic patients. These patients can be more dependent, and have closer

ties to the therapist than their neurotic counterparts; they are often highly sensitive to the psychotherapist's mood, indeed they may be more aware of the therapist's mood than of their own. They tend to want to know what the therapist is thinking rather than what they themselves are thinking about the therapist. The relationship has intensity, and the patient yearns for a feeling of harmony, as described by Balint in *The Basic Fault.*

A woman fashion-designer said, when she entered my room she felt she was a walking polaroid camera, she stripped off the photographs and compared them with the ones taken the previous day. She wished the camera could also take a photograph of what her therapist was thinking and feeling. This patient experienced intolerable fear that she would lose me. However quickly the doorbell was answered, she had the feeling that I must have died before she arrived; she also felt that she must hurry up the stairs in case she might die before reaching me. The feeling of harmony was reached if everything seemed to be as usual when she entered my room.

A borderline patient detected and interpreted my unconscious counter-transference. She had been discussing her problems with her man-friend, and this, she told me, had made her even more unhappy. She occasionally phoned me when unduly distressed, but, she said, she could not telephone me at the weekend because I would be sitting with my husband talking about how awful she was. The monster inside her, she added, killed off all the good. She went on to say: "Of course you do not know my needs, you were bloody angry when I spoke to John instead of you, you were jealous, you were talking about your feelings not mine." Her interpretation was correct.

With the hope of preventing such errors, it is important to keep in mind how much of the patient's responses are transference, and how much are reactions to the real person of the therapist. We need constantly to refer back to our counter-transference, and to be aware of shortcomings in our methods of work. Our character-traits may be seen by our patients, but not brought to our attention. When the patient remarks on mistakes, it is necessary to time the admission of an error correctly, if the real relationship is to be preserved. The patient's reaction to the therapist's acknowledgement of a mistake must be analysed together with his feelings about errors. The acknowledgement of a good piece of insight on the part of the patient encourages the patient to do more analytic work, and to appreciate the spontaneous human reactions of the therapist.

I have tried to show that two people with separate existences have separate experiences, but share some of these experiences. Reality for one person is his reality: through words he tries to share his reality. We attempt to enable the patient to judge

between his imaginary objects and real ones, enabling him to make corrections in his daily life, and thereby make changes.

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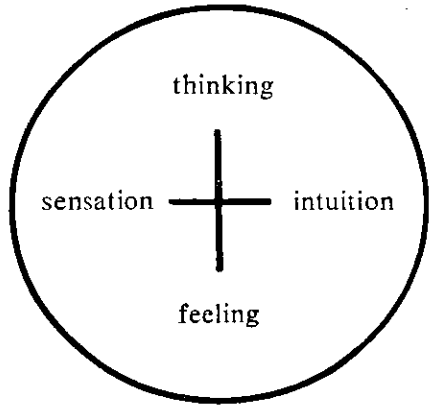

EXTRAVERTED AND INTROVERTED PATIENTS AND THERAPISTS

Marianne Jacoby

Jung's model of patterns of adaptation and functions comprises eight types. I shall illustrate these from some recognisable attitudes of patients in therapy together with the therapist's typical responses. The model highlights attitudes and moods which remain unobserved without it, but the model has its limitations. I shall outline its use and misuse.

Jung's "Psychological Types" appear in a volume of over 600 pages, Volume VI of the Collected Works.[1] I cannot do more than merely hint at the theory which is built on the psychic energy of opposites, in this context, the opposites of Extraversion and Introversion. Jung classes these as the regularly recurring conscious patterns of adaptation, together with the function types. Although these types meander through the Jungian literature, I have found that only Jung described them as profiles or portraits of people in whom we can partly or wholly recognise ourselves, our patients, our friends and enemies.

My own attempts at portraiture are limited to my experience with patients and my typical responses to the attitudes of the types—I am conscious of being one of them myself. Hence, within this circular model there is no illusion of a total objectivity—and it is for this reason that I find the model eminently recommendable. It never suggests that the patient is cast into a type by the objective observer/therapist, who is blissfully beyond the mess. In this inescapable roundabout, one type is always perceived by another. Thus, the two protagonists, patient and therapist, face,

compensate, oppose, enhance, interpret, and misunderstand each other according to their typical attitudes.

