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ACTING OUT

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The old saying, 'Fools rush in where angels fear to tread', is very well known. I suggest it may be a precursor, on the folk level, of the technical term and concept of acting out. Fools act, and act too quickly, whereas angels and analysts consider the matter carefully and may postpone comment or interpretation (which are forms of action) until the next session, or even the next week or month. Whether my speculation is apt or not, I forgot both the saying and the moral behind it when I was invited to be one of the speakers at the Day Conference on Acting Out in September 1983. I fell for the flattery of the invitation. But the purposive and adaptive aspects of acting out (of which I will say more later) are that I probably needed to put a lot of thought into what acting out means, and means to me as a Jungian. The term does not feature in the *Index* to the *Collected Works* of Jung, but it is used by modern Jungians. I did not realise that only very little written attention has been given to it by us. In twenty-eight years of the *Journal of Analytical Psychology* not a single paper has been wholly devoted to the phenomenon itself, to clinical descriptions of its manifestations, to dynamic or structural considerations, or to the theory of it — let alone a discussion of the now several conceptualisations. But even only a few of the recent annual indexes of the *International Journal of Psychoanalysis* revealed the existence of almost innumerable papers which either fully attend to several of the many aspects of the subject, or in which the concept is used and its meaning is assumed to be understood. Perhaps it features as a seminar topic of psychoanalysts in training? Analytical psychologists learn about it in supervision, that is, in clinical experience rather than from the theoretical angle. Some discover it during their own analysis. It has been pointed out to me by Dr J Redfearn that the concept signifies a clinical judgement or a practical problem in handling, rather than an analytical attitude which takes account of the subjectivity of the analyst's feelings as well as of the patient's actions (personal communication).

For many Jungians, and especially in centres other than here in London, anything smacking of technique is suspect. It is sometimes even attacked on the grounds that it is 'scientific', more particularly by those who call themselves archetypal psychologists, who favour working mainly with images, symbols and mythological amplifications. That suspicious attitude has resulted in it being all too easy to be a little casual about the use to which such a technical term is put. This term, 'acting out' is the one which, before anything else, denotes something presumably identifiable, and in the past has been considered usually as done by a patient. As well as a denoting term, it is a descriptive one. The range of occurrences that it describes is, however, a wide one. Equally wide is the range of possible ways for the analyst to proceed, respond or react, or techniques to use, when he considers that the patient is acting out. It is also possible for the term to be applied to the analyst, thanks to the development over the years of sophisticated thinking about counter-transference, and in consideration of the view Jung expressed that the analyst is in the analysis as well as the patient.

This paper consists of some reflections on the concept and its manifestations, linked to the major lines of thought in contemporary analytical psychology. It is neither exhaustive nor definitive. For example, as I have no delinquent in my practice, I am leaving out the whole question of actand delinquency.

Short Selection of the Literature

The Jungian use of the term 'acting out' is evidently based on Freud's formulation in 'Remembering, repeating and working through' (Freud 1914) in which he went into more detail than he did on the first occasion that it features in the *Standard Edition* of his publications, which was 1905, when he was explaining why the patient known as Dora broke off her treatment. In 'Remembering, repeating, and working through' Freud wrote:

> 'the patient does not remember anything of what he has forgotten and repressed, but acts it out. He reproduces it not as a memory but as an action: he repeats it, without, of course, knowing that he is repeating it'
>
> (Freud 1914, p. 150)

That is a compact statement, and even more compact is the definition offered by Phyllis Greenacre in a symposium held at the Thom Clinic for children in Boston in 1962:

> 'We might define acting out, then, as memory expressed in active behaviours without the usual sort of recall in verbal or visual imagery'
>
> (Greenacre 1978, p. 216)

But Laplanche and Pontalis showed how those definitions fail

> 'to distinguish the element of *actualisation* in the transference from the resort to motor action — which the transference does not necessarily entail'
>
> (Laplanche & Pontalis 1973, p. 4)

When they composed the *Language of Psychoanalysis* they had the benefit of the work of the many contributors to the Copenhagen International Psycho-Analytical Congress held in 1967, and the commentators on the papers there, who added a wealth of sophistication to the subject. And since Laplanche and Pontalis, Dale Boesky has reconsidered the concept very thoroughly (Boesky 1982). Any Jungian wishing to study the subject has to take notice of contemporary Freudian work on it.

Among analytical psychologists the one who up to now has most conspicuously thought and published anything about acting out is Michael Fordham. In the chapter entitled, 'Notes on the transference' (significantly published in the book entitled *Technique in Jungian Analysis*) there appears this statement:

> 'Acting out is a special form of defensive behaviour whenever it occurs, and is based ... upon a projection to which neither analyst nor patient has been able to gain access'
>
> (Fordham 1974, p. 126)

He stated the same thing in longer form (in the same chapter):

> 'The gradual development of an analysis can lead to the analyst's becoming the centre of it, so that the whole patient may become involved in the process of transformation. If, as sometimes happens, this concentration of libido is made into an aim, almost anything whether adapted or not, that happens outside the transference in the life of the patient is considered undesirable. These supposedly undesirable activities have come to be termed "acting out", and this term seems to have received greater prominence than its more vivid equivalent of "living the shadow" '
>
> (Fordham, *Ibid.* pp. 124-5)

My next quotation from the same chapter, leads on from those statements:

> 'In using a psycho-analytic term, *acting out*, it is necessary to realise that it is being altered in the process [by analytical psychologists] and at the same time extended, to cover and emphasise the *purposive* [my italics] aspect of the act in question'

Then he refers to Stein (Stein 1955) who described certain women patients who,

> '... walked round the analyst's chair in a menacing manner ... [in] increasingly narrow circles, reminiscent of the "hag track" ... *in order to try to stir him up*'.

I would interpose at this point that the hag was a witch-like creature, a female, probably elderly, believed to have super-natural powers which she used and worked up by means of circumambulating. The hag-track, according to the Oxford English Dictionary, is another name for the fairy circle. The man was encircled with the bad archetypal power, the hag or the witch being the obvious opposites of the good mother and the good woman. The hag and the witch are the archetypal shadow-figures of the woman.

Jung wrote about the shadow at the collective level as being evident in the present in such 'counter-tendencies in the unconscious' of modern people as those which appear in 'spiritualistic séances, in what he calls 'puerile and inferior' character-traits, in carnival customs and in other 'traces in folklore' (Jung, 9, para 469). He adds that 'the main part of [the shadow] gets personalised'.

The personal shadow consists for each of us of what we do not like about ourselves, what we repress from consciousness, what we postpone discovering, but also a factor that we need to find and to accept for full personality development. The man partly wants to be stirred up by the woman (I refer to the quotation from Stein's paper), perhaps even wants that to take a sexual form, but at the same time he does not want her to be more powerful than he is. He has a shadow-problem about the powerful woman and the internal woman-image. Fordham writes that the patients who walked round the analyst's chair were,

> 'enacting a primitive drama ... which was not realised at first by Stein or the patients. They were *living their shadow*, which contains an archetypal image'.
>
> (Fordham 1974, p. 126)

That phrase *living the shadow*, conveys that the events referred to are potentially useable for purposes of bringing personal or archetypal shadow elements to consciousness, preliminary to their being integrated with the ego. But Fordham, in the chapter from which I am quoting, went on to say:

> '*Living the shadow* is likewise considered undesirable in analytical psychology, but for the added reason that it is acting in a primitive manner and is undesirable because it is consequently unadapted' (*Ibid.*, p. 126)

And he explains that in Stein's paper called, incidentally, 'Loathsome women', the patients wanted to stir their analyst up, to get him to 'man-handle' them, but also did not really want that, since they had come to the analyst 'because of the failure of their primitive and guilt-ridden activities to produce adequate satisfaction' (*Ibid.* p. 126).

Some Varieties of Acting Out

As the analytic attitude eschews as far as is humanly possible criticism, moralising and didacticism, I think we might notice, as well as what Fordham calls the undesirable fact of the primitivity of the patient's action, that this 'undesirability' of acting out stems also from the analyst's feeling of defeat when acting out takes place (he may ask himself 'What did I say, or fail to notice, that led to the acting out?'), and also where matters of technique are concerned that it is often difficult to get the patient to accept interpretations of it. Those may be directled only at the particular form of action that has occurred, rather than to the underlying transference fantasy, which is what is going on behind the reliving of earlier interpersonal experiences. And interpretation, I find, only succeeds after quite a lot of work has been done on the patient's unconscious transference, so that the analyst first and then the patient both see what each is *doing*, as well as *being*, or claiming that the other is *doing* and *being*. I would, however, add a *caveat* at this point: what I have just said might be taken to imply that I advocate blurring the distinction, which has always been at the centre of the concept of acting out, between, on the one hand, remembering, thinking and speaking, and, on the other, acting, or enacting or re-enacting. I only wish to point out that we have all — Freudians and Jungians alike — come to the stage of analytic sophistication when we know that thinking, fantasying and dreaming are psychological forms of action, so that the idea of a spectrum of actions is what we are dealing with, rather than simple set of opposites. For example: a certain patient spoke several times one summer about her wish, and indeed her strong urge, to bring me a rose from her garden, but she refrained from putting the urge into action. Two years later, she did bring two roses — very carefully selected ones which were going to develop into perfect blooms. On each occasion analysis revealed the previously unconscious transference projections which were currently at work, their origins in the ways of interactions that there had been in the oedipal triangle in childhood, and, more significant of course, her feelings about her mother and her father, and what she took to be their respective feelings about her. I did not find that the actual bringing of the roses impeded analysis nor was it more 'primitive' than telling me that she wanted to bring a rose. In fact there was more positiveness in her having dared to take action.

I am somewhat cowardly about interpreting Christmas presents at the time they are given. They often signify a defensive manoeuvre against separation anxiety. One particular patient, whose father had left the family when she was still very young and who never gave her any presents or sent her birthday cards, used always to give me two presents, and a card at the same time; and a second card was sent through the post. I was meant to be good father as well as good mother. I hope it would nowadays be possible for me to interpret along those lines, which would not have been an attacking way to do it. I should have pointed out, perhaps, that bad father-me was giving her neither card nor present, and that there was hidden attack by her, laced with irony in her giving me two of each. (How I wish that some of my early patients would come back now that I am less cowardly!)

Acting Out and Archetypal Theory

At a different point in the spectrum of talk and action lie car accidents, which obviously don't happen *in* the consulting room as did those two examples I have just given, and which are clearer instances of what is generally meant by acting out. They can be suicide threats, and on one occasion some years ago, when the accident involved no other car, I felt I needed to find that out by asking whether or not the patient was wearing his seat-belt. He was in a hyper-manic state. Acting out can precede a psychotic episode. I usually investigate the circumstances of a collision or a near-miss in order to discover whether the patient considered himself or herself attacked by the other driver (who may be standing in for me in the transference) or whether he or she was the attacker. One woman patient knocked down an elderly woman on a pedestrian crossing after a session when her ambivalence towards both her analyst and a certain member of her family had not yet become adequately conscious. There was still a great deal of analytic work to be done on a number of major difficulties in her life; they could be conceptualised in terms of the archetypal conflicts highlighted in the transference projections at various times. When she had the accident, the feature that was most prominent in the analysis was the mother and child interaction, both in the day-to-day work and at a deeper level. The fact that she hit a woman much older than herself is an illustration of that. But she also had an animus problem with me, as she was far from sure that I was — in her terms — as intelligent and powerful as her previous analyst or as herself. That was the representation in the transference of the animus and anima problem that she and her husband had: the mutually unsatisfying marriage relationship had contributed to the tension between the couple and their nearly grown-up children. She was putting into action revengeful retaliations, impulses of which the mean had not yet emerged. It is precisely in that primitive area of the psyche where lies the trouble which leads to acting out: the forces at the instinctual pole of the archetype are activated by powerful emotions, and the other pole, that of meaning, has not yet been reached.

For those not familiar with analytical psychology, I would explain that on the one hand — or at the one pole — 'the archetypes are the unconscious images of the instincts themselves, in other words ... they are patternss of instinctual behaviour' (Jung, 1936, para 91). But, at the other pole, 'instinct brings in its train archetypal contents of a spiritual nature', it 'stimulates thought' and thought activates the search for meaning. In acting out, there is too little thinking, let alone hard thinking, and too little appreciation of meaning.

The example of the driving accident illustrates potentially many features of the Jungian view of the dynamics of acting out. There is, first, that bi-polar quality of the archetype which is an extremely valuable aspect of Jungian theory when we are working with developmental issues and the need for strengthening the ego. It was shown in that instance not classically, as it were through an image or a symbol in a dream or in a fantasy, but in what the patient *did*: first she used the maternal object, the car, as a weapon with which to attack the older woman; and, secondly, she misused what should be a container or a valid protective outer shell, because she was defending herself against what would have been very painful affects if she had discovered her anger against me in the transference. Her adolescent son was being very difficult at the time, acting out instead of having verbal rows; she felt angry with her husband, who she considered had been inconsistent in his attitude to the young man; she was also angry with her mother (long dead) who she believed had given in too easily in any marital disagreement and who had never been able to criticise her husband, my patient's father — and that was one of her own problems. The impulsive or instinctual pole of the archetype was responded to, in other words the more primitive factor, or the more infantile one, the pre-symbolic forces were let loose and the meaning pole of so many archetypal affects could only emerge during the following weeks when the unfortunate accident was analysed.

The second feature of theoretical interest to the dynamics of acting out was that shadow factors were at work. Fordham, in one of the passages quoted earlier, drew attention to a possibility whereby analytical psychology could make a substantial contribution to demonstrating and understanding the subtleties of the concept. The term 'living the shadow' is a valuable one and it certainly applied to the patient about whom I have been speaking. She was obsessional in her attempts to get her behaviour to reach an impossibly high ego-ideal, which exerted a heavy-handed influence on her. She wished to see herself both as being more emancipated than her mother from a 'little woman' pattern of life, and as being her father's favourite daughter. She was envious of her husband. She feared criticism both from him (she described him as being a passive-aggressive man), and from internalised parents, with whom she had identified more than she yet realised. A 'forbidden' impulse was trying to emerge in the transference: she had been experiencing me in consciousness as likeable and very different from either her mother, her father or her husband, but from the unconscious area she was in fact striving to criticise and attack me. In the counter-transference (I realised after she had knocked down the woman), I had been slow to appreciate the urgent need for her negative criticisms to emerge: they might have taken the form of, for example, 'you are not seeing what is going on', which might have led to: 'you are like my mother who over-protected my father'. I had unconsciously colluded with her not-yet-analysed transference fantasies. For her the important shadow problem was he fear of being, and being seen to be, what both her childhood family and her present one disapproved of, namely critical of authority and power-figures. Her perfectionism got in the way of noticing and criticising my imperfections. Instead of understanding the meaning of the shadow, she was dominated by it. In the immediate events it was the personal shadow which gripped her and which prevented valid ego-development. There was also the archetypal shadow and an animus problem, the unconscious masculine element: the patterns of unintegrated potential were operating dangerously

from generation to generation. The analyst's endeavour is to see to it that they are interrupted and enabled to contribute developmentally by becoming conscious through emotional experiences in the transference. The ego is strengthened by acceptance of the shadow. But that involves pain, which she naturally wished to avoid — she was already suffering much unhappiness.

Those of us working with the concepts of analytical psychology know that 'living th shadow' may need to be worked through many times in a thorough analysis. The shadow in the form of anti-developmental and regressive forces is a deep one. It is of course linked with trickster, *puer* and *puella* problems, or (I would offer to Freudian readers) a Peter Pan complex. Representations of both the *puer* and the trickster figures may need analysing and bringint to consciousness, when there is acting out, since both of them are connected with attempts on the part of the patient to remain powerfully young in relation to the analyst or to other figures in his or her life. The appeal of the perpetual small boy kind of man, who is charming, delightful, perhaps even has a cherubic quality about him, disguised under a form which leads people to say such things as, 'he's still a boy, even at seventy' — that appeal is certainly very strong, and particularly to sentimental women. The naive woman who plays the kitten, who wins through by charm, or who pleads innocence, when unfortunately all she is innocent of is experience, and what she has refused is responsibility — she also gets what she wants, perhaps for a long time, and enjoys tricking people into credulity. The boy, the *peur* archetype, the girl, the *puella*, and the trickster who of course is always a boy at heart, are all three acting out, and they try to get the people in their lives to accept the implicit idea that they do not have to grow up, with all the loss of fun that that would involve.

The figure of the trickster is usually referred to as 'he': I have been struck by the relative paucity of examples in Jungian papers of trickster possession in women; but I find in practice that women patients whose difficulties or pathology lie in the hysteric area rather than the obsessional, and who defensively develop somatic symptoms, can be enabled gradually to accept interpretation of those symptoms (which are a form of acting out) if I bear in mind that the trickster is at work. The trickster possession acts in an attacking way against my analytic efforts, and in a self-attacking way against the patient. The attempt to seduce the analyst-father and the alternative attempt to get him to change back into being a kindly mother-analyst, who the patient hopes will be sympathetic towards her physical troubles, are ones which the analyst must understand and interpret. In the background of the somatising and hysteric manoeuvre is the oedipal confusion between the desire for the mother's continued early mothering and the other desire for a love-affair with the father. The trickster and the incest archetypes both affect the patient severely, and acting out in the form of perhaps very obstinate psycho-somatic illnesses may hold up the analysis until the transference fantasies of regression and incest have come to light and been worked through.

The trickster is always unwilling to be exposed — there is a lot of resistance against being shown up. It likes working out of reach of the adult, plotting, if it is a child-trickster, anywhere out of sight — in the bushes, or at the far end of the beach — where

small boys and girls investigate each other's genitals. It does this to retaliate against the parents who do mysterious things behind closed doors and who do not wish to be interrupted or peeped at through the keyhole. Neither tricksters nor conjurors nor spies can bear the light of day, that is to say, interpretation. The trickster-patient who acts out wants it both ways: he or she in the short run wants magically to confuse the analyst-parent, owing to the very powerful loving and attacking impulses which are operating, and which are both feared. The acting out defensively protects the patient from insight. But in the long run, or at a deeper level, the patient wants the analyst not to be trusted. The therapeutic alliance should not be understood to consist simply of positive feelings on both sides; rather it is an alliance between the patient's developmental needs and the analyst's artistic skill in fostering them. Behind the patient's childlike desire to be special, or perhaps the favourite, to be charismatic and marvellous, lies a large inflation of the self. Physical actions seem to the immature mind to be more powerful than mental or psychic ones — and, of course, they very often are, in the short term. The immediate is at the instinctive pole of the archetype, the psychic and meaningful take longer to reach.

Acting Out and the Self

A strong case can be made for analysing acting out in terms of ego-possession by the self, whether 'the self' is taken in the sense of the primal undifferentiated self of very early infancy prior to the development of the ego, or in the classic Jungian sense of the central archetype, to which Jung gave particular attention when working on individuation in the second half of life. Psychological development ahs been found by analysts of all schools, I think, to involve cyclical phases — or ones to which the image of the spiral applies perhaps even better. Acting out in one form or another occurs in most analyses, and recurs in many. At times ego, ego potential or ego features are difficult to discern: they are concealed within the postulate we name the self. The self may feel to be, or be expressed as, a very small dot, so to speak a nucleus, or it may be felt to be all-inclusive, everything. In analysis we sometimes feel that the patient 'is' a powerless baby or that he 'is' omnipotent. We ourselves as analysts may oscillate between those two extremes. Both are pre-symbolic, and they precede ambivalence. Dominance by the undifferentiated self temporarily deprives the ego of all competence. People, whether they are patients or not, whose psychic development has been excessively harassed or over-beset with difficulties, or who have suffered repeated losses, will tend to regress to states where ego functions very largely disappear. And this happens as many times as it needs working through. When there is acting out and particularly the physically dangerous kinds, the *puer, puella* or magical child has been re-absorbed by the primal self, the earlier de-integration has been negated.

The theory of de-integration in contemporary analytical psychology refers to the concept first put forward by Michael Fordham to the effect that the earliest integrated psycho-somatic state of wholeness at, and soon after, birth, which he called the primal self, spontaneously divides into parts (Fordham, 1978). The primal self is seen as containing in a state of potentiality all the necessary archetypal stages of development, including relationship to part-objects and whole objects. Instinctual activity, or de-integration, takes place, which is the beginning of ego-development. It must, of course,

not be confused with disintegration, going to pieces. De-integration is conceived as being essential for the infant to emerge from its earliest self-enclosed state.

Using the other theory, that of the self as the central archetype, it can be seen that a return to possession by an inappropriate psychic unity and by the over-powerful archetypal contents of the self is dangerous to healthy functioning. Each of us falls into possession by the self and indulges in a form of acting out when we assume , as I suppose infants implicitly do, that we will be safe in acutely dangerous situations. It is a kind of identification with immortality (Edinger 1960). It is closely allied to the loss of ego functioning which is evident at times when omnipotence is in the ascendant, which is so frequent in episodes of acting out. And that, in turn, is allied to the omniscience which almost invariably tries to postpone acceptance of interpretation of acting out. It is not just cussedness or resistence on the part of the patient: the analyist needs to undertand that there is a perhaps inevitable regression of the ego in the direction of an undifferentiated self, so that renewed painful experiences of de-integration are going to be necessary before insight is admitted.

Many analysts have noticed that instances of acting out tend to be ignored (by the patient) as soon as they are felt to be over. They are sometimes called 'attacks of acting out' and that is indeed an apt expression. Moreover, ego-development has been under attack. So has the analyst as the representative of the ego. If ego-functioning is then rapidly and defensively re-established, the patient does not want to know about the attacks and tends to be surprised or even offended if the analyst refers to them. The patient fairly naturally wants to be brought back, as it were, like a child onto the lap after he or she has had a tantrum, and for the misdeed to be forgiven. There is a diminution of the wish for insight, for elucidation and for thinking, which are all aspects of ego. It is an effort to try to examine and think through what happened. In 'psychic conflicts in a child', Jung wrote,

> I lay stress on the significance of *thinking* and the importance of concept-building for the solution of psychic conflicts ..... the initial sexual interest strives only figuratively towards an immediate sexual goal, but far more towards the development of thinking (Jung 1946, p. 4).

Two of my patients used to tell me at intervals of fearsome fights and rows, shouting and screaming, which irrupted at home, usually at week-ends, but neither of them ever screamed at me. The exciting orgiastic sexual character of the incidents was clear. Each would regress, at those times, to what was in fact a re-production or re-presentation of early infancy situations in which screaming was their only weapon of attack and defence. One of them toned down in the transference the manifestation of frustrations and used to nag, fuss and niggle in a manner that I experienced as merciless. Invariably she would leave with a little girl smile and a quiet 'thank you'. The other one for many months on end regularly used the last session in the week to go at me non-stop, trying to wear me down. While the real tantrums took place with their men and against their men, the mitigated attacks were all they could allow themselves with me, presumably because ego possession by the self could be allowed to be more extreme at home than in the transference where protection of the mother-me was essential to their survival and their development.

The two patients who attacked their men much more overtly than they went at their analyst were both prone to have phases of envying me inordinately. The acting out at home was a defence against understanding how enviable they considered my analytic work to be. In trying to reduce me to reactiveness, to irritation, to defeatism and self-reproach they were concealing from themselves the sharpness of their envious attacks. When it became possible to point that out, and to link their envy of me with childhood rivalries and with infancy attacks on the breast, the acting out diminished in intensity. It occurred less frequently when the patients had, after much working through, fully accepted the origins of their attacks. Acting out which had had a high component of aggression came to be seen as stemming also from hunger for development and understanding. That was an acceptable instinctual urge (Hubback, 1972).

Finally, where ego-possession by the self is concerned, I would draw attention to the connection between the victim-victimiser syndrome and acting out. In the transference the acting out kind of patient who feels himself to be the victim of the analyst is likely to retaliate against others in his environment: they in turn are then victimised by his not-yet analysed persecutory anxieties, which he projects. Deep affects have been activated in the transference, stemming from pre-symbolic levels of ego-development. The aggressive and destructive components of acting out have been delineated here, which situates them very early in life. The body, body-affects, pleasures and frustrations get expressed in activity and in re-enactment.

I mentioned the purposive potential that there is in acting out at the beginning of this paper when I said that probably I had, when undertaking to write it, a need to study the whole question. Rather than merely fall into the trap, to be tricked and to forget that one feature of appearing in public (and of publishing papers) is that it can represent d version of regressive childhood exhibitionism, I found when I began to reflect, to study the matter, and to put careful thought into it with a view to drawing attention to what analytical psychology has to offer on the subject, that that was ego-functioning as compared with the earlier more primitive reaction. There is a symbolic intercourse between those who ask for a professional paper and those who give one, and it is to be hoped that the concepts which emerge are legitimate offspring.

Interactions

On the whole, as was said earlier, analytical psychologists have not tackled acting out as a separate topic, and on reflection I think this may stem from the view they have that analytical psychotherapy is in its essence a matter of interaction. Jung himself felt strongly that the analyst was in the analysis as much as the patient, and even on occasion told a patient a dream he had had, thereby resolving a counter-transference/transference block in which both were stuck (Jung 1963, pp. 133, 138). I have heard recently that in Jungian circles in the U.S.A. increasing attention is being given to acting out by analysts. Even if trainee-therapists are made very anxious by open discussion of the danger of sexual acting out with patients, their anxiety has to be risked so that they can discover the dynamics of it. The trend among analytical psychologists who closely study 'the infant in the adult' has resulted in a potentially good understanding of how easily psychic interactions with the patient can be

distorted into acting out. For many years I have felt and found in practice that 'in this work [psychotherapy] actions and interactions are of even greater interest than are concepts' (Hubback 1969), and that 'the important happening in therapy is the interplay between therapist and patient, on the basis of the fact that play and interplay between the mother and the infant set the tone of his later interplay and interaction with other people' *(Ibid.)*. Those are only sketchy, outline, remarks. They could be fleshed out, on the one hand, with examples of how the analyst's unconsciousness of what is happening (the purist meaning of counter-transference) delays True Therapy, and, on the other, examples of how self-analysis during interactions which might be physical helps them to move on to becoming properly psychic: the transcendent image may be brought to life by the analyst's dream, fantasy, reverie or reflection. Then, if all goes well, there is not acting out on the part of the analyst: psychological activation and interaction develop instead. I do not think that description is unduly idealistic.

Summary

The paper outlines a Jungian view of the originally Freudian term 'acting out'. After outlining what the author owes to some of the writers who have published on the subject, and giving an example of what can be called positive or valuable acting out, she shows how archetypal theory illuminates many aspects of a patient's dangerous acting out and the analyst's part in the interaction. The two contemporary theories of the self in analytical psychology (the archetypal and classical, and the theory of the primal self) are used to show how a better understanding of acting out may be reached. It is stressed how unanalysed counter-transference can become a kind of acting out by the analyst, and an attempt is made to show how the interactions between patients and analysts are dynamic and symbolic.

REFERENCES

Boesky, D. (1982) 'Acting out: a reconsideration of the concept'. *Int. J. Psychoanal.*, 63, 1.

Edinger, E.F. (1960) 'The ego-self paradox'. *J. analyt. Psychol.* 5, 1.

Fordham, M. (1974) 'Notes on the transference' in *Technique in Jungian Analysis.* Library of Analytical Psychology.

(1978) *Jungian Psychotherapy.* Chichester: Wiley.

Freud, S. (1914) 'Remembering, repeating and working through' Standard Edition, 12. London: Hogarth Press.

Greenacre, P. (1978) 'Problems of acting out in the transference relationship'. *In a Developmental Approach to Problems of Acting out.* Ed. E. Rexford. Rev'd Edn. New York. International Universities Press.

Hubback, J. (1969) 'The symbolic attitude in psychotherapy'. *J. analyt. Psychol.*, 14, 1.

(1972) 'Envy and the shadow'. *J. analyt. Psychol.*, 17, 2.

Jung, C.G. (1936) 'The concept of the collective unconscious'. *Coll.wks.* 9, 1.

(1946) 'The symbolic attitude in psychotherapy'. *Coll.wks.* 17.

(1963) *Memories, Dreams, Reflections.* London. Collins and Routledge & Kegan Paul.

Laplanche, J., & Pontalis, J-B. (1973) *The Language of Psycho-analysis.* London: Hogarth Press

Stein, L. (1955) 'Loathsome women'. *J. analyt. Psychol.*, 1, 1.

ACTING OUT

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On initially considering the theme chosen for this conference I found myself wondering what there was that was new or original that could be said. Then I thought that that was probably not the wish nor the intention of the membership of the Association. For the choice of theme is one that invites participants to address themselves to one of the most compelling aspects of our day to day clinical experience with our patients. There is not a day, I suspect, nor even perhaps an hour that we spend with our patients in which we are not called upon to face the strong pull in them and, if we are honest, in ourselves, of the impulse to act out. It will immediately become clear that we cannot consider the concept of acting out in isolation; it must be considered in the context of the transference and then in the context of the counter-transference.

Freud described acting out as action in which the subject, in the grip of his unconscious fantasies and wishes relives these in the present *with a suggestion of immediacy* which is heightened by the refusal to recognise their source and their repetitive nature. Such action generally shows an impulsive aspect which may be relatively out of harmony with the person's usual patterns of motivation and on the whole fairly easy to isolate from the overall trends of the subject's activity. Acting out may take the form of aggressive behaviour directed at the self or others. When it occurs in the course of analysis — or a therapeutic endeavour — and whether it is in a session or not — acting out is to be understood in relation to the transference — and most often, classically, as a basic refusal to recognise the transference.

The word Freud used to denote acting out was *agieren* which I understand is not part of common German usage. He employs the word transitively — as he does *abreagieren* which has the same root; its object, that is, what is acted out, is instincts, phantasies and wishes. *Agieren* is nearly always coupled with *erinnern* — to remember — the two modes being contrasting ways of bringing the past into the present. (Laplanche and Pontalis 1973).

Freud describes the concept of acting out in his 1914 paper, Remembering, Repeating and Working Through. (Freud, Standard Edition volume XIV). He reminds us in the early part of the paper that the process of remembering the past took a very simple form in 'the old hypnotic treatments'. He then writes of 'one special class of experiences for which no memory can as a rule be discovered. These are the experiences which occurred in very early childhood and were not conscious at the time but which were subsequently understood and interpreted. One gains knowledge of these through dreams ...' He resolved to treat of these and their appearance in dreams elsewhere — it is the Wolf Man's dream at the age of four that he may have had in mind specifically, because it is likely that he was working on that material at the same time as this paper. He then returns to the second method of discharge and writes ... 'the patient does not

remember anything of what he has forgotten and repressed, but *acts it out.* He reproduces it not as a *memory* but as an *action;* he *repeats* it without, of course, knowing that he is repeating it.' Here we have the core formulation of the concept which concerns us today.

As you will probably recall, he goes on to give some telling examples — ...'the patient does not say that he remembers that he used to be defiant and critical towards his parents' authority — he behaves in that way towards the doctor. He does not *remember* how he came to a helpless and hopeless deadlock in his infantile sexual researches; but he produces a mass of confused dreams and associations, complains that he cannot succeed in anything and asserts that he is fated never to carry through what he undertakes. He does not remember having been intensely ashamed of certain sexual activities, and afraid of their being found out; but he makes it clear that he is ashamed of the treatment on which he is now embarked and tries to keep it a secret from everybody.' Freud contrasts clearly the two modes — what is not remembered is acted out and acted out immediately from the first moments of the analytic encounter, in the transference. He emphasises the note of repetition and notes that 'as long as the patient is in treatment he cannot escape from this compulsion to repeat; and in the end we understand that this in his way of remembering.'

The last statement struck me anew with its powerful sense of recognition. This is what we as therapists are engaged in — the task of recognition of the nature and extent of the manifestations of unconscious processes in patients as demonstrated by the pressure of these processes to break through in the direction of acting out rather than remembering. Freud draws our attention to the transference '... as a piece of repetition'. He warns us to be prepared that the patient yields to the compulsion to repeat which now replaces the impulsion to remember not only in his personal attitude to his doctor but also 'in every other activity and relationship which may occupy his life at the time ...' In other words he makes us fully aware that acting out is of the very essence of the analytic encounter. There is almost something rueful in his remarks that the plain setting aside of resistance in the hypnotic treatment is not available to the analyst. Instead he must deal with the viccissitudes of the transference. This may be easy enough if there is a mild positive transference but as work proceeds and an intense and hostile negative transference occurs the need for repression increases and 'remembering at once gives way to acting out'.

At this point I would like to offer an idea which we may discuss later; that the intensity of repression and the subsequent intensity of acting out may be related to the degree of hostility in turning away from the primary object. I would, for instance, link this with some of the ideas formulated by Elizabeth Zetzel in her paper 'The So-Called Good Hysteric', in which she was trying to develop criteria for analysability in patients with hysterical pathology. One of the factors to be assessed was the degree of hostility in the turning away from the maternal object — the excluding factor being that if this was assessed as being too intense, then a fruitful analytic situation was unlikely to occur because however skilled the analyst, it was anticipated that excessive acting out would put the analysis at risk. (Zetzel 1968.)

Freud evokes for us very clearly the contrast between the hypnotic technique and that of analysis — 'remembering could not but give the impression of an experiment carried out in a laboratory. Repeating, as it is induced in analysis according to the newer technique ... implies conjuring up *a real piece of life*; and for that reason it cannot always be harmless and unobjectionable ... this opens up the whole problem of what is so often unavoidable ... deterioration during treatment'. What a relief it always is, on coming back to re-read Freud, to realize that he has faced the same dilemmas and confronted the same anxieties that we encounter day by day in our clinical work. He reminds us that the patient's attitude to his illness must change under the impact of the beginning of analysis — attention is concentrated on the manifestations which may have been avoided before; the patient must hear himself in a specific way and acknowledge in the immediacy of the analytic setting the nature of the '... enemy who cannot be overcome when he is absent or not within range.' He warns that there may be a luxuriating in symptoms and that the patient's acting out outside the transference may do harm in his ordinary life or the actions may have been chosen to permanently invalidate his prospects of recovery. These signs will be familiar to us all. Freud clearly used prohibition to curb acting out. How do we view that now?