I have lived with the model for all my working years of which there are many. But I do not mean to imply that I am aware of my type year in and year out and speedily cast every patient into the mould—I make use of the types as and when they come into my mind, that is, spontaneously—and mostly for my own orientation—I discuss them with a patient only if he/she is interested in Jung's theories, which is usually in the later stages of an analysis.

The two attitude types which have gained general popularity are the best part of the model—not that they are really understood for that reason—they are the compensatory pair of extraversion and introversion. How does one qualify for the one or the other? Jung says little about their origin. Fairbairn criticises Jung for not giving enough consideration to the psychopathological factors which could be decisive.[2] Fairbairn holds that the depressive patient belongs to the extraverted, and the schizoid patient to the introverted type. I suppose that he had in mind the manic-depressive patient whose moods swing out into the external world from which the schizoid patient tends to withdraw.

But Jung is not only concerned with psychopathology. In his view, extraversion and introversion are equally healthy and necessary adaptions to our world: the extraverted type being more at home in the external reality, the introverted type in the inner world. Accordingly, two patterns of creativity can be distinguished from each other: for instance, psychotherapists are extraverted when they found societies and training institutes, and they are introverted when they write their papers and retreat into the quietude of their consulting rooms for individual therapy.

The types become pathological only when they escalate—then extraversion turns into a compulsive flight into external reality, and introversion becomes a fear-ridden withdrawal from it.

What determines our type is—more often than not—recognisable by what we do in a crisis:

the E type in a crisis goes out into the world—he experiences himself as an integral part of a social whole—or a group—he spreads himself into the external world and its fascinating objects—he is sure of some help coming to him from there—

the E type is not devoid of a measure of introversion, although this is not under his conscious control—it comes over him in bouts—thus in a crisis he may, much to his surprise, welcome an evening alone at home.

It is when his E escalates, as it were, that a day at home in solitude is—in the words of a patient—" a sheer waste of time".

Such an evening alone will produce mainly, or only, neurotic symptoms.

In contrast, the I type in a crisis turns away from the world—into the cloisters, symbolically speaking—there to think it over—or to sleep it over—while awake he will cut down external stimuli to a minimum, while waiting for the way out of the crisis to mature within himself—

The I type is not devoid of some extraversion—going to an international congress he will enjoy the hustle and bustle and the meeting of so many people as a change from his preferred solitude.

But if his I escalates he will cut down on social gatherings and pronounce that the continuous chatter with so many people is absolutely useless!

Of course, the opposite types have a way of misinterpreting each other: the extraverted says of the introverted type that he disregards the demands of society, that he is haughty, aloof, and out of touch with reality—besides being utterly selfish; whereas the introverted says of the extraverted type that he is only superficial, that he is an idiot who has not an original thought in his head and repeats the conventional claptrap ad infinitum—and that he wants to be on good terms with everybody.

Therapists have devised extraverted and introverted models of therapy, no doubt, to suit their own temperaments, of which the non-Jungians are not sufficiently conscious.

The extraverted therapist puts the emphasis on the correct diagnosis, because the reality is in the external object, that is, in the patient and his symptoms and maladjusted behaviour whose origins are searched for in the patient's environment and his external objects—a therapy will be recommended in which the patient can relive his trauma in an adjustable environment, such as group and family therapy, or psychodrama.

In contrast to the several extraverted therapies there is only one introverted model—the individual analysis which is conducted in a quiet consulting room—external stimuli are kept at a minimum—emphasis is laid on the interaction between the two people concerned, and on dreams, and on imagination as an on-going process which transforms them both, the patient as well as the therapist.

In Jung's time—he finished the *Psychological Types* in 1920—there was no extraverted therapy in our sense of group therapy which was developed after the Second World War. However, in an individual analysis, analyst and patient might focus on external objects rather than on the "inner world"—which is a term ascribed to Freud.

Jung's model comprises not only E and I, but also four psychological functions—these are less well known. It is the combinations of the four functions with the E and I attitudes which makes eight types.

The four functions are:

1. the sensation function—

it ascertains that something is there

it collects sense-data and defines isolated elements of perception

well developed it will achieve the highest pitch of sense perception. (Example: alas, no therapist comes to my mind, but Turner, the painter).

2. Thinking as a function—

it states and describes what it is that is there

it reflects on experience by ordering its sequences—by theory building—and by model making.