Again Freud is closely in touch with the predicament of the analyst, with the commitment, as he says, '... to leave untouched as much of the patient's personal freedom as is compatible with these restrictions ...' He then re-asserts that the main tool for curbing the patient's compulsion to repeat and for turning it into a motive for remembering is the handling of the transference. 'We render the compulsion harmless and indeed useful by giving it the right to assert itself in a definite field. We admit it into the transference as a playground in which it is allowed to expand in almost complete freedom and in which it is expected to display to us everything in the way of pathogenic instincts that is hidden in the patient's mind ...' I have quoted extensively from Freud's paper because it reminds us of his thinking and his formulation on the theme, and because he puts so vividly the essence of the predicament faced by both patient and analyst.

Sometimes a distinction is made between acting out in the transference — that is behaviour in the patient's life apart from the analysis, and that which occurs in the consulting room; the latter may be designated as 'acting in'. As far as I can understand it Freud tends to describe even transference onto the analyst as a *modality of acting out.*

It may be a current task of psycho-analytic theory to attempt to ground the distinction between transference and acting out on criteria other than technical ones. This task may well include the reformulation of such concepts as *action* and *actualization* and a fresh look at what we call acting out in terms of communication.

I would like to offer two examples of clinical material which may illuminate aspects of the theme.

Introduction to clinical examples

I would like to preface this material with a quotation from Dr Nina Coltart who spoke to the Association at your conference last year. In an as yet unpublished paper on the theme of 'Beyond Words ...' she writes, 'It is of the essence of our impossible profession that in a very singular way we do not know what we are doing.' She continues to enjoin us not to be distracted by random associations to this statement and not to decry the arduous training, the technical competence and continual self-examination of ourselves and our technique. But we should take into account the essential mystery at the heart of the work we attempt.

I find this an enormous relief. In our development as analysts and therapists we must foster the growth of our work ego. We cannot do this without acknowledging the presence of a work super-ego. It can be a tormenting structure — perhaps never more so than when we are trying to grapple with difficult acting out behaviour in a patient that we do not understand and think we 'ought' to be able to comprehend and bring within the compass of the analytic endeavour. Dr Coltart later in her paper recalls the value of being taught by Wilfred Bion with his insistence on the importance of learning to tolerate not knowing in the analytic setting. The first patient I shall describe presents me with this situation in a particular way; the second presents a different dilemma.

Patient 1

The first patient is a woman of 43 who has been in analysis for some two years. If I were to give her a diagnostic category I would say she was a depressive, with some hysterical features — but that peculiar kind of depressive, the smiling depressive. She has the great misfortune, for her, to have been born wealthy and never to have had to earn her living — although she has trained for a profession comparatively late in life and exercises it from time to time in a somewhat desultory way. That she is talented and able in her profession and capable of much more than she has so far achieved, there can be no doubt; there is something deeply pathological about her lack of will to actualize her potential in this, as in many other aspects of her life. My first response to her, which I shared with her at our first meeting, was that she does not take herself seriously; I wondered with her whether anyone had ever taken her seriously and said that I thought she was seeking analysis to try to find out if she could take herself seriously with the help of someone who would so regard her and the analytic enterprise she would engage in. Amnesia is a pronounced feature in her; the d ay to day continuity of her sessions, now after some two years, begins to have some coherence for her; for a long time it did not. She still barely knows what day it is. The material she brings is full of events, people, patterns of relationships, masses of names and 'stories' — she has a wide network of friends and acquaintances — I am sorely taxed to remember. I am asked to find meaning in this frequently rambling discourse. The patient has had a lot of experiences — in an external sense she has a rich and interesting life — but in a profound sense her experience is not located in her; somehow it has not been lived by her, has not become rooted in her, has no settled meaning for her and therefore is barely memorable for her. With such a dearth of meaning to her self experience she compels others to provide the meaning.

On returning from a break the patient brought a dream — she read it from a piece of paper and it was clear it had been dreamt some time ago — she had forgotten the significance of it and barely recognised it as hers. I found myself scarcely able to attend to the dream and certainly unable to distinguish elements in it — I felt I was being presented with something unanalysable and attempted nothing with it except to note to myself the hostility contained in this opening move in the session and to wait. It was not a long wait. She produced from her handbag an invitation to a large party she was to give to celebrate her birthday and this she gave to me, remarking that she thought perhaps I would not come, as analysts, she knew, usually did not do things like that, nevertheless she would like me to come. She continued that it would be interesting for me to meet her circle and it would make things easier for me if I had faces to attach to the names of people she mentioned. It would also be interesting for her to know how I responded to her friends, her family and her lover. In this and several subsequent sessions we explored the following themes: her wish to move me from the analytic setting with its task of concentration on her inner world and her understanding of it, to her external world, with the aim of getting me to experience the world directly rather than through her experience of it — and to deflect us both from the task of understanding. I related it to an attempt on her part to test out how seriously I took the analytic task — and whether, perhaps under pressure of my own wish to enjoy her party, or feelings of guilt about what might be construed as a rejection — I could be persuaded that the central task was not important enough. The whole issue of how seriously I took her need for analysis — when she was quite clearly prepared to jeopardize it — was explored by us in great detail. It was an illuminating time in the work. The patient felt she gained some useful insights about herself, for this was the latest in a series of attempts to deflect herself and me from the analytic task and one which involved me more directly than had previous ones. Primarily as a result of the work we did she realized that her analysis was important to me and that it was just possible that it was becoming important to her.

Patient 2

This material comes from the last year of the analysis of a woman in her mid thirties. What is significant to know about her was that she was born during the last war while her father was abroad in the army; he was killed and never saw her — she of course never saw him. We knew that her mother was living alone with her then eighteen month old baby at the time she received news of the father's death. We knew — as information — that the mother remained alone for some ten days before she contacted her family who then came to collect her with her baby and took the two of them to join the family. The young mother was distracted and emotionally disintegrated — a state from which it might be said she never really fully emerged. What we never really knew until the period in the analysis I am going to describe is what happened psychically in the 'lost' ten days to the distracted mother and her baby.

Although a lot of productive work had been done in this analysis the patient had the feeling that there was something that could not be changed or resolved. It was to do with self-experience and was not primarily to do with object relating. We were both

aware that something had not happened in the analysis and were perhaps reaching a point of resignation, while working through the termination phase, that whatever it was may not be going to happen.

However, this highly motivated and usually co-operative patient began to miss sessions without phoning me. When she re-appeared she said she did not want to come. She was irritable and fed up with the work — I was seeing this as perhaps predictable responses to the termination phase. But then there was a change. The patient came to her sessions and sat mute, for the entire session. I say mute rather than silent to try to convey the intense quality of the experience and its impact upon me. This was much more than a kind of resistance. It lasted over five weeks. After some interpretations about anger or withdrawal from the analysis — I stopped interpreting anything unles it was soundly based on a conviction, from counter-transference sources and a kind of reverie I found myself entering in her presence, that I had something to contribute. I found myself deeply attentive to her posture and expressions and movements. She was very still. Apart from walking into and out of the session she moved rarely and when she did so it was clearly with great and painful effort. She was gradually able to let me know that what was happening to her was confined to the sessions and that she could continue her ordinary life outside, not without some difficulty. I was relieved at this and grateful that she was able to let me know. She was able to communicate that she wanted me to go on doing what I was doing and that it was extremely important that I should not change anything. I had, for instance, over a Bank Holiday extended weekend offered her a session on her normal day; she thanked me but wanted to keep things as they would be normally.

One day when we were together in a session in this deeply silent state — I noticed that her eyes wandered about the room, that she looked at the floor, the ceiling, objects in the room, the window behind my chair, but she never looked at me. I was present but utterly unseen. It was then that I became convinced that she was experiencing in the analysis a recreation of her experience of the 'lost' ten days, with her mother. I realised that at that moment I was the unseen baby — unseen because of the mother's profoundly withdrawn state. From time to time tears would pour down her cheeks. Gradually I understood that she could hear me and eventually she became able to speak more so that we could exchange words about what was being experienced by both of us. At times she was herself — the baby — and at times she was the mother. Perhaps it is enough to say that with her eventual emergence from this state we were able to continue and reach termination of the analysis with some sense that something fundamental which had been missing had been brought within the compass of experiencing and remembering.

Associating from the last fragment — a patient whose life and psychic development were profoundly affected by the last war, I note that we meet today on Septem ber 24th. On September 23rd 1939 Freud died here in London. W.H. Auden wrote a poem *In Memory of Sigmund Freud* and in concluding I would like to quote part of it. I find the whole poem moving but this section especially refers in poetic form to the theme of today's discussions.

All that he did was to remember
Like the old and be honest like children.
He wasn't clever at all; he merely told
The unhappy President to recite the Past
    Like a poetry lesson till sooner
    Or later is faltered at the line where
Long ago the accusations had begun,
And suddenly knew by whom it had been judged,
How rich life had been and how silly,
And was life-forgiven and more humble.

REFERENCES

Auden, W.H. (1958) *Selected Poems.* Penguin Books in Association with Faber and Faber.

Freud, S. (1914) 'Remembering, Repeating and Working Through'. *Standard Edition, 14.* London: Hogarth Press.

Laplanche, J. & Pontalis, J-B. (1973) *The Language of Psycho-Analysis.* London: Hogarth Press.

Zetzel, E. (1968) 'The So-Called Good Hysteric'. In *The Capacity for E motional Growth.* London: Hogarth Press.

REFLECTIONS ON ABORTION AS ACTING OUT

Susan Fisher

My involvement during the past five years with over 1,000 women with unwanted pregnancies, as an abortion counsellor, has led me to believe that one of the major forces behind abortion is the unconscious desire for separation-individuation.

Introduction

The initiative for writing this paper came from interviewing Ann, a child-like, chaotic, unmarried, 40 year old university graduate who was living on social security while studying to be a portrait painter. In an affectless voice she told me that this would be her fifteenth termination of pregnancy, commenting, "fifteen is not really many in 23 years". When she informed me that she would not be needing a follow up appointment, I felt frustrated, angry and impotent. I felt as if I were with a frightened, vulnerable child, unable to accept help. She went on to tell me about looking after the 27 year old putative father (psychiatric patients), described as "a bit alcoholic", and her 14 year old son, (child guidance patient) described as, "a bright, withdrawn, sensitive boy", who is very dependent on her. The patient seemed to be compulsively giving the mothering which she so desperately wanted but could not allow herself to accept — the kind of woman who acts as if she expects nothing and wants nothing.

From the time I began seeing abortion patients in 1979, until I left my hospital social work post at the end of 1983, I interviewed well over 1,000 women with unwanted pregnancies. Each had a unique story to tell, yet there were familiar strands in their stories. I distinctly remember Barbara, an attractive, child-woman, 27 year old secretary, whom I met four years ago. She came to me with a history of three previous therapeutic abortions, a first suicide attempt at the age of 15 — a most recent one only six weeks earlier. She had over-dosed at least once every two years and had in-patient psychiatric treatment for anorexia nervosa and depression. At the time, I recall thinking "What is she trying to do or say?" "What is she trying to abort?" "Why does she have to keep repeating it?".

Now after four years, having reached what has been described as "an advanced stage of muddle", I will attempt to answer this question. Despite uncertainty and doubt, I will try to bring together my knowledge and experiences as a social worker and as a psychotherapist, with my personal analysis and life struggles as my daughter's mother and my mother's daughter.

Several years ago my intuition and clinical observations led me to wonder if therapeutic abortions are as much related to the struggle of women to separate from mother, as to the relationship with the sexual partner or to contraceptive failure. That is, any relationship with the putative father/husband seems to also be a reflection of the mother-daughter relationship (i.e. Do women marry their mothers as often as their fathers?). Now, at a time when abortions and contraception are both more readily

available than ever before, there appears to be an increase in the number of women having more than one termination of pregnancy. Although, I accept that there are genuine contraception failures and mistakes, I feel that we should try to understand and deal with the motivations behind abortion, since society pays dearly in physical and emotional suffering, as well as financial and practical strain on medical resources.

Notes on Acting Out

The idea of acting out is a helpful concept in formulating hypotheses on termination of pregnancy. I will refer to papers by Judith Hubback (1984) and Mary Twyman (1984) published in this bulletin. A 1973 study of pregnant adolescents showed that "fifteen per cent of the group were clearly suffering from severe acting out character disorder" (Kane et al, 1973). Schmidt & Priest (1981) found many of the women in their study were acting out "difficulties in their family of origin" by unwanted pregnancies. I see some therapeutic abortions as an unconscious attempt to touch, re-enact and repair early emotional damage in order to proceed in the process of separation-individuation. At the pre-verbal stage of development, where the original failure occurs, action is the only means of communicating feelings. These women with unwanted pregnancies are not able to symbolize, fantasize or verbalize their unconscious conflicts (i.e. progress vs. regression, creativity vs. destruction, fusion vs. separateness), so they act them out.

Maturation Process

Even though many who read this paper will be familiar with developmental theory, I am including it as a basis for discussion.

Absolute Dependency Attachment

'Oneness' describes what others have called primary relationship, infant-maternal care unit, states of fusion, mother-infant dyad, symbiotic relationship, and dual unity. Winnicott (1963) calls the mother's attitude towards her infant "primary maternal preoccupation" because, "she is preoccupied with (or better, given over to) to the care of the baby which at first seems like a part of herself". The infant is the centre of her world and vice versa. There is absolute dependency on mother to satisfy physical and emotional needs and to relieve tensions. The infant has no control over the care provided — it seems to happen magically.

This state cannot be taken for granted and it is not certain that mothers can succeed in mending the early distortion (Winnicott, 1956). According to Winnicott, excessive failure produces reactions which lead to threat of annihilation — a primary anxiety. According to Klein (1945), "the girl's main anxiety situation is loss of love". Without love she is exposed to distressing fears and tensions.

Partial Dependency

The infant gradually begins to develop a personal identity and differentiate-out from the primary relationship. This is 'twoness'. The infant discovers 'me' and 'not me', becomes aware of its need for care and expresses an active interest in its body and objects in the outside world. If all goes well, the infant uses its aggressive feelings to cry or protest, bringing the cuddles, food or warmth needed to satisfy its frustrations.

According to Fisher & Cleveland (1958), "parental attitudes towards him (infant) are expressed in how they go about satisfying his hunger sensations, how they pick him up, and handle him and how they regulate such body processes as excretion and defaecation". The "how" refers to the quality of touch and look in the eyes which register as body sensations which will be left. If the infant's interaction with the environment is meaningful, clear cut and predictable, it internalises a well defined body image with boundaries. A 'good enough' environment is one in which there are not a disturbing number of interruptions or intrusions on the infant so it can get on with the business of becoming a person in its own right rather than having to continually react and adapt to the environment.

On the other hand, if the environment is unreliable, erratic, inconsistent because of immaturity, ill health (narcissistic damage, depression, anxiety) or stress, the infant's boundaries are ill defined and fluid. Care may be incorrectly timed, over stimulating or merely un-understanding or indifferent. A rejecting or witholding environment deprives the infant of the pleasure of its body in the close physical intimacy of a mother-child relationship. If care is provided automatically, before the infant feels the frustration, the pleasure of satisfying its own needs is taken away. A possessive mother usurps an infant's body pleasure for her own pleasure and satisfaction.

When the infant finds that the environment cannot adapt to its needs, it may try to hide feelings away and to adjust to the environment. It is not appropriate in this paper to discuss, at length, the states of withdrawal and disassociation of body from emotions. This topic is widely covered in the literature about narcissistic personal disorder, borderline personalities, and schizoid personality disorder. The feelings which might be hidden away include infantile omnipotent rage, fear, weakness, anxiety, shame, sexual excitement and guilt. In order to protect potentially destructive or shamefully weak aspects of the self, the body forms a protective barrier. It may become like an inanimate object (e.g. a robot, puppet, doll, clown).

It is the doll image as a protective barrier, which seems particularly prevalent in women with unwanted pregnanciess. Carol, a 16 year old school girl who was first referred to me for depression following her second abortion, reminded me of a 'Cindy' doll. When I met her I had the feeling that she was an empty shell who had been meticulously dressed and groomed by a mother playing dolls.

Dr. Alexander Lowen (1969) describes the doll image at some length. They present as child-women or doll-like women, unreal and lacking in human warmth. They are like play things, helpless, pretty, asexual objects. They may become dolls to protect themselves from the anger, sexual excitement and guilt which is aroused by unconsciously seductive or overly stimulating handling. A parent can take advantage of the infant's need for closeness and warmth to obtain unconscious sexual excitement for itself. Infants enjoy touching and being touched, holding and being held. The dilemma is that, in order to receive the love and approval the infant longs for, she must split off her body from her feelings, relinquish the right to protest and be self-assertive. It is a great sacrifice. Her body is given to the environment and her feelings are hidden deep inside her.

Towards Independence

If the environment has been 'good enough' the infant develops feelings of security along with trust that its needs can be met in continuing care. Then, gradually, the child moves out of the pre-verbal phase (from which acting out originates) into verbal communication which includes intellectual understanding, fantasy, symbolisation and reality testing. It is a shift from the 'twoness' to 'threeness', so the infant's father becomes an important person.

For girls, father can become an 'other' who provides boundaries, and 'otherness' based on sexual difference. Fathers go away and come back. Ross (1979) noted that fathers play with their infants by tossing them in the air, romping and rough housing, which helps to "intensify body eroticism, enhance the child's sense of body self and encourage the exploration of space". Games like hide-and-seek, peek-a-boo are used to practice short periods of separateness. Loved ones and objects are lost and regained, thrown away and recovered. In a healthy environment the child, in fantasy and reality, pushes the parents apart and pulls them together again, including and excluding himself.

The father is important, not only as the 'other' but also as part of the union with mother. If the father is available to support and satisfy the mother, the child feels supported by their union. Content in knowing that they can satisfy each other, the child has the freedom and space to grow and develop at his own pace.

The 'missing father' and the deprivation he causes are discussed by Seligman (1982). These fathers are experienced as 'unavailable' although they may be physically present. They may either be excluded because of unconscious collusion between mother and child to maintain their mutually satisfying 'oneness', or they may exclude themselves because of their own temperament and needs. Often both factors may be relevant. Without the help of father as the third person in the separation process, generational and gender boundaries may be blurred. Carvalho (1982) points out "the father's absence results not only in the fact that the objects and part objects available for self representation are fused and confused, but also in the fact that the onus for differentiation from the mother lies with the infant".

A study showed that women with abortions are significantly more likely,than control subjects, to recall that their parents were not affectionate, were in fact hostile towards each other (Abernethy, 1973). They found that in early childhood the mother was the favoured parent but that this closeness was then followed by alienation. They conclude that "insufficiency of mothering now seems to go beyond failure to provide an estimable role model and propels the girl into a consciously sympathetic alliance with her father, whom she sees as a fellow victim and who may be functionally impared by passivity or alcoholism". In my clinical experience it is not unusual for women to speak about the 'special' relationship with a violent or alcoholic father and their hostility towards mother. Mothers, within the marriage, are often perceived as non-sexual, unloved, unloving partners.

What is she trying to do or say?
What is the unconscious message being acted out?

Some women with unwanted pregnancies seem to be saying, "Here I am!", "Please see me as the person I am in the process of becoming!". Mary Twyman (1984) uses clinical examples to illustrate acting out in terms of communication and Judith Hubback (1984) refers to the purposive aspect of acting out. Patients who seek abortion can also be described as 'play acting'. They rehearse in the outer world, tasks which need to be performed in the inner world. These tasks are intitially to integrate positive maternal aspects of their emotionally damaged mother, then to integrate the authority, love and intellect of their 'missing' father and last to unite the parents in a 'good enough' marriage — freeing the person to become a woman in her own right.

It is a conjecture that the action of terminating a pregnancy can be a 'rite-de-passage' which has a healing, therapeutic effect. One can think of it as a transformation rite from childhood to adulthood, or a move from absolute dependency towards independence, or simply a change from one self-image to another, Jung (1969) wrote "A further form of transformation is achieved through a rite, used directly for this purpose. Instead of the transformation experience coming to one through participation in the rite, the rite is used for the express purpose of effecting the transformation ..... the renewal must 'happen' to him from outside ..... the event then naturally remains 'outside' like a ritual action performed by others". What I think of as the 'abortion ritual' is performed within the established medical structure. It will be useful to describe a scenario of a 'good enough abortion ritual'. I begin with a quotation by Dinora Pines about pregnancy in adolescent girls which I believe applies to many abortion patients. "In these girls, the body is used in the search for an object which is never found in actual experience and contained an underlined fantasy of being looked after, cuddled and fed. Genital sexuality is the price they pay for it and it seems fairly obvious that these girls do not enjoy being penetrated but have tremendous pleasure in foreplay where pre-genital, infantile experiences can be revived" (Pines, 1972). Often, even mature intelligent women are surprised or shocked to find themselves pregnant since they only wanted to be cuddled. They act as if they were not present at the conception and in one sense they were not.

In my clinical work many women have confirmed Pines's statement. Doris, a 21 year old Asian woman, contacted me after her second abortion, complaining that she found penetration painful and unpleasant. Her partner was a maternal 44 year old, black American social worker who was having great difficulty dealing with his frustrations and her inability to enjoy genital sex.

Confirmation of having a fertilised egg, a foetus inside a woman, gives undeniable proof of her fertility and femininity — she takes pleasure in identifying with her mother's life giving body and her separateness from mother. Weight increase, swollen breasts, as well as vomiting, tiredness and nausea, bring reality into her changing body image and feelings of 'womanliness'. The woman is physically examined and emotionally related to by doctors ('good enough' father figures), nurses and social workers ('good enough' mother figures) in an understanding, benign atmosphere. They say to her, directly or indirectly, "it is your choice, it is your body". They offer her authority and freedom of choice. She struggles to work through ambivalent feelings, to reflect on her past, and to evaluate her present external circumstances. In the ritual the woman decides to terminate the pregnancy and suitable arrangements are made in advance, so that she will know what to expect and the attendant risks. Patients are admitted as day-care cases or spend one or two nights in hospital. In-patient treatment gives the woman a temporary sanction to regress in a caring, safe environment. She is respectfully and reliably handled with tenderness and confidence by surrogate parents (doctors and nurses) who unite to satisfy her needs. The patient has an opportunity to move freely between being a baby or a mother, being an adult or a child, being creative or destructive. Many aspects of her personality are reflected in the friendly, accepting faces of the hospital staff — she can begin to experience herself as a whole person.

She is taken to the operating theatre, given an injection which makes her lose consciousness, the uterus is aspirated, she wakes up feeling empty and uncomfortable so goes to sleep. Once she feels strong and adult enough, she gets out of bed, stands up, puts on her clothes and goes back into the outside world. It is a bit like going through a hurricane, or any other traumatic experience. No matter what has happened, she can never be the same person that she was before the pregnancy. One can either be strengthened by the experience of surviving, or can be frightened back into a situation where one wants to hide forever (i.e. progress or regress).

There are a few studies on the outcome of abortion. A 1974 report says several studies "have shown that abortion is generally therapeutic in many cases ..... have found a general promotion of maturational processes following abortion" (Friedman et al. 1974). A follow up study (Schmidt and Priest, 1981) concluded that abortion did not always have an adverse, psychological effect on women's lives but, that frequently, it gave them an opportunity to think through problems and conflicts for the first time. They cite one woman for whom the care and support of nurses and doctors appeared to renew her faith in the possibility of a caring environment. This supports my thesis that there is transformation and healing in the 'abortion ritual'. In-patient care can be equated to holding during partial dependency. If it is a positive experience (i.e. goes well) the woman will be able to move forward towards independence. If it fails (either

because holding was not 'good enough' or because the original failure was too emotionally damaging) she may need to regress back to absolute dependency.

Schaffer & Pine (1972) studied twenty four pregnant adolescents seeking therapeutic abortion with respect to how they handled the conflict between 'being mothered' and 'being a mother'. A 'regressive resolution' group of girls involved their mothers in the decision, arrangements, took a passive infantile position, and seemed to long for 'the mother-of-infancy'. At the other extreme, a 'progressive resolution' group did not involve their mothers, used the abortion to identify more strongly with the maternal role and gain a "new and important sense of mastery of both their bodies and the external world". There were other girls in the midway position. Schaffer & Pine point out that the movement back and forth, between identification with the mother and the mothered is the "essence of doll play". It seems to me that the pregnant women are acting out the doll role which they took on in infancy as a defence against overwhelming fear of annihilation and anxiety about loss of love. They neither take on the role of a real mother, nor allow themselves to be a real infant, but 'play at' finding a safe position between.

Clinical Material

Barbara, the 27 year old secretary mentioned earlier who was having her fourth abortion, had a glamorous actor father living in New Zealand. Her mother worked in London and commuted daily from the country. Her parents married when Barbara was expected and separated when she was 16. A pretty only child, Barbara was over-indulged by her parents. From what she said, her father related to her in an intensely flirtatious seductive manner. At the same time, he was experienced as rejecting. He probably felt incestuous longings and sexual guilt, so kept Barbara at a distance. She clung tenaciously to her over-protective, martyred mother. Following Barbara's fourth abortion, her father returned from New Zealand for a Christmas visit with mother and daughter. Barbara was able to make up for what she had missed in childhood by pushing them together, pulling them apart again, excluding and including herself. It was an especially significant time because on Christmas Day, 11 years earlier, her father had announced his departure for New Zealand. Following a contract of brief psychotherapy, father left, Barbara took a job in France, and she and her mother made conscious efforts to live separate, satisfying lives.

Carol, the 16 year old 'Cindy doll' was also a spoilt but rejected only child. She felt close to her professional father but they rarely spoke. Her father apparently related in a quietly seductive/rejecting manner. Carol felt unwanted and unloved by her bossy, intrusive, professional mother, although she believed that her mother had wanted her as a baby. Carol felt responsible for her parents unhappy union — they were not married. Carol's father left his wife and three children after Carol was conceived. One year after ending our sessions for depression (related to her first two abortions), I interviewed Carol at the district service before her third abortion. The third time she was making her own decision. The first two private abortions were organised by her mother against Carol's will. At the time of the third abortion, Carol's father had decided to live alone on the opposite side of London; he and Carol were relating more

honestly and affectionately with the prospect of a moe comfortable distance between them. Following the third abortion, Carol took a satisfying secretarial post in her mother's law office and broke up with the 17 year old black, putative father she had been with for four years.

What is being Aborted?

The unseen foetus carries projections of both the internalised, negative aspects of mother, the helpless and aggressive infantile parts of the self and also the negative aspects (i.e. engulfment and suffocation) of 'oneness'. Pines (1972) puts it another way. She says in pregnancy, "childhood sexual theory combines with conscious and unonscious fantasies such as those where the foetus is represented as a devouring, destructive creature within the maternal body. Later, anal childhood sexual theories are revived in the form of the foetus being something dirty and shameful that the mother needs to expel".

During interviews with pregnant women, they sometimes refer to the foetus as a "monster". I have noticed that a high percentage of these women's partners are of an age, race, colour, religion or nationality which they believe to be unacceptable to their parents. One could speculate that aborting a 'foreign foetus is an unconscious attempt to gain approval and a state of 'oneness' with mother. Perhaps these women are also trying to identify with their mothers (and avoid envy) by having an 'inferior' partner.

As a result of inadequate environment (particularly inadequate mothering) an infant becomes increasingly aware of smallness, weakness and helplessness. Gradually the child grows to feel that it is too frightening to be weak and helpless in an unfriendly world where your needs make your dependent. It grows up feeling contempt and hatred for weakness and neediness. It models its attitude of intolerance and rejection of weakness and neediness on parental attitudes (Guntrip, 1960). Abortion can be seen as a direct attack on the hated, feared 'cry-baby' part of the self and the mother, and on their stifling union in an attempt to make separation and individuation possible.

Why does she need to repeat it?

If a woman is at a developmental point where she is ready and able to integrate 'good enough' holding experiences of the 'abortion ritual' perhaps she can move forward toward independence, and if she is not at that stage the ritual will need to be repeated. I believe that it will not only depend upon the patient's emotional maturity but also her parent's maturity (i.e. her ability to tolerate and relate to changes in her daughter). Hubback (1984) notes in her discussion of the shadow aspects of acting out, "the patterns of unintegrated potential were operating dangerously from generation to generation which could only be interpreted and enabled to contribute developmentally, if they became conscious through emotional experiences in the transference". If we accept abortion as a 'rite-de-passage', perhaps action rather than transference can facilitate change. What the patients need are parents who will welcome them without undue anger or envy, as mature, sexual, independent people.

However, this may not be possible because of the mother's envy of her daughter's sexuality and freedom or the mother's fear of abandonment. Pines (1982) states "it follows that a mother who is not satisfied with herself as a woman and who cannot accept the father as a man, has difficulty in separating from the child in whom she hopes to find all that she herself missed and through whom she wants to live again".

Twyman (1984) points out that the greater the resistance (to remembering painful experiences) the more intensely will be the acting-out (repetition). Push-pull, in out, peek-a-boo actions are means of testing out and acting out independence. It is rather like the toddler who darts away in order to be rescued by mother. The 'abortion ritual' is a means of renegotiating boundaries and distance between mother and daughter which produce intolerable anxiety or fear of annihilation. The conflictual wish for and fear of love and the fear of annihilation needs to be contained. The abortion patient may be immobilised in her push towards independence by feelings of guilt, regret and shame at not being able to satisfy her parents' wishes as well as her own. If she can accept her parents as 'good enough' and capable of satisfying themselves, perhaps she will be free enough to make a real choice about becoming a mother in the future.

There is a distinction between a woman wishing to become pregnant and wishing to become the mother to a live child. In order to continue a pregnancy, there probably must be enough maturity and basic security to allow trust in the possibility tha there will be continuing care and needs can be met. "Basic and underlying the various potential hinderances to the creative process, is the capacity to trust". "There must be some trust that there is an inner world and this world is neither empty nor sterile" (Gordon, 1978). The 'abortion ritual' may need to be repeated until the women can trust that there are 'good enough' internalised parents united in a satisfying, creative union.

Ann, the 40 year old woman who had 15 abortions, did not seem to have any 'good enough' internal objects. Ann spoke only of a "wicked step mother" who "mistreated" her. There appeared to be within Ann, a deep compulsive need to destroy any creative achievement or connectiveness. She had not only aborted pregnancies, she had aborted numerous relationships, jobs and attempts of help.

Summary and Concluding Remarks

This paper has dealt with therapeutic abortion as acting out in the general framework of separation — individuation, and suggest tentative answers to three questions:

- What is she trying to say or do?
- What is being aborted?
- Why does she need to repeat it?

It is hypothesised that patients act out the wish for and fear of separating from mother and becoming women in their own right. The task is first to integrate the positive material aspects of a negative mother, second to integrate the love, authority and

intellect of the 'missing father' and third to bring the parents together. There is a deeply unconscious desire to get 'un-stuck' and get on with life but they are fixated on mother. I discuss what I call the 'abortion ritual' as a 'rite-de-passage' used to promote healing and progress.

It is my belief that the unseen foetus which is aborted represents negative, potential damaging aspects of both the mother and the infant self (i.e. weakness, neediness, aggression and sexual guilt etc.). Abortion is also an unconscious attempt to reject the mutually satisfying dependency which is seen as destructively impairing the development process. It is my impression that abortions are repeated because of either failure of the patient and/or her mother to tolerate separation due to immaturity or ill health, failure to find the 'missing father', or failure to relinquish the longing for 'oneness' which was never attained in real life.

As I conclude this paper I am left with many uncertainties and unanswered questions. I would like to know more about the sado-masochistic elements of abortion, the links to child abuse, attempted suicide and the relationship to the women's liberation movement. Germaine Greer (1984) claims, "the whole world is involved in an orgy of cutting and burning reproductive tissues".

Most of all I wonder about the unseen wounds inflicted on individuals by ambivalent mothers who continued their pregnancies but are never able to relate to, or love their child. We must try to help women become more conscious of what is being acted out. We must assume that all unwanted pregnancies are a life crisis which need to be taken seriously.

We should seek to improve our methods of relating to, handling and holding these pregnant women. In abortion counselling and hospital care we should strive to be warm, predictable, understanding, consistent, reliable, sensitive and adaptable. As workers we need to integrate rather than defensively act out the feelings of impotence, frustration, anger and guilt stirred up by these patients.

REFERENCES

Abernethy, V. 'The Abortion Constellation: Early History and Present Relationships'. *Archives of General Psychiatry,* Vol 29(3) 346-350.

Carvalho, R.R.N. (1982) Parental Deprivation in Relation to Narcissistic Damage. *J. Analyt. Psychol.,* 27(4), 341-356.

Fisher, S. & Cleveland, S.E. (1958) *Body Image and Personality.* Princeton, N.J., D Van Nostrand Comp., Inc.

Friedman, C.M., Greenspan, R., Mittleman, F. (1974) The Decision-Making Process and Outcome of Therapeutic Abortion. *American Journal of Psychiatry,* Vol 131(12) 1332-1337.

Gordon, R. (1978) 'Dying and Creating: A Search for Meaning'. London: *The Library of Analytical Psychology Ltd.*

Greer, G. (1948) *Sex and Destiny: The Politics of Human Fertility.* London: Secker and Warburg.