3. Feeling as a function—

it gives value-judgement to the experience and sense perception

it defines the value of a dream or a mood or an interaction, whether it is agreeable or disagreeable to whom and why.

4. Intuition as a function—

it perceives a global view on the spur of the moment—as in interpretations of dreams and symbols

it perceives future development or events of a dim past, as if they happened now.

The four functions can be so divided that thinking and feeling are more rational than sensation and intuition. The first pair produces ideas and feelings on morality and aims and ideals, whereas intuition and sensation are irrational—more hypothalamic and more irresponsible. Intuition can be so ingenious as to find a way round any conflict and thus avoid a confrontation—and the sensation function is so unreflective as to deny that there is a conflict at all.

Each of the functions, or a combination of two of them, can become habitual, when the ego identifies itself with it and a way of life or a profession is chosen accordingly. But then the other functions can remain unconscious and underdeveloped. They are the cause of the so-called failures in life.

What is brought into the therapy is always the least developed function. It is the gateway to the misery of life, and there is incompetence, defeat, resentment and envy. For instance, if thinking is underdeveloped, what is envied then is someone else's perfect thinking function.

So far my introduction—which will be followed by my illustrations, or rather sketches, of the individual types. Obviously, I present them as I conceive them, that is, as my type responds to them. Mine is an admixture of intuition with feeling. Hence, anybody who distrusts intuition and feeling will dislike my rendering and perhaps disregard the types altogether.

1. The thinking function type:

He/she thinks, of course, that everybody thinks!

but the other types do not " think "—

for instance, I assume that Bion[3] thinks that every analyst thinks and can use his grid which is built up entirely on the thinking function—

the introverted thinker, like Bion, is concerned with the truth of ideas—he reflects on inner objects and develops theories and builds models—

Jung classes himself as an intuitive thinker—and Freud? thinking, intuition and sensation?

In contrast to Freud—the extraverted thinker supports the theories and standards of the scientific majority of his time and certainly of his particular organization, and as he is on good terms with society, he is rewarded with a stable social position.

Enter the patient:

His/her thinking function will have secured him a reasonable social and scientific status—

but his feeling is inferior: there is trouble with personal relationships
(I feel that) he thinks when he should be related to other people's emotional needs—

my patient is a thinking woman of about 32—a political scientist with a high I.Q., a future professor—she daydreams of her inaugural address—

thinking determined her way of life—

it is her feeling that lags behind as her inferior function— hence, no feeling language is possible with her—

not: what do you feel about it? she would reply that she does not know what she feels—yet, she talks interminably about her feelings for a boy friend who seemed ill chosen—

her feeling has a strong masochistic flavour—it makes a sickly morass in which she is stuck—her feeling function has an autonomous way of heading towards disaster

here is Denis Scott's " disaster-mindedness "[4]—as this patient's feeling rambled on and on I had no chance to get to know anything else about her, until I felt my own extraversion welling up in me

I resorted to my extraverted sensation which I rarely do

I demanded to be informed of such basic facts as whether she had a job, whether she was satisfied with her salary—what her living conditions were—at long last my questions brought some observation of external factors into the therapy.

Her extraverted sense-perception was just dormant under the surface, and as it developed it took the middle position between her thinking as the superior function and her feeling as the inferior function. There were now three areas: (1) what do you think about it? (2) what do you observe about people and facts? and (3) what do you feel about these observations? These areas brought into the therapy more problems rather than less, but they came to hang together and rounded off her horizon.

2. The feeling function type:

Most of us—as therapists—will participate in this function—

to be conscious is to feel, to agree, to disagree—

to be sure of one's value judgements without being dogmatic—

to assess the value and nature of social interactions and conflicts the feeling type is vital for the survival of society

but the feeling type does not get famous

it is the thinking type who writes the books and excels in public lectures

the feeling type is concerned primarily with the realm of personal relationships, with the individual uniqueness and with the uniqueness of the interaction at the particular moment at which it takes place, it does not generalise

hence the feeling type is an excellent therapist in the privacy of his consulting room,

or the social worker with the big case load

the therapist is endowed with empathy, that is, feeling as well as intuition, and the social worker with his accurate assessment of wrong-doing.

Enter the patient:

the presenting problem—he/she is in a humble position—wants to improve career but cannot pass the necessary examinations as these presuppose a good thinking function which is underdeveloped.

in the therapy there is immediate contact

the conversation flows easily

but soon the patient will talk about other people's feelings without reference to herself

the feeling type loves all members of her tribe or social family

she will fit her analyst into her " family " for if the analyst is to be trusted, the analyst must be " one of us "

but if the analyst is an I feeling type he/she will react rather surly to being thus roped in and his feelings will go into hiding.

Jung says about the I: everything in him is designed to make him disappear. Yet, the analyst's developed feeling, although in cold storage, does not disappear, except from the surface—in the deep— " still waters go deep " the feeling remains loyal to, and caring for, the patient.

Introverted feeling is mono-centred and relates to one person, one idea at the time, whereas extraverted feeling spreads and embraces a whole social group or several ideas and occupations, it is poly-centred.

The I therapist interprets the E patient to be lacking in depth and if the patient feels rejected, she will turn to her thinking function which is negative

she is having bad thoughts about her analyst and in order to bolster them up she resorts to quoting Jung and reiterates a lot of book knowledge, supposed to be Jungian.

The sessions get into a stalemate.

What will help here is to bring in a fresh breeze of intuition

an intuitive interpretation of the symbolic image of the great master, Jung, who is supposed to think for all of us!

The further interactions in the therapy develop not only feeling, introverted and extraverted, but also thinking and intuition.

3. The intuitive function type:

The I intuitive comprises three quarters of Jungian analysts.[5] Also Melanie Klein belongs here, yet she had a remarkable capacity for E and social success.

Enter the patient:

The E intuitive is inventive, speculative, flighty and has been all over the world, is a jack-of-all-trades, his home is like an airport.

The presenting problem: he/she spoils his excellent ideas by forgetting them

he is fear-ridden about his body and of the " inside " of himself.

He is a journalist

thinks that his therapist has a poor job—always sitting in that same chair

instead of flying round as a travelling lecturer

the patient wants to find out what else could be done with the same method

meanwhile he forgets why he came to therapy—but is full of expectations

and starts the session with: " what are we going to do today? "

forever hunting for new possibilities

he does not keep regular sessions—his life style requires constantly moving about

the here and now is a prison for him

hence the stoic sameness of the therapist's attitude bores him to tears!

The I intuitive patient wants to find out for himself what Jungian analysis is about and tries to invent the whole procedure for himself

he assumes that my therapy is *my* original invention and is disappointed that I am a mere pupil compared with Jung himself.

In this patient, as in all introverts, the me/ness is all important. Hence, he brings his dreams fully interpreted,

that is, as he understands them—not as the analyst interprets them

he keeps his own and his therapist's interpretations as two separate streams.

The I intuitive is a hoarder of objects.

case material, quotations and parts of unfinished mss which cannot be used because they cannot be retrieved from the muddle of books, journals, loose papers, etc.

His observation and perception are inaccurate and anxiety-ridden.

The more E the patient, the greater is his fear of what is wrong " inside " him

his bad perception feeds hypochondriacal and hysterical symptoms.

Quite spontaneously, a therapist will feed into the sessions one of the responsible functions, thinking or feeling, in order to stabilize the patient's fears and to harness his many intuitions to an aim.

4. The sensation function type:

(A rare bird among therapists)

The reality of objects, whether external or internal, is experienced at the highest pitch of sense perception. The more introverted type is a collector of rare delicacies, such as objets d'art, first editions, precious stones—he is a gourmet on every level. The more extraverted type is an excellent sportsman or a press photographer.

The presenting problem:

He/she wants to do too many things, possesses too many things in too many places, cannot decide which to cut out

has several lovers for different sense perceptions

and is in a general mess about himself.

Patient enters the consulting room and makes accurate observations—

finds my interior decorations of a rather poor taste

before settling down he/she re-arranges the cushions

then gives a most detailed report of recent events

if he tells a dream, he tastes each dream element like a delicacy: the scenery, the colours, precisely where is what

the dream is important only for its aesthetic appeal

my interpretations are refuted by bringing in more perceptual details of the dream

if my interpretations are intuitive, they are found." far-fetched ".