Guntrip, H. (1960) *Resistance, the Self-induced Blockage of Psychotherapy in Schizoid Phenomena, Object Relations and the Self.* London: Hogarth Press.

Hubback, J. (1984) 'Acting Out'. *BAP Bulletin No 15.*

Jung, C.G. (1969) 'The Archetypes and the Collective Unconscious'. *Coll. wks.* 9, 1. London: Routledge & Kegan Paul, Ltd.

Kane, F., Lachenbruch, P. Lipton, M. Baram, D. (1973) 'Motivational Factors in Abortion Patients'. *American Journal of Psychiatry.* Vol 130(3), 290-293.

Klein, M. (1945) 'The Oedipus Complex in the Light of Early Anxiety'. In *Love, Guilt and Reparation.* London: Hogarth Press.

Lowen, A. (1969) *The Betrayal of The Body.* New York: Macmillan Publishing Co. Inc.

Pines, D. (1972) 'Pregnancy and Motherhood: interaction between fantasy and reality'. *Br. J. Med. Psychol.*, 45, 333-343.

(1982) 'The Relevance of Early Psychic Development to Pregnancy and Abortion'. *Int. J. Psycho-Anal.*, 63(3) 311-319.

Ross, M. (1979) 'Fathering: A review of some psycho-analytic contributions on paternity'. *Int. J. Psycho-Anal.*, 60, 317-327.

Schaffer, C., Pine, F. (1972) 'Pregnancy, Abortion and the Developmental Tasks of Adolescence'. *Journal of American Academy of Child Psychiatry.* Vol 11(3) 511-536.

Schmidt, R., (1981) 'The Effects of Termination of Pregnancy: A Follow-Up Study of Psychiatric Referrals'. *Brit. J. Med. Psychol.* Vol 54(3) 267-276.

Seligman, E. (1982) 'The Half-Alive Ones'. *J. Analyt. Psychol.* 27(1) 1-20.

Twyman, M. (1984) 'Acting Out'. *BAP Bulletin No. 15.*

Winnicott, D.W. (1956) 'Primary Maternal Preoccupation in *Through Paediatrics to Psycho-Analysis.* London: Hogarth Press.

(1963) 'From Dependency towards Independence'. *In The Maturational Processes and the Facilitating Environment.* London: Hogarth Press.

SCREEN MEMORIES: ANALYSIS AND CREATIVE USE DURING PSYCHO-ANALYTIC TREATMENT

Margret Tonnesmann

From the beginning of his psycho-analytic investigations, Freud has repeatedly drawn attention to the paradox that our earliest impressions have a decisive influence on our whole life but that at the same time they are not available to us. We do not remember our earliest and early childhood. At best we may remember condensed, distorted and displaced substitutes of such impressions. Freud maintained that at the beginning of latency when the oedipal—phallic phase has declined, a barrier is created of repression and counter-cathexis to which he attributed infantile amnesia. Freud, however, also thought that all childhood impressions stay alive in the unconscius and could potentially be reconstructed during analytic treatment from the substitutes which our patients communicate to us when memories come to their mind or from the dreams they report. In other words, our patients' communications are *always veiled* in their unconscious aspects and we continuously strive to understand the latent content covered by it. I have often observed when teaching that understanding the latent content which is hidden by the manifest communication, the dynanic forces which deny reality and substitute it by phantasy, distort reality perceptions or displace objects, presents the most difficult learning task when trying to evaluate transference and counter-transference phenomena.

Ernest Kris (1956a) has pointed out that we can only construct for patients a biographical picture of a special kind, one which would not satisfy any requirements of the ordinary historical biographer. The biography we deal with is the one of psychic reality. Freud says in his Leonardo paper (1910) that '..... the memories man has of his childhood, correspond as far as their origins and reliability are concerned, to the history of the nation's earliest days, which was compiled later and for tendentious reasons.' He conceives of the origins of historical writings as having '..... cast a glance back to the past, gathered traditions and legends, interpreted the traces of antiquity that survived in customs and usages, and in this way created a history of the past. It was inevitable that this early history should have been an expression of present beliefs and wishes rather than a true picture of the past; for many things had been dropped from the nation's memory, while others were distorted, and some remains of the past were given a wrong interpretation in order to fit in with contemporary ideas. Moreover, people's motive for writing history was not objective curiosity, but a desire to influence their contemporaries, to encourage and inspire them, or to hold a mirror up before them.'

Ernest Kris (1956a) in his paper 'On Childhood Memories' has shown how maturational processes of libido and ego development influence and change the child's memories. He refers there to a longitudinal study of some nursery children and reports how a little girl exposed to several successive traumata of separation and loss at the age of two reported these events over the next two years condensed and falsified by the

dominant libidinal and ego developmental stages. At the age of four she told her nursery teacher about the loss of her favourite dog and when she was asked whether she could remember it, she said 'Yes, that was when I wanted to put my face into a bucket of water'. Kris suggests she had by then displaced her tears into the external reality, and he then asks the question what an analyst would reconstruct if this girl would seek psycho-analytic treatment as an adult.

Freud has repeatedly viewed all spontaneous childhood memories as cover memories because of their distortions by primary process. But he has delineated also a special category of memories as 'screen memories' in the narrow sense. These are characterized by their visual, luminous and plastic quality and the visual self-representation as a child within a childhood scene. Such screen memories cover the repressed memory either by temporal displacement on to earlier or later times or by displacing the offensive, often traumatic experience, on to trivial impressions which are perceived simultaneously. Greenacre (1949) has drawn attention to the healthy child's ability to substitute one reality for another one by denial, the normal ego — mechanism of childhood and Greenson (1956) has drawn attention to the similar role of denial in the playing and games of children. Fenichel (1927; 1928) conceived already during the nineteen-twenties of screen memories as a compromise resulting from a conflict between remembering and denial. Greenacre (1949) differentiates also between those screen memories which are of a traumatic nature and therefore point to a strong sado-masochistic trend at the time when the screen memory was formed and healthy libidinal screen memories. We are all familiar with such memories I think.

A patient of mine remembered at a relevant point during the session, vividly and three-dimensional as she said, how her father spoon-fed her in the kitchen. She saw herself sitting at the table with a thick, woollen scarf round her neck recovering from a throat infection. Her little baby brother was asleep in his cot in the corner. The sun was shining and the colouring was bright and light. — This screen memory covered a wealth of material: her phantasies of oral conception, her jealousy of her baby brother who was often breast-fed in the kitchen but also the violent scenes between her father and his brother which took place there. This screen memory had all the features described: Visual, of plastic clarity and with the patient seeing herself as a child in the scene.

Since Freud (1899) advised to treat screen memories like dreams during psycho-analytic treatment as both are formed by primary process, the concept of screen memories as a special instance of veiled childhood memories has undergone modifications and changes. In the course of the shift of interest from oedipal and pre-oedipal phases to earliest pre-verbal development screen memories have been re-evaluated. The question has repeatedly been asked whether earliest memories are also repeated during analytic treatment in cover memories of a special kind and terms like screen sensations, screen emotions, screen identity and screen hunger have been introduced mainly in connection with narcissistic and borderline pathology.

Anna Freud (1969) in her critique of the Independent Group or, as she called it the 'Revolutionary Group', reasoned in 1968 that in her opinion there is no evidence that

Freud thought that it was possible to deal *therapeutically* with pre-verbal experiences in spite of his knowledge and conviction that this is an all-important period in the individual life when essential lines of development are laid down, reaction patterns preformed and basic deprivations and frustrations assert an influence which threatens to be lasting. Contrary to this view, most of us think that we can reach out to experiences of our patients' earliest life. Remembering then becomes repetition and verbal communication re-enactment.

Re-enactment and acting-out are screen phenomena of a specific nature. Many authors* have emphasized the positive value of gaining information from it for the re-construction of early traumata. During the adolescent phase such screen phenomena are normative as I have tried to show on another occasion (1980). If we understand the "milieu" (Heimann) or "climate" (Balint) or "containing function" (Winnicott) of the psycho-analytic situation as a specific facilitating environment which fosters the patient's re-enactment of experiences of veiled or screened earliest needs, we may also understand Paula Heimann's (1956) thesis that the original "mild, positive transference" which was not to be interpreted according to Freud has allowed patients to be in touch with screen phenomena of early pre-verbal memories from the beginning.

J. Lampl-de Groot (1967) has related all those obstacles against cure which Freud listed in his paper "Analysis Terminable and Interminable" (1937) to specific traumata suffered during the earliest pre-verbal developmental phase. In a more recent paper (1976) she describes in detail how she becomes a "real" person for the patient whenever one of these obstacles like the negative therapeutic reaction, poor instinct control, lack of fusion of the libidinal and aggressive drives and faulty ego development hinder the analytic process. She stops interpreting and she describes to the patient an infant's experiences when he is failed by the environment. She also stresses that on such occasions she responds to the patient in her counter-transference feelings with great warmth and emotional care and hopes to convey this to the patient in various ways. The interesting point is that she claims as a model for this her own analysis with Freud. She describes how Freud alternated between being very friendly, warm, talkative and sometimes even saying something about himself and a strictly neutral attitude exactly as he recommends in his technical papers. This was so whenever she entered a period of transference neurosis towards him. Now, if we regard the actual verbal communications during the friendly periods as having been of secondary importance, as a vehicle so-to-speak, then we could say that during such phases repetition and re-enactment of earliest pre-verbal experiences took place. In his counter-transference response of emotional warmth Freud became the facilitating environment to a patient who had regressed in the service of the ego.

* Fenichel, O. (1945), Greenacre, P. (1950), Khan, M. (1964), Limentani, A. (1965).

If we now look at the history of conceptualisation of earliest pre-verbal development and its possible therapeutic use during psycho-analytic treatment, we could say the following: At the beginning there were periods during psycho-analytic treatment when the emotional contact between the patient and the analyst became the centre of the analytic process. This may have been what was understood at the time by the mild, positive transference. Lampl-de-Groot then (and many others of whom we do not know) developed this technique and whenever her patients showed a negative therapeutic reaction she conceived of this as a regression and repetition of early developmental failure to which she verbally responded by using metaphors. In this context, one could say the metaphors were verbal screens covering the re-enactment of the early memory. In other words, Lampl-de-Groot gave what she had experienced with Freud an aim-directed structure when faced with patients who had regressed during treatment. That she described herself in this context as a 'real person' is, in my opinion, unfortunate. Even under conditions of regression to maximal dependency when, as Winnicott says, the analyst *is* the mother, it does not mean that the analyst is the mother substitute. There is an essential difference between an interpersonal relationship and a therapeutic encounter. We respond and react to our patient's communications or the patients' usage of us. We are orientated by those psycho-analytic concepts which we have chosen to understand infancy and childhood development and we conceive of the psycho-analytic treatment as determined by the transferrence and counter-transference relationship, be it of an oedipal, pre-oedipal or pre-verbal nature.

Since Balint, Winnicott, James, Khan, Heimann during her later years and other object-relation theory analysts have presented concepts which conceive of early pre-verbal development as being facilitated by environmental provisions, the analyst becomes the facilitating environmental agent, part of the nursing couple so-to-speak, who enables the patient to re-enact with him in the transference-counter-transference his early personal history of success and failure. But even then it remains a screen experience.

I have tried to show how the development of concepts concerning early, pre-verbal infancy has influenced and widened the understanding of screen phenomena. It is my thesis that even those screen memories which are visual, luminous, plastic images in which the patient sees himself as a child, can have a double function. They are not only memories of repressed, infantile impulses and conflicts veiled by primary process; they also give valuable information about early pre-verbal emotional experiences. Saul, Syder and Shepperd (1956) have maintained that earliest childhood memories, however factually wrong, built on hear-say and distorted, present nevertheless the nuclear emotional constellation of the patient. What has been selected by the ego for the screen memory serves the emotional constellation best. I think if we re-evaluate Freud's autobiographical screen memory we may well come to the conclusion that it does not only cover all those conflicts of jealousy and oedipal conflict he analysed but that it gives also a visual image of emotional significance of a happy early time before he had to leave his home at the age of three.

I have observed that screen memories may become important material in the analysis of those patients who suffered traumata during infancy and also during the oedipal phase. Reasons of confidentiality prevent publication of the clinical material I presented when reading this paper. The material concerned three patients of mine, two women in their early thirties and a man in his forties, who had a history of severe disruptions of their sense of continuity of being during infancy but all three of them had also experienced intrusive fathers during the oedipal stage. Their screen memories functioned as screens for early traumata and also later conflict material. They were overdetermined and condensation and displacement obviously played a part in their formation. Even after many years of analysis they were still referred to but they had lost their screening function and served to express here-and-now emotional states.

The use these patients made of their screen memories varied. A., a visually gifted woman, often playfully modified and enriched her visual picture. She would become absorbed in this and it conveyed meaningful experiences of self during the sessions. B., a gifted writer, repeatedly recalled seeing himself as an infant lying in the pram and also seeing himself as a young child in the early hours of the morning being alone in the garden. The sun is just rising and the stones sparkle as the sun rays cover them one by one. He is thrilled observing this. Other screen memories covered later traumatic sado-masochistic experiences. All these memories have been important in B.'s life and also during his treatment. He, too, could play with them but he often re-enacted them outside and inside the analytic relationship. They then functioned as screen experiences of early non-verbal life. They are B.'s legends and they were often actualized in his states of schizoid loneliness in spite of his wide social contacts, in his obsessional compulsions and also in his attempts of writing when he tried to capture the emotional quality of his garden screen memory like a mini Proust who spent a good deal of his life in trying to re-capture the emotional quality of the memory screened by the taste of the Madelaine mother once gave him for tea. As Anthony (1961) has pointed out in his psycho-analytic study of Proust's search, he succeeded in giving the world an account of it which is of the highest literary value.

The third patient, who had an unusually traumatic infancy and childhood and also an intrusive and seductive father, enacted some of her screen memories in dramatic acts which had a hysterical,fugue-like quality. During the analysis she gradually made more creative use of them and the dramatisation became less compulsive.

It is my thesis that screen memories can become autonomous and gain in emotional meaning for the patient instead of loosing their importance after their defensive function has been analysed. Only after the screening significance for early, pre-verbal experiences and also later childhood conflicts and traumata have been understood have my patients made use of these memories in the ways I have described.

The *formation* of those screen memories which are of the visual, luminous and plastic kind and the person remembering sees himself as a child in them, draws on early mental functioning. Freud has compared them to dreams because of the primary process contributions. Fenichel (1927) has shown that they have an oral aspect and Proust's

hunger for the re-finding of his early emotional experiences bears witness to this. Greenacre (1949) has postulated that the luminous quality of screen memories is due to contributions from earliest visual sensations of the infant. She refers to Lewin's concept of the 'dream screen' (1946) which signals sense impressions of the infant falling asleep at the breast and it is the dream screen on to which everything which disturbs the sleep is projected in dreams. Greenacre maintains that the luminous quality of screen memories signals the infant being awake and visually incorporating. But Greenacre also maintains that the formation of screen memories draws on later developmental stages as well. In her opinion a certain structural development of the super-ego has to have taken place as it is part of the screen memory's definition that the person having the memory sees himself in it.

I have said before that all childhood memories contain important emotional experiences of early childhood. I believe that this is equally true for the specific type of screen memories mentioned in this paper. I have tried to show how they may function as a legend of personal history. They are legends, but not personal myths, which are phenomena of day dreaming and have therefore to remain a personal secret, as Kris (1956b) has suggested. Screen memories are neither phantasies nor internal objects. Greenacre (1955) has convincingly shown that 'Alice in Wonderland' and 'Through the Looking Glass' are creative transformations of Lewis Carrol's screen memories. When he suffered great anxieties he also acted them out compulsively in perversions- All the patients of mine mentioned periodically erotisized parts or the whole of their screen memories in perverse phantasy or acts.

Screen memories are objects of the self, as the self is an object of the screen memory. They have 'me' and 'not me' aspects. They are neither inside nor outside and I think they are situated in the transitional space. I do not think they are transitional objects as such but they are relatives of them, so-to-speak. Screen memories can be playfully handled or creatively transformed in experiences of the self, but they can also become erotisized and then become objects of perverse activity in thought and action.

Anthony (1961) and Greenacre(1955) have both asked the question whether the world would have been poorer if Proust and Lewis Carrol would have been analysed. I have tried to show that this is unlikely, taking the experiences of my patients as a guide who made extensive use of their screen memories once the defensive screening aspects had been analysed. It seems that the extent to which early non-verbal emotional experiences are screened has a bearing on the usage made of them, which ranged from playfully handling them in imagery, to screened re-enactment, to total dramatization of the actual content of the screen memory. This sequence is in line with the severity of the early traumatisation in my patients. A. was least traumatised in infancy, C. the most.