The more introverted type uses external objects as mere triggers for internal associations

for instance, the patient says to me: " the way you just looked reminds me of . . ."

and out comes a long series of memorised observations of other objects which release more associations, perceptions and memories

nothing to do with the therapist who feels left out.

Whether the patient's associations are sad or enjoyable, they are deceptively devoid of conflict and worry—there is no philosophy of life.

The therapist will react, usually quite spontaneously, by putting the emphasis on the functions which can assess the nature of conflicts and assess guilt and the measure of personal responsibility, as thinking or feeling will do.

Generally speaking, thinking and/or feeling safeguard a responsible and humane approach to the many conflicts which are worked over in therapy, and intuition and sensation add a certain lightness of touch and further the flexibility of the whole process.

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COMMUNICATIONS

From the Chairman:—

The Executive Committee—called the Council since the change of legal status of the Association to a Company Limited by Guarantee, in June 1976—has met on 15 occasions since the last A.G.M. in March 1975. The change of status has taken up much time, and the committee was also actively concerned with the question of registration for psychotherapists. Dr. de Berker has acted as the Association's representative on the Working Party (of interested bodies, including the Institute of Psychoanalysis, the Society of Analytical Psychology, the Institute of Group Analysis and the Royal College of Psychiatrists), which is negotiating with the Ministry, and has engaged Mr. Paul Sieghardt as Counsel. Discussions are also starting with the D.H.S.S. about the status of Adult Psychotherapists within the National Health Service.

A good deal of the business of the committee has been concerned with training, with the selection of candidates, and with the admission of applicants to the various categories of membership.

Consideration has also been given to the procedure for appointing Full Members of the B.A.P. as training therapists or supervisors of students. It has been agreed that any full member should be eligible who qualified as an Associate Member no less than five years ago and has been practising psychotherapy with adults since qualification. Each application (to the Secretary) will be considered in the first place by the Training Committee whose recommendations will have to be approved by the Executive Committee.

A. W. F. ERSKINE

From the training sections:—

There are 60 student members of the Association.

The Freudian stream consists of the following: 10 third-year students, seven second-year students, 14 first-year students. Thirteen Freudian students have completed their theoretical training and are continuing with their training patients in preparation for reading-in for Associate membership.

VICTOR KANTER

The Jungian stream is divided into two groups: beginners and advanced. There are 16 students altogether. The first-year students joined with the Freudian stream for four seminars (out of their total of 22), and for one of these the advanced students came too. Two seminars were shared by all Jungian students. The advanced students wished to meet as yet unfamiliar Jungian leaders in their last term in order to discuss their different approaches to therapy.

We enlisted the help of 18 analysts—more than one analyst for each student. However, they had double or treble functions to fulfil as training analysts and supervisors as well as lecturers. Two were responsible for the planning of the beginners' curriculum and did most of the teaching. On the whole, the image of the archetypal pair—master-pupil—was well-conceived and each half was keen to get to know the other half. MARIANNE JACOBY

From the affiliated bodies:—

The LONDON CENTRE FOR PSYCHOTHERAPY now has on its register over 100 trained psychotherapists and counsellors. It has handled up to 400 referrals this year for individual and/or group treatment, as well as many more enquiries. In addition, the Centre is running three courses:

1. A two-year training-course in group psychotherapy.
2. A two-year course on " Pyschodynamic Interaction ".
3. A one-year Inter-Disciplinary course.

The L.C.P. Council has also ratified a four-year training-course in psychotherapy to start in January 1977. This will specialise in adult psychotherapy based on once or twice-weekly sessions. It is hoped that this course will meet the specific requirements of the majority of L.C.P. patients, most of whom ask to be seen once or twice a week only.

The training course will also include training in group psychotherapy, in family therapy, and in psychodrama. ILSE SEGLOW

The COUNSELLING SERVICES ASSOCIATION has been interviewing the new intake of students for the part-time course lasting over a period of two years. The tutors will again be Dr. Arnold Linken, Donald Twoomey (the Secretary), and Jean Scarlett, acting as supervisor to past students, Rosemary Watts being the Treasurer. Fifteen students successfully qualified this year. Valerie Hatswell's special project, where counsellors are attached to G.P.s' group practices, continues to function extremely well and is currently expanding. As usual, I should like to thank the Committee, and students, for all the good work they have put into the Association. ROBERT ANDRY

OBITUARIES

We record with regret the deaths of: PENELOPE BALOGH, LAURA BLUMENAU, PAULINE JOSEPH, HAROLD KAYE, HENRIETTE MEYER, PAUL SENFT, ANNI SOLDI, LESLIE WEATHERHEAD, E. L. GRANT WILSON.