I have tried to show how the conceptualisation of non-verbal early development has widened our understanding of childhood memories and their handling during psychoanalytic treatment. I have then applied these notions to a special type of childhood memory, namely memories which have a visual, luminous, plastic quality and contain a childhood event in which the patient sees himself as a child. I have come to the

conclusion that they do not only screen conflictual and traumatic events from the pre-oedipal and oedipal period but also early pre-verbal emotional experiences. They are not only part of the ego's defensive functioning but also achievements of the ego's integrative or synthetic systems.

* Abridged version of a paper read to a Meeting of the Middle European Psychoanaltyic Associations, Murten, Switzerland, 1982; The Group of Independent Psycho-Analysits, London, 1983; The British Association of Psychotherapists, London 1984.

REFERENCES

Anthony, E. James (1961) 'A Study of Screen Sensations', *Psycho-Anal. Study Child,* 16, 1961.

Balint, Michael (1968) *The Basic Fault,* London: Tavistock

Fenichel, Otto (1927) 'Economic Functions of Screen Memories'. In *The Collected Papers of Otto Fenichel, I.,* New York: W.W. Norton, 1953.

Fenichel, Otto (1928) 'The Inner Injunction to 'Make a Mental Note' '. In: *ibid.*

Fenichel, Otto (1945) 'Neurotic Acting Out'. In: *The Collected Papers of Otto Fenichel, II.* New York: W.W. Norton, 1954.

Freud, Anna (1969) *Difficulties in the Path of Psychoanalysis,* New York: Int. Univ. Press.

Freud, Sigmund (1899) 'Screen Memories', *Standard Edition, 3.* London: Hogarth Press.

Freud, Sigmund (1910) 'Leonardo Da Vinci and a Memory of his Childhood. *Standard Edition, 11.*

Freud, Sigmund *(1937) 'Analysis Terminable and Interminable'. Standard Edition, 23.*

Greenacre, Phyllis (1949) 'A Contribution to the Study of Screen Memories', *Psycho-Anal. Study Child, III/IV.*

Greenacre, Phyllis (1950) 'General Problems of Acting Out'. *Psychoanal. Quart., 19.*

Greenacre, Phyllis (1955) ' 'It's My Own Invention', A Special Screen Memory of Mr Lewis Carrol, its Form and its History'. In: *Emotional Growth, II,* New York: Int. Univ. Press, 1971

Greenson, Ralph R (1958) 'On Screen Defences, Screen Hunger and Screen Identity'. *J. Amer. Psychoanal. Assoc., 6.*

Heimann, Paula (1956) 'Dynamics of Transference Interpretations'. *Int. J. Psycho-Anal.,* 37.

James Martin (1960) 'Premature Ego-Development', *Int. J. Psycho-Anal., 41.*

Khan, M. Masud R. (1964) 'Ego Distortion, Cumulative Trauma and the Role of Reconstruction in the Analytic Situation'. *Int. J. Psycho-Anal., 45.*

Khan, M.Masud R. (1974) *The Privacy of the Self,* London: Hogarth, 1974.

Kris, Ernst (1956a) 'The Recovery of Childhood Memories in Psychoanalysis'. *Psycho-Anal. Study Child, XI.*

Kris, Ernst (1956b) 'The Personal Myth, A Problem in Psychoanalytic Technique'. *J. Amer. Psychoanal. Assoc., 4.*

Lampl-de Groot, Jeanne (1967) 'On Obstacles standing the Way of Psychoanalytic Cure'. *Psycho-Anal. Study Child. 22.*

Lampl-de Groot, Jeanne 'Personal Experiences with Psycho-Analytic Technique and Theory during the last Half Century'. *Psycho-Anal. Study Child, 31.*

Lewin, Bertram D. (1946) 'Sleep, The Mouth and the Dream Screen'. *Psychoanal. Quart., XV.*

Limentani, Adam (1965) 'A Re-Evaluation of Acting Out in Relation to Working Through'. *Scient. Bull. Psycho-Anal. Soc., 1.*

Saul, Leon J., Snyder, Thoburn R. & Sheppard, Edith (1956) 'On Earliest Memories'. *Psychoanal. Quart., 25.*

Tonnesman, Margret *(1980) 'Adolescent Re-Enactment, Trauma and Reconstruction'. J. Child Psychother.,*6.

Winnicott, Donald, W. (1965) *The Maturational Processes and the Facilitating Environment,* London: Hogarth, 1965.

Winnicott, Donald W. (1971) *Playing and Reality,* London: Tavistock, 1971

Winnicott, Donald W. (1975) *Through Paediatrics to Psycho-Analysis,* London: Hogarth, 1975.

REJECTION OF TRANSFERENCE INTERPRETATIONS AND THE USE OF A SPLIT COUNTER-TRANSFERENCE

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Qualifying paper for Associate Membership of the British Association of Psychotherapists.

Introduction

I will present my second training patient, Miss K, a woman who is now thirty two years old. She had been turned down as a training patient by the Institute of Psychoanalysis because of the danger of acting out and had consequently been accepted by the BAP. The assessment said that she was "a good training case with a wealth of psychopathology to learn from" and it was seen as "unlikely that the patient will break down in a psychotic episode or show serious suicidal impulse". Right from the outset there was some difference of opinion in the assessment of the patient. Her ability to present herself in the most opposing and puzzling ways has been one of the main features of therapy from the beginning in September 1981 until nearly two years later.

In this paper I will focus on the description of the relationship between transference and countertransference which served as a guide to the therapist through the first two years of therapy of a patient with hysteria who initially often seemed to show signs of total collapse and psychic disintegration. The initial transference manifestation, as well as the patient's psychiatric history, raised the question of whether the transference manifestations were an expression of a strong ego which was under the influence of a fierce super-ego and which defended strongly against forbidden Oedipal impulses, or whether they were an expression of ego weakness due to a mainly pre-oedipal psychopathology.

History

Some history first. The patient had sought therapy beause she felt unable to relate to people she liked. She had no close relationships with women and all relationships with men broke down very abruptly, some after open violence. Other complaints centred around eating. Compulsive overeating at times alternated with losing weight considerably at others. The weight loss brought the patient down to a minimum of under seven stone, near to the anorectic margin, although she had never been clinically manifest anorectic. In addition, the patient suffered from several psychosomatic symptoms, especially from pains in her right thigh which impaired her walking at times and of "feelings of anaemia". A third complex of symptoms was related to work. Miss K felt unable to concentrate or to take in anything she read. On several occasions the patient complained that she was unable to read at all. Miss K also suffered from severe sleep disturbances which included both the difficulty to go to sleep as well as the ability to sleep through. Since the age of sixteen the patient had continuously been on sleep medication which was sometimes heavy. All symptoms were connected with panic attacks, with feelings of paranoia and with the anxiety of going mad and of having to be hospitalised as she had been at the age of eighteen. The patient saw all these symptoms as part of self destructiveness which made her tense and frightened her.

These complaints were presented in the context of a personal history as the only child of a father from a small Scottish catholic community and an English mother with a working class background. Miss K's mother had been a model and had always wanted to be middle class. Her father was a self made business man who had been a member of the labour party all his adult life. Miss K was born after eleven years of childlessness in the marriage. Miss K's mother had been ill for two years after the birth and had had to take vitamins and other drugs. From the patient's report, it sounded as if she had suffered from a postpuerperal depression. The patient grew up as an isolated child in a working class area in East London, always being with her mother who did not allow her to play with other children for fear that she would acquire a working class accent. The father had always wanted more children saying "one child is unhealthy". When she was five, Miss K started to run away from home regularly. The first day at school she tried to climb over a wall to get away. Under the pressure from her mother, the family moved to a middle class area when Miss K was seven years old. There the patient was allowed to play with other children but she found it very difficult to relate to them.

The parent's marriage split up when the patient was eleven years old. However, the parents were never finally divorced and after twenty three years of separation are still legally married. At first Miss K lived with her mother. She went to a private school but her father was only prepared to pay for her and her mother on the condition that the patient would come to his house every day after school. This arrangement involved complicated travelling. At thirteen after a continuing row over school performance, Miss K was taken by her father from the small private school and placed in a very large comprehensive. The patient did not manage the transition and had her first breakdown. She cried for several days and was unable to leave the house. She received child psychiatric treatment and was seen by a child psychotherapist for about eight months.

At fifteen the patient left her mother and went to live with her father. After her father had approached her sexually she ran away to live with friends. She left school at sixteen without exams and went to Paris. She came back to London to live briefly with her father again. She became a stripper and a prostitute and became pregnant by the owner of the brothel who was about thirty five years older than herself. She had a backstreet abortion with complications. Six months later aged just eighteen she had a mental breakdown and was hospitalised for six months. She received two series of ECTs.

After recovery, Miss K had innumerable jobs and tried a great many different professional careers including child nursing and acting. At twenty she broke off all contact with her mother and has not seen her for the last fourteen years although she lives nearby. Miss K went to a business school at twenty five. She had a tutor who took a father role and helped her through school and examinations and got her into a position in a major bank in the city. The patient had a great number of relationships with men of whom two were significant. One with her own GP who ws twice her age, a caring father figure who died when Miss K was twenty five, and the other a three year relationship between twenty seven and thirty with a man who was violent and used physical force to beat her up and kick her on the floor.

At the time of referral the patient, as a highly qualified professional in the banking world, lived as an illegal squatter in north London.

The Patient and Some Features of the Treatment Process

Miss K was fifteen minutes late for the preliminary interview. She apologised in a rather firm manner and in a business-like voice which seemed to be put on in order to give the impression of masculine toughness. This was underlined by the patient's appearance. She had rather short moth-eaten hair and wore a dark brown leather jacket which obviously served the purpose of presenting herself like a man. This appearance was in contrast to some other features of the patient. Miss K was very slim, of medium height and of very delicate stature. She had slim hands with long fingers and there was something very elegant about her movements. Even her soldier-like marching when she walked down the corridor was unable to hide the elegance of a potentially very good looking and attractive woman.

The association of Rosenkavalier springs to mind. A woman plays the role of a man who, in the opera, in turn pretends to be a woman. The patient was in many ways like this Russian doll of both sexes in one.

When Miss K entered the consulting room for the first time and saw the couch she gave a long sigh. However, the anxiety of this expression was immediately taken away by producing a packet of cigarettes, taking one and lighting it in the same abrupt, business-like manner she had shown when she apologised for being late. After a moment of open anxiety, the patient immediately and visibly pulled herself together again to regain the posture of a coping and controlling male.

I was aware of the patient's history as a prostitute and stripper when I suggested the use of the couch for the future. Miss K did not react verbally, She took a quick deep drag at her cigarette. There was a quick move with the other hand over her dress and she gave a quick nod. Immediately after this sequence the patient diverted from the issue and took control herself by starting to ask me enquiringly how long the therapy would take, whether I had the appropriate qualifications to treat her, for how long I had done therapy and how high my failure rate was.

At the very end of the meeting after we had dealt with issues of times and fees like bankers in the city deal with shares, Miss K suddenly asked me "Do you want me to pay cash in advance?". With this she was right back to my suggestion of the use of the couch, and therapy had already started. The patient's question was an immediate act of projection in which I had already become the prostitute and she was the tough bloke who had controlled the conversation in an inquisitive manner asking what I as therapist-prostitute had to offer for the money she had to pay.

After the session I noted "why is she talking like a robot?". In contradiction to the patient's abrupt and depersonalised behaviour my immediate counter-transference left me with a feeling of warmth and an internal smile. I felt, while the tough bloke in the patient tried to give me the impression of a distant and independent person who was in control and who had nothing but business to do with me, that at the same time and unconsciously a frightened Rosenkavalier had started to relate strongly to me already,

asking whether I, as therapist, would be able to control the woman in her who wanted "cash in advance" and who was afraid of her sexual wishes and her feelings of sexual power and destructiveness.

In the following initial period of treatment the anxiety level seemed to drop. There was a very quick development of an intensive positive transference. I became the idealised perfect male therapist with whom the patient was identified as a firm and tough male. Miss K referred to herself repeatedly as "bloke" and reported that she liked to be called a "good bloke" by her friends. Parallel came an immediate success at work where Miss K, within weeks, got a highly qualified new job in her strongly male dominated profession. The instant improvement was also expressed by improvements at home where the patient refurbished her flat, removed a wall and got hot water in preparation for the winter.

Even before the first break, after less than three months, the patient thanked me in the session and said that her "waffling" about herself in my presence had helped her to sort herself out. In this initial period transference-interpretations were neither rejected nor accepted. The patient often behaved as if she had not heard them at all and ignored what I said. Nevertheless, Miss K brought back several interpretations I had made in previous sessions or weeks, now turned into active statements of hers which she told me as her own ideas and which according to her had no relationship to what I had said. On the other hand she put words into my mouth which I was certain I had never said. This was how the patient tried to keep the session under total control. I was often confused and did not know where the statements the patient made came from and I felt stupid and completely castrated (10). In addition, the acknowledgement of any therapeutic relationship was denied. For example, the patient often talked about her tutor and how he had given her helpful advice. When I interpreted her wish for care and advice from me she ignored what I said only to come back in a later session saying suddenly "sure I want advice but everybody wants advice sometimes and that has nothing whatsoever to do with you here".

At other times the patient used transference-interpretations to openly denegrate the therapist and therapy as a whole by saying laughingly and in a patronising way "you talk like a cliché" or "I know that is the game in *your* therapy". The rejection of the transference and the defensive denegration of the therapist was accompanied by the rejection of therapy as a whole as a potential framework for any meaningful therapeutic relationship.

Intellectualising by holding controlling monologues, intellectual generalisations and frank denial were the main defences the patient brought during this period. "This is logic" or "everyone feels that" were comments following interpretations. The strongest form of denial of transference was when the patient said on numerous occasions "everybody feels that, I felt that long before I met you and you are talking rubbish. This has nothing whatsoever to do with you". This was usually said in a panic with high anxiety and transference was more fiercely denied when I made positive interpretations.

The initial strong transference-formation and at the same time the continuous denial of any acknowledgement of the transference pointed to great anxiety in acknowledging any closeness in therapy and in giving what happened in the sessions any meaning at all as therapeutic relationship. There was a strong phobic impulse and the wish to keep me at a distance as an idealised and good object, which the patient treated like a robot. This was a strong defence against guilt. All destructive elements and guilt feelings were split off and denied through the denial of any transference.

Openly I had become defensively an idealised part of the patient. I was like her dog who was "the most important person in her life". When she talked about some financial problem the patient honoured me with the transference statement "don't worry whatever happens the dog will get his food and you your money". For Miss K, therapy in the first three months had nothing to do with relating and even less with transference. The patient tried to make therapy into an autistic exercise where she in my presence made herself better by drawing logical conclusions and using all forms of obsessional defences possible, sometimes saying angrily "I wish you were a fly on the wall". Any interpretation, which in itself is a statement of separateness, was a threatening intrusion into the defensively employed male identification with the therapist.

Any female part was repressed. The patient tried to keep her weight down and presented as male in appearance as well as in the verbal content of the sessions. Whilst the father was talked about constantly the patient's mother was not mentioned once during the entire first six months and thereafter only in the most hostile manner. A female colleague who had come to work at the bank was immediately attacked by the patient "she is just a middle class bitch" and she presented a fierce battle between two female rivals.

This material came into the session after four months at a point when transference changed from an idealised and defensive father-transference into a negative paternal tranference. The therapist was attacked as being unhelpful and the patient showed me how useless and stupid I was with "my therapy" compared with the sensible advice her father and her mentor had given her. My seemingly unhelpful and useless being as therapist was underlined by the patient's sadistic attacks in telling me that her father had said she should stop therapy and stop wasting time and money with "the shrink" whose therapy did not work.

The patient acted out strongly. She had not yet begun her new job and was in fact in danger of losing it. The patient started to bring most confusing material. She switched rapidly from one topic to another and within the session confused totally what she had said and what I had said. The contradictory situation in which the transference had developed rapidly but was more fiercely denied the more it had developed quite often left me with very puzzled and confused feelings. I felt I could not do it right. I felt I had let her down when I left her in her immense confusion without having given the right interpretation. At the same time I felt attacked and therapy was threatened by my giving any interpretation at all. "I wish you would shut up" was a frequent comment when she felt attacked by my interpretation. "You are useless, your therapy does not

work, how high is your failure rate?" was her own attack on me often followed by high anxiety and a phobic impulse asking "Is it time to go now?". She was angry with me and missed a great number of sessions at the same time denying any feelings of anger towards me. In fact denying any feelings at all, still treating any interpretation contemptuously as "your therapy game". At the same time my patient expressed great anxiety about going mad.

Six months after therapy had started the patient drove herself on her push bike into a bus and broke her collar bone. The transference interpretation of this event met with phobic anxiety and was totally unacceptable. It had in fact been six months after the termination of the pregnancy from the brothel holder at the age of eighteen that the patient had been admitted to the psychiatric hospital. Now, six months after the patient's first question whether I wanted cash in advance she broke her collar bone and threatened to break down again.