Lady Penelope Balogh

I first met Pen Balogh at the Institute of Experimental Psychology in Oxford where we were both students, after the war. She was an exceptional person. Her intellect and her vitality made a great impact upon the students there.

The rigours of experimental psychology were not conducive to psychoanalytic thought but Pen became a focus for this in Oxford and established many contacts in the university. These, whilst perhaps remaining sceptical in varying degrees, were not unsympathetic. Her husband was a don, and Pen therefore had her circle amongst students, university staff and also, because of Tom Balogh's interests, amongst many politicians, mostly of the left.

Pen joined us in the B.A.P. very early in its life and played a vigorous part in its early struggles. Her wide contacts enabled us to set up our first distinguished Advisory Council, and their help sustained us through many stormy passages with what was then the Establishment.

From the early 1950's, Pen had her own clinic in Oxford and this operated in conjunction with our first London centre at St. Anne's, Soho. Later this moved to Lord Faringdon's house and then to Pen's London home where it became known as the Well Walk Centre. This grew and like all healthy children gradually assumed a separate entity as the London Centre for Psychotherapy—as it now is.

But Pen was impatient. She tried always to experiment and to improve on psychotherapy in its various forms. She found the restrictions imposed by cautious growth, both in the B.A.P. and the L.C.P., little to her liking. Gradually once more she strengthened her own centre and although the links between her and the B.A.P. were never severed, they became less strong as her interests found expression elsewhere.

Pen found Kleinian theory closest to her own ideology and she was a brilliant exponent of it. She was a talented writer and has several books on psychoanalytic themes to her credit. She found new ideas exciting and had a great fund of enthusiasm for them. Her friends at times found her enthusiasms difficult and occasionally her impetuosity led her into strange paths.

She was a great and large person and has made a true contribution to psychotherapy both in a personal sense and in the help

she gave to patients and friends, and also by the mark she has left on the form and spirit of our Association. P. DE B.

Paul Senft

Paul Senft died in August 1975, aged 69. Many members of the B.A.P. will remember him for his lively and stimulating seminars, before a series of strokes led to an increasing inability to carry on with his work.

Born in Pressburg (as I think he would still like to think of it rather than the Bratislava that it has been for over half a century) of a Protestant-educated Austro-Hungarian-Jewish family, he was educated at the German University in Prague, where he obtained a degree in law. He later read Psychology and obtained a lectureship there. His real vocation was writing; he was influenced by Max Reinhardt under whom he had studied. Later, in 1942, he presented *Everyman* in St. Mary's Church, Oxford.

With the advent of the Nazis he emigrated to Paris, having to escape once again after the fall of France less than a year later. He was evacuated to this country with the Czech army and, after recovery from an attack of T.B., soon established himself here, first working at the Institute of Experimental Psychology in Oxford and later moving to London, where he practised as a psychotherapist, as well as lecturing for the W.E.A. and working with the U.S. Air Force in evaluating their strategic bombing policy. He became a naturalised British citizen at the earliest opportunity and was devoted, though not uncritically, to this country. He worked as a psychotherapist in the N.H.S. from its inception, first at the Social Psychotherapy Centre (later the Marlborough Day Hospital) and then at University College Hospital. He was the first to fight for and secure a grading as Psychotherapist in the N.H.S., refusing to accept any post under any other title. He also worked in groups with Foulkes from the late 1940s, and was interested even in those days in Psychodrama. He made use of these various techniques, together with individual psychotherapy on psychoanalytic lines, in various flexible combinations, both with patients and students.

He was critical of much of the underlying theory and philosophy of psychoanalysis and of its practical development. He had a sociologically oriented view of it, which he had hoped to elaborate in a series of seminars for the B.A.P. He will be known to the outside world chiefly for his foundation of and contributions to *The Human Context,* a multi-lingual international publication.

To his friends, colleagues, students and patients (many of whom would indeed regard him as a friend) he gave his time and the benefit of his prodigious intellect with an unstinting generosity.

A.W.F.E.

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