The interpretation of breaking the collar bone as being a vengeful attack against the therapist led to a change in the patient. She changed from presenting herself as a sadistic male into behaving as a totally collapsed and incapacitated woman. The open aggression in the acting out of breaking her collar bone was followed by an instant and very strong regression which became the predominant feature in the next period of therapy. When I interpreted aggresion or guilt feelings the patient repeatedly said suddenly "I feel like crying now" withdrawing instantly from the battleground by regressing from what was going on between therapist and patient in the sessions. Miss K had now become identified with the masochistically attacking castrated female. She was often confused and irritable, and she complained about "feeling anaemic" and paranoid. She felt unable to concentrate and had pain in her groin. The patient tried to blackmail me into activity by threatening that she would harm herself again because of her inability to look after herself. She indicated that this could lead to disaster unless I would admit her as an in-patient or take over the responsibility for her entire life. At the same time Miss K denied that the accident had any meaning in the context of therapy. I had come into the negative maternal transference, the mother who failed her daughter.

In this period the patient used next to regression a form of strong thought blocking and concrete thinking as main defences. She not only rejected transference-interpretations, brought no dreams nor childhood memories and rejected any reference to her childhood as irrelevant, she now atomised the session itself. She jumped from one topic to another with high speed and used concrete thinking by taking symbolic interaction literally. It was impossible to make sense of the material and to record or to report the sessions adequately. Miss K missed a lot of sessions and walked out of others taking flight from therapy. I felt lost and not only confused, but increasingly frightened. This process was mirrored in supervision where I always felt I was talking about something slightly different from the supervisor. My own anxiety in supervision reflected the patient's anxiety of losing her obsessional defences and it reflected the patient's fear of mental breakdown.

The seemingly psychotic type of transference which developed on the manifest level of accessible material provoked strong countertransference feelings of confusion and anxiety. However, in the situation of the patient's extreme acting-out and her threat of self mutilation, which was acted upon, there was nevertheless another level in my countertransference where I felt very confident and in a transference-countertransference-state of whole-object-relating with the patient. Interestingly, I was unable to convey this part of the countertransference verbally and I was unable to back it up with material from the session when I tried to present it in supervision or in seminars. I just knew it was there and I had to sit through it and go on interpreting.

In retrospect, the material about the dog which the patient brought continuously interspersed in the confusing flow of material indicated the presence of a latent part of the preverbal countertransference as expressions of whole-object-relating. In the same defensive way in which the patient had identified with me as therapist, she also identified herself with her Alsation dog, Ben. The dog was described as male and beautiful but sick inside. From birth he had the wrong proportions, his head was too big compared with his body. He had a pancreas deficiency and he could not walk properly. But he was described as happy and easy going thanks to the patient's good care. The total identification of the patient with her dog, together with repeated reports of him being well looked after, told me that there was another level of transference where the patient related to me positively as a whole object. The open presentation of the dog as part-object was the defensive presentation of a false part-object. This was confirmed in a most impressive way when the patient much later in therapy suddenly told me that Ben had in fact been the name of her first lover at the age of fourteen.

It was to me as to the dog as preverbal and pregenital object to whom the patient related strongly in a positive transference. This was the basically healthy aspect of the patient. The dog was loved and well cared for and this was certainly one of the main communications of the patient which created the second level of the split countertransference. There must have been other verbal and nonverbal communications which I was unable to pick up consciously myself at the time.

However, on the level of the manifest transference-countertransference whatever I said was wrong or not relevant and even whether I said anything or nothing could be wrong either way. Although I felt rejected and completely confused and very guilty in the open part of the transference-countertransference-relationship the preverbal countertransference gave me the strong feeling that the seemingly total disintegration of the patient's ego which was presented at this stage in therapy, was defensive and did not reflect early or pre-oedipal psychopathology with the real danger of psychotic breakdown. The preverbal part of the split countertransference enable me to sit through the period of chaos in which I felt openly and consciously confused and guilty that I had made the patient worse but in which at the same time I felt confident underneath that the patient would be able to get through this pseudopsychotic transference.

In fact, the strong rejection of any transference interpretation and the presentation of material which was impossible to interpret at all did not mean that there was no strong

transference. From my own strong counter-transference towards the end of the first year, it was clear that therapy was at a stage in which the therapist as object was rather overcathected by the patient but with the phobic denial of any acknowledgement of this cathexis. The acknowledgement was too anxiety provoking and too guilt-laiden. It seemed to bring about Oedipal disaster like the separation of the patient's parents with the analogue of breakdown in the therapeutic relationship. Consequently any Oedipal transference had to be defended against. The rejection of the acknowledgement of any tranference was maintained at all costs with the extremes of self injury, defensive regression and the creation of a pseudo-psychotic transference in sessions where the patient showed completely concrete thinking with the loss of any ability for symbolising which made any interpretation of explicit content hopeless and which made meaningful symbolic communication impossible.

Several times the patient was late because she had become confused and had got lost in the street or even in the building. The patient took flight into any defence she could get hold of. On a symbolic level when she changed subject and fell into concrete thinking and physically by storming out of the sessions whenever the form of defences employed was not sufficient to reject the acknowledgement of the transference.

There was clearly anger present, but it was denied. When I commented on weekend breaks or on her telling me in the material that she felt excluded the patient replied with a standard phrase "this has nothing to do with you whatsoever" followed by a long rationalisation why she was not angry with me. Miss K seemed unable to contain any negative feelings and she seemed to have no capacity for reflection or insight. She had not brought a single dream during the entire first year. When I interpreted guilt feelings Miss K seemed to bring about how she was treating me, she denied at first any guilt feelings at all and in particular towards me, only to come back later to talk about people who in general may feel guilty.

The repeated interpretation towards the end of the first year of the patient's sadomasochistic triumph of her self-destructive behaviour as an expression of revenge against the therapist in which she would even go as far as getting in danger of killing herself only to punish the object and to make me feel guilty was the first interpretation that the patient did not reject totally. I was able to connect the masochistic attack of breaking her collar bone with the patient's wish for self punishment as a form of reliation against her parents as she had done previously when she had got herself admitted to a psychiatric hospital. There the treatment with ECTs had been self punishment for her sexual activities with her father but even more, it had been a sadomasochistic attack against both parents.

In interpreting the accident, I felt in my countertransference like a parent who shakes an over-excited child who throws a temper-tantrum endangering herself. I felt angry with the patient and my listing of other self-destructive accidents the patient could bring about in order to punish me could perhaps be called acting out on my part. But it felt right at the time in the sense of acting like a parent who sets firm boundaries to prevent further disaster. I felt in the situation of the Winnicottian parent who smacks the over-excited child who has been out of control in order to bring her back to her senses (11).

However, this process took more than six months. Initially the patient did not accept the interpretation of the accident or of her self-destructive impulses in the session directly. Under continuing sadomasochistic attacks from the position of a strong regressive defence the patient said often only several weeks and even up to four months later, something like "what you said the other day was perhaps a fair description" admitting that perhaps she had wanted to show me something by breaking her collar-bone or by other self-destructive acts or fantasies. However, the patient used to add immediately "although I don't feel it". The distance had to be recreated instantly.

At the beginning of the second year the material brought into the sessions was still in bits and pieces where the patient still changed from one minute to the next often talking like a waterfall drowning me in a stream of words. At the same time I became increasingly aware of islands of more open guilt feelings and feelings of depression, especially in relationship to damage she had done by deserting the sick dog and a dying friend. In the countertransference I felt increasingly guilty about what I had done to the patient, bringing her into a state far worse than at the beginning of therapy. Since the manifest content of the material was still chaotic I interpreted strongly from the countertransference suggesting that the guilt feelings and the sense of failure the patient was inducing in me were in fact feelings of herself which she may be unable to bear to look at. The manifest countertransference of guilt feelings and at the same time the continuing preverbal positive countertransference indicated that Oedipal material of guilt, shame and responsibility for destruction was defended against. By means of interpreting from my own countertransference I brought the defensive split of the transference into the session (1).

Nevertheless the split between the two parts of the countertransference was still so strong that it was impossible to communicate and link both parts as resulting parts of one integrated transference most of the time. The defensive split to avoid the Oedipal transference was also reflected in the total split in the patient's way of identifying herself with either her own male part or female part exclusively, always avoiding a triangular constellation in the session. A shift in transference had gone in parallel with the weakening of the male identification. I had become the failing mother who only wanted the child "to play the game of being a good child". This was reflected in the material when the patient accused me of not being interested in her as a person at all but only wanting her to play the good patient in what she still called "your therapy game". The use of countertransference brought the third person into the session, which made the transference oscillate with increasing speed between maternal and paternal transference. Within seconds I seemed to change from a "weakling" into a "brute" and these changes were so rapid that it was not possible to follow them. The female identification with the blackmailing and collapsed woman prevailed and the patient's strongest attack of blackmailing took place when the patient threatened not to return after the Christmas break trying to punish me for having left her out, going off with somebody else over Christmas. The patient refused to come back and in a letter she declared therapy finished. She missed three weeks and once she returned refused furiously to pay the January bill. Both the abortion as well as the parental separation were acted out and in the transference. The responsibility was given to the parent-therapist (9).

When the therapist did not accept the divorce in therapy but went on interpreting the patient's anger as well as her sense of guilt, the first pieces of the confusing puzzle started to come together for the patient and began to make sense in different sessions (6). The patient, herself, began to link material before she could accept interpretations. However, she kept distance and control at the same time by linking material from sessions which were far apart and seemingly unconnected, referring to sessions which were sometimes one or two months ago. She also still projected onto me what she herself had said in previous sessions and often she referred to an interpretation in an entirely distorted context. Often I felt puzzled at first and thought I had probably forgotten what I had said until I learned that this was the patient's way of beginning to include me openly and allowing for the first acknowledgements of transference by linking her present emotions with transference-interpretations I had made earlier in a way which allowed her to remain still in total control. The patient still needed the distance to defend against dependency in order to avoid overwhelming feelings of guilt and shame. Immediately when transference interpretations met with actual feelings the patient reacted with a phobic defence. When she managed not to act on this impulse by leaving, but stayed with the material the patient came back with a strong attack on me. It felt in the countertransference like always being one of the parents who is at war with the other. I felt I was never both parents at the same time, although both parents came closer together in the transference within the sessions.

The first signs of the return of a positive transference, now for the first time as openly acknowledged transference, immediately showed the impulse of the patient to control and possess the object completely. Miss K acted out again by phoning me at weekends or trying to enter the consulting room early. She admitted for the first time that she "naturally after two years therapy wanted to know with whom I was living" denying at the same time that this was anything more than a superficial and understandable wish for social contact between acquaintances. That same week, she left a pink handkerchief on the couch. For the first time the patient openly and immediately accepted the interpretation of her acting out as her wish to be with me and to control me. At the same time, she expressed for the first time immediate and strong guilt feelings about how she had treated me.

The transference now shifted towards an integration of both maternal and paternal transference and the patient began to be able to tolerate triangular constellations. For the first time Miss K talked about guilt feelings towards her mother whom, as an act of punishment, she had not seen for fourteen years and she talked about the horror as well as the power and triumph of her sexual relationship with her father. The patient reported that she felt guilty about having seduced her father to sleep with her after the parent separation. She told with great embarrassment that still at the age of thirty two when she visited her father she would lie in bed at night in the room next to his with horrified excitement that he might come into her room at any moment.

A sudden stream of most intensive Oedipal material came into therapy at the end of the second year. It was brought in after the relief that I had continuously interpreted the patient's attempt to blackmail me and her wish to avoid any guilt feelings of responsibility in therapy as well as in her relationships outside. The interpretation of

the patient's feelings of omnipotence as well as strong castration anxiety had helped to bring the separated Oedipal parental couple in the patient together. First positive comments about the mother went parallel with the patient's arrangements before the summer break to return to her professional work after the break. Miss K arranged her return to work entirely in accordance with the therapist's holiday allowing for ten days therapy before she would start work. This was at that time the strongest possible open acknowledgement of positive transference.

The summer break itself was for the first time not used for acting out but was used creatively to make first contact with the patient's mother as well as keeping in contact with her father. The patient said about her mother "perhaps she really only wanted the best for me. I do want to see her but I have to do it in my own time". That same week, Miss K paid, eight months late, the bill for January taking responsibility for her own acting out when she had missed a whole month. In another session the patient said in tears "I am embarrassed but I have to tell you that I do mind about you, but it is so much safer not to mind. Now I know how important you are to me I am suddenly frightened something might happen to you".

At this point the two split parts of my own countertranference came together in a shift towards a positive maternal transference-countertransference-constellation. There were, within the sessions, still often very quick defensive regresions from Oedipal to pre-oedipal transference. But the countertransference became coherent and it was possible to interpret the material in a normal fashion and in a way which was accepted by the patient. The sessions were coloured by deep feelings of shame and embarrassment as well as fear of losing the positive maternal object. The patient reported that all she had done so far in therapy was exactly what she felt her mother had done to her father, trying to blackmail, playing the collapsed woman who needs attention as well as trying to manipulate at all costs. The patient even felt that she had behaved worse than her mother who perhaps had not known better.

Only now did two earlier dreams brought several months previously and both composed of three parts begin to make sense. Both dreams showed striking similarity. The first part in both dreams was about positive relating and about positive identification in two cornered relationships. In the first dream about the patient's dog, and in the second dream about a female friend. The second parts of both dreams were confusing, dark and frightening and the patient was unable to recall any specific content of these parts. The third parts were clearly remembered again and contained material of loss and disaster in a triangular situation. In the first dream the patient and two men had been killing a dog and in the second dream the patient was with a therapist and a frightening third person who was like a robot. The defence against anxiety and guilt feelings on Oedipal level which had dominated treatment for the first two years came from the anxiety of the second parts of the dreams. The patient had moved from a positive two-cornered relationship of the first parts of the dreams going into a state of castration anxiety and immense guilt feelings contained in the confusion of the non-remembered second parts of the two dreams which had resulted in a state of threatening three cornered Oedipal relationships in the third parts. To fill in the second parts of the only two reported dreams had been the work of the first two years of therapy. This meant

linking the first and third parts of the dreams and with it linking the split dyadic pregenital parts and the triadic oedipal parts. In the therapeutic setting this split was reflected in the total split of the transference-countertransference-constellation.

I had felt the latent positive preverbal countertransference deriving from the positive dyadic transference of the first parts of the dreams right from the beginning of therapy but had only been able to verbalise the defensively employed manifest transference-countertransference of the third triangular parts of the dreams which had been driven by the anxiety of the repressed and non-remembered second parts. The second parts of the dreams represented the patient's amnesia in the first two years of treatment for all the Oedipal material the patient was now bringing into therapy with great intensity and richness (4).

Rosenkavalier, a woman who acts the man who pretends to be the woman, did not need to continue to play the false woman as defence against male identification, a bloke who in turn defended against the Oedipal guilt of a woman who had interfered in the relationship of the parental couple. Miss K's first name was Paula but her father liked to call her Paul and her mother would have liked her to be a more feminine "Pauline". Paula had never wanted and no longer needed to be Pauline, mother's daughter-doll, nor did she any longer need to be Paul, father's son whom she could never have been. She could start to be Paula, herself, the child who had in therapy experienced that in the tranference she could be the child of both parents who did not allow her to interfere. Now the patient brought into therapy her real female part which related in a strong and immediately extremely intensive and powerful positive transference (12). The patient was now able to contain the anxiety which was connected with a positive transference due to the overwhelming power of the patient's sexual wishes. When she threatened the boundaries trying to interfere with the therapist's relationships by phoning him at home, it had become possible to interpret this material without provoking a phobic defence. The patient was able to become herself openly when she expressed her sexual wishes towards the therapist within the sessions. In the external circumstances there was a marked change towards women and the patient showed the ability to relate positively to female colleagues. The patient started to dress elegantly and her short moth-eaten hair became an attractive perm. The patient became openly identified with her mother when she reported that she had discovered that, like her mother had to, she had to wear elegant black clothes at work and that like her mother she did care about her looks and her figure. Now Miss K as a real woman felt deformed by the broken collar bone which had not healed properly.

At work the patient had become able to marry both parental parts within her. The good looking woman who at the same time is logical and uses her intelligence to be successful in her profession. With some surprise she commented one day about a female colleague she admired "I think Ann is like my mother and I am surprised that you can care about clothes and at the same time be natural and successful at work".

Discussion

I want to come back to the initial question at the beginning of therapy. How could the therapist know whether the rejection of any transference-interpretation, the acting-out and the strong regression were signs of a strong ego which defended against Oedipal guilt or whether they were signs of a mainly preoedipal psychopathology? How could I decide whether the manifest presentation of a psychopathology on a dyadic level was really mainly defensive? The intuitive or explicit answer to this question had important implications for the handling of the material.

Defence against Oedipal impulses requires immediate interpretation of regression and acting-out as defensive against castration, anxiety and guilt. Not doing so in a patient with a strong tendency of acting-out in a self-punishing sadomasochistic way would increase the danger of acting-out especially of suicidal attempts as sadomasochistic attack against the therapist. If, however, the acting-out and aggression, in the context of the inability to bear transference-interpretations, were an expression of a weak ego with the main pathology on preoedipal level the constant and immediate interpretation of defences may lead to psychotic disintegration. Whilst the defence against Oedipal impulses required much more of a classical Freudian approach of immediate interpreting the defences against libidinal impulses, a possible preoedipal psychopathology would have required a much more careful approach using mainly concepts and techniques deriving from object-relation-theory.

Due to the absence of an acknowledged transference by the patient the answer came from the countertransference-manifestations in the therapist (5). A strong initial open positive paternal countertransference was later followed by an even stronger countertransference of confusion and guilt about the damage I had inflicted on the patient by making her worse rather than better and by feeling totally useless. The feelings of impotence and castration had been mixed with countertransference-feelings of anger. The second period was followed by a stage of countertransference feelings of total confusion and the anxiety of the patient's psychotic breakdown which she induced by her way of concrete thinking creating, on a manifest level, a psychotic transference. However, the second and third stages in the development of the countertransference were characterised by a powerful split. The manifest countertransference was in the second period indicative of defensive mechanisms against Oedipal conflict and seemed in the third stage to indicate preoedipal disintegration. The manifest part of the transference-countertransference was available for verbal reports and interpretations. The other part of the split countertransference was an underlying strong positive maternal countertransference on the level of early whole-object-relating. This part of the countertransference was preverbal and it was impossible to communicate or report verbally or in writing. On a symbolic level it was only possible to represent the chaos of the defensively regressive material and the seeming disintegration of the patient's psyche. The split between the two parts of the transference-countertransference-manifestations was so strong initially that the nature of the split as defensive against the acknowledgement of an Oedipal transference was expressed in the re-enactment of the split in supervision reflected in the therapist's inability to convey the early preverbal and presymbolic dyadic parts of the split countertransference.

It seemed vital to let the "not knowing" in terms of availability for interpretation as a result of complex unconscious communications stand. More important, however, was the effect the early countertransference had on the therapist for the creation of a positive therapeutic frame of holding. The presymbolic positive countertransference induced in the therapist an early dyadic maternal relating in a form analog to Winnicott's primary maternal preoccupation with the infantile part of the patient. It also created a facilitating environment in which, behind the false and defensive dyadic transference, the true dyadic transference developed unconsciously whilst in the session the manifest battle of the defensive regression against Oedipal guilt took extreme forms (14). Although what I have described as transference-countertransference-manifestation on the level of preoedipal whole-object-relating may developmentally have to be dated later than the primary maternal preoccupation in terms of the stage of psychic development a similar or even the same mechanism may be involved. However in the case described it will only possible to make any more precise statement about the patient's early dyadic object relationships at a much later stage of treatment at a point when under true regression, true preoedipal material has come into the manifest transference-countertransference-relationship (15).

The therapeutic alliance as a result of firstly the interplay between the degree of conscious and unconscious motivation, secondly the ability of whole object relating as the basis for the ability for symbolisation and thirdly the degree of conflict on Oedipal levels, was strongly held by the patient's well developed psychic ability for strong whole-object-relating on pregenital level which on the basis of a strong positive preverbal transference-countertransference-constellation allowed for the containment of the fierce Oedipal battle. Even further, the Oedipal battle could only develop because the patient unconsciously knew exactly how far the latent early dyadic positive transference-countertransference-relationship carried the manifest negative triadic transference (16). Whilst denying the acknowledgement of the Oedipal transference in any possible defensive manner the preverbal transference-countertransference was never challenged and the positive preverbal countertransference in the therapist remained stable throughout the storms of oedipal conflict representing the patient's early experience of a good mother-object.

The strong positive dyadic countertransference had been the indicator that the material the patient brought was defensive against Oedipal guilt and that the patient was in fact a full blown hysteric with a strong ego and with the developed ability for object relating, but with weak libidinal instinct control (2). The wealth of hysterical characteristics which the patient showed consequently, reminds us of Freud's Dora Case. The pattern of rationalisation, acting-out, thought-blocking and the lack of childhood material were only a part of the hysterical pattern the patient had presented (3).

If we take Zetzel's criteria for a good hysteric the patient would score poorly (17). If we had taken the parameters of the manifest level of the transference-countertransference-relationship in therapy, the strong acting-out, the intensive regression, the inability to remember and the failure to symbolise in combination with the patient's life history of parental separation would have put the patient firmly in Zetzel's third or fourth

category with a rather poor prognosis. Having only access to this level would have been alarming, as it was indeed to outsiders to whom the therapist reported in supervision or seminars. Zetzel's concept only includes the manifest level of the transference-relationship as a level of symbolic and interpretive availability. The manifestation of the preverbal and presymbolic countertransference in the therapist which was only available to the therapist himself who, together with the patient is part of the same therapeutic communication-system (7). Categorisation can only include material which is available on manifest symbolic level. The preverbal countertransference could not be part of an explicit assessment procedure. The therapist was only able to state that next to the manifest countertransference there was "something else" without really having conscious and symbolic grasp of what the "something" was.

If we had followed the manifest transference-countertransference we would have had to classify the patient into the third or fourth category of Zetzel's classification. This would have been dangerous since it would have implied a weak ego structure. We would have missed that the presented psychopathology was defensive against a very high degree of Oedipal guilt and anxiety. It shows the crucial importance of including the countertransference as parameter of prime importance into the assessment procedure (8). Only the therapist's own experience and the use of a latent positive and preverbal countertransference in a split overall counter-transference enabled him to treat this patient as a full blown hysteric with highly developed Oedipal defences.

A note on conceptualising a training case

Any conceptualisation of transference-countertransference-manifestations in psychotherapy very much concentrates on the relationship between infantile parts of the patient in relationship to parental representations in the therapist. However, a reading-in paper always contains as further dimension the third generation on grand-parental level represented in the therapist's own analyst and in his supervisors as maternal and paternal figures. A training case is only partly the therapist's case, and the treatment result is the outcome not only of the transference-countertranference in therapy but also of the reflections from supervision as well as from the candidate's own analysis.

As Winnicott says, "there is no such thing as an infant", but "the infant and the maternal care together form a unit" (13). In therapy this is reflected in the basic maternal acceptance of the patient by the therapist. So it can be said following Freud's concept, that the super ego of the child comes from the grandparents, and accordingly the way in which the training patient develops thus also reflects the way the therapist himself has had conscious and unconscious experiences in supervision and in his own analysis. The oscillations of the mirroring processes and reflections between the two levels are of prime importance in any training case and they deserve more intensive exploration. However, the moment of initiation is not the occasion to analyse this relationship, but it is the moment to thank my supervisors and my own analyst for standing behind me and guarding the therapeutic process.

Addendum

The material used for this paper covered the first two years of treatment up to and including the first sessions after the second summer break. Since then the patient has settled into her new job and has rapidly become very successful. She has met her mother twice and has, for the first time, found two female friends. At the same time she has been able to keep in contact with her father without being drawn into the continuing quarrels between her parents.

The positive transference has been strong in both parental roles. The patient reported with great intensity of feelings how her mother had read the same story to her over and over again when she was ill as a young child. The patient accepted my interpretation that now she had recovered in therapy she was able to appreciate that I had interpreted and did still interpret over and over again. She reported how, until the age of ten, she had loved to be in bed with her mother. She described how she had curled up and cuddled into her mother's body. She had liked her mother's body and described how she had admired her mother for her posture and how she had enjoyed looking at her. This strong homosexual love was illustrated in several dreams. Once she reported, with embarrassment, a dream in which a man had come into a flat where she was living with an older woman. It was clear that the man would sleep in her room, and the patient herself identified him as the therapist. The patient went on "but I did not tell you the really embarrassing bit of the dream: before the man came in, the woman and myself had made love". The patient herself linked this dream with a brief lesbian affair she had had in the past. In the material as well as in reality, the patient is presently very occupied with babies and pregnant women, sometimes identifying with the baby and sometimes with the mother.

At the same time the true positive paternal transference developed. One dream was about James, the fatherly friend who had died. He stood in the door looking at her in a friendly way and the patient linked this to me sitting behind her and looking at her. On several occasions the patient showed signs of acute separation — anxiety and fear of loss. She suddenly became frightened that I, as a foreign doctor, might under the new law, have to leave the country, or that I might disappear over Christmas like her father had disappeared when her parents separated.

The material which indicated separation anxiety was also loaded with guilt feelings about what she herself had done to the parents, especially to her mother. She felt that her destructiveness had driven her mother away. These feelings came strongly into the transference in connection with the Christmas break when the patient was frightened that she might drive me away. "It was always me who has driven away people I am fond of" and, "but the most upsetting thing is that I am fond of you and I find it hardly bearable because it makes me so vulnerable. The good thing about not being fond of anyone is that you can't lose what you haven't got".

After the analysis of triangular war and divorce, the analysis of the child in the patient who deeply loved her mother has started. A child who in her mind destroyed the marriage of her parents but who nevertheless has experienced their love. It is the treatment of a patient who has in fact a great capacity for love and concern.

REFERENCES

1. Bollas, C. (1983) 'Expressive Uses of the Countertransference', *Contemporary Psychoanalysis,* 19:1

2. Freud, A. (1936) *The Ego and the Mechanisms of Defence,* London: Hogarth Press

3. Freud, S. (1905 (1901)) 'Fragment of an analysis of a case of hysteria', in *Standard Edition,* 7. London: Hogarth Press, 1959.

4. Freud, S. (1914) 'Remembering, Repeating and Working-Through (further Recommendations II)', in *Standard Edition,* 12. London: Hogarth Press 1959.

5. Heimann, P. (1950) 'On Countertransference', *Int. J. Psycho-Anal.,* 31

6. Heimann, P. (1956) 'Dynamics of Transference Interpretations', *Int. J. Psycho-Anal.,* 37.

7. Heimann, P. (1960) 'Countertransference', *Brit. J. Med. Psychol.,* 33:9.

8. King, P. (1978) 'Affective Response of the Analyst to the Patient's Communications', *Int. J. Psycho-Anal.,* 59.

9. Moeller, M.L. (1977) 'Self and Object in Countertransference', *Int. J. Psycho-Anal.,* 58.

10. Racker, H. (1968) *Transference and Countertransference.* London: Hogarth Press.

11. Winnicott, D.W. (1958) 'The Capacity to be Alone', *Int. J. Psycho-Anal.,* 39.

12. Winnicott, D.W. (1960a) 'Ego Distortion in Terms of True and False Self', in *The Maturational Processes and the Facilitating Environment* London: Hogarth Press 1965.

13. Winnicott, D.W. (1960b) 'The Theory of the Parent-Infant Relationship' *Int. J. Psycho-Anal.,* 41, p87.

14. Winnicott, D.W. (1963) 'Dependence in Infant-Care, in Child-Care, and in the Psycho-Analytic Setting', *Int. J. Psycho-Anal.,* 44.

15. Winnicott, D.W. (1959-1964) 'Classification: Is there a Psycho-Analytic Contribution to Psychiatric Classification?', in *The Maturational Processes and the Facilitating Environment,* London: Hogarth Press 1965.

16. Zetzel, E.R. (1966) 'Additional Notes upon a case of obsessional Neurosis: Freud 1909', *Int. J. Psycho-Anal.,* 47.

17. Zetzel, E.R. (1968) 'The So-called Good Hysteric', *Int. J. Psycho-Anal.,* 49.

TRANSFERENCE AND COUNTER-TRANSFERENCE IN PRACTICE

Herbert Hahn

This paper looks at some psycho-analytic definitions of transference and counter-transference, notes aspects of the wider application of these concepts and offers three examples from professional practice which relate to the theme.

TRANSFERENCE

Freud on Transference

Transference is the English translation of Freud's term "Ubertragung". (Langenscheidt New Concise German Dictionary definition: "Assignment (of rights), delegation (of powers), transmission (radio), spreading (disease)."). Freud first saw transference as a form of resistance, later as a powerful therapeutic tool. He mentioned it initially in 1895 as a manifestation of the patient's resistance against insight, then developed in "The Interpretation of Dreams", 1900, the theory that transference is part of our psychic functioning by which unconscious impulses find expression in our dreams. In his clinical paper on his patient Dora (1905) he finally introduces the notion that transference is the central factor in the therapeutic process: There he says that transference refers to the "series of psychological experiences" which are "revived, not as belonging to the past, but as referring to the therapist at the present moment." Treatment does not create transference, but brings it to light. It is an "inevitable necessity" in treatment, and only after the transference "has been resolved" does the patient gain "a sense of conviction of the validity of the connections which have been constructed" during the therapy. In his paper "The Dynamics of Transference" (1912), Freud states: "In each individual as a result of the interaction of heriditary and environmental influences, "what might be described as a stereotype plate" is produced (or several such) "which is constantly reprinted afresh — in the course of the person's life, so far as the external circumstances and the nature of the love objects accessible ..... permit, and which is certainly not entirely insusceptible to change in the face of recent experiences."

Melanie Klein on Transference

In one of her early papers (1927) Klein speaks of even young children having "inner images" of their parents, which can emerge in treatment if the therapist adopts a sufficiently neutral stance.

In her 1952 paper on the 'Origins of Transference' she offers her comprehensive view: "My conception of the transference as rooted in the earliest stages of development and in deep layers of the mind entails a technique by which ..... the unconscious elements of the transference are deduced (from the total communication of the patient) ..... The patient is bound to deal with conflicts and anxieties re-experienced towards the analyst by the same methods he used in the past." She then continues "Our field of

investigation covers ALL that lies between the current situation and the earliest experience ..... It is only by linking again and again (and that means hard and patient work) later experiences with earlier ones and vice-versa, it is only by exploring their interplay, that present and past can come together in the patient's mind. This is one aspect of the process of integration ..... Fundamental changes can come about through the consistent analysis of the transference."

In another paper, 'Some Theoretical Conclusions Regarding the Emotional Life of the Infanct', also published in 1952, she emphasises the importance of analysing the negative transference. She states that it is only by analysing the negative as well as the positive transference that the patient is able to work through, and so modify early anxieties leading to a synthesis of "good" and "bad" figures. She gives a vivid example of interpreting the negative transference, very early on in her first session with her patient Rita.

We glimpse another image of transference as she conceived of it in her book "Envy and Gratitude", 1957. She says there that "The whole of the infant's instinctual desires imbue the mother's breast with qualities going far beyond the actual nourishment it affords ....." and she adds in a footnote "All this is felt by the infant in much more primitive ways than language can express. When these preverbal emotions and phantasies are revived in the transference situation, they appear as 'memories in feeling' as I would call them, and are reconstructed and put into words with the help of the analyst."

Wilfred Bion on Transference

Crucial, it seems to me, to the development of Bion's ideas on Transference is Melanie Klein's concept of projective identification. She conceives of it as "A particular form of identification which establishes the prototype of an aggressive object-relation." (M. Klein, "Notes on Schizoid Mechanisms, 1946)*

Bion states that "The elements of the transference are to be found in that aspect of the patient's behaviour that betrays his awareness of the presence of an object that is not himself. No element of his behaviour can be disregarded; its relevance to the central fact must be assessed. His greeting or neglect of it, references to the couch, or furniture, or weather, all must be seen in that aspect of them that relates to the presence of an object not himself; the evidence must be regarded afresh each session and nothing taken for granted for the order in which aspects of the patient present themselves for observation are not decided by the length of time for which the analysis has been endured ....." (Elements of Psycho-Analysis, 1963, ch. 15).

* Meltzer proposes that we differentiate between: Projective Identifications: "Unconscious motivation to communicate feelings and have them understood" and "Intrusive Identification": unconscius wish to intrude into and control the analyst as a way of dealing with anxieties." (J. Child Psychotherapy, 1982).

In "Transformation" (1965) Bion elaborates his concept of "Transference as follows: "The idea implicit in the theory of transference is that the analyst is the person onto whom the analysand transfers his images. (However) this does not help the analyst to recognise ..... that a patient may use the mechanism of projective identification in a field which is multi-dimensional and includes the analyst, his own personality and even the relationship between himself and the analyst — all those and more — in a particular way."

COUNTER-TRANSFERENCE

The term refers to an experience in the therapist which is the result of "the patient's influence on" the therapist's "unconscious feelings". The therapist must discover how this relates to the therapist's own complexes. ('The Future Prospects of Psycho-Analytic Therapy', Freud, 1910).

The therapist must recognise that a patient's falling in love with the therapist is induced by the therapeutic situation, and Freud sympathetically warns the therapist against any "tendency to counter-transference", meaning here, falling in love with the patient. ('Observations on Transference Love', 1915)

Paula Heimann on Counter-Transference

Heimann (1950) defines Counter-transference as the analyst's emotional response to the patient, and she regards it as one of the most important tools for analytic work. She says "our basic assumption is that the analyst's unconscious understands that of his patient. This rapport on the deep level comes to the surface in the form of feelings which the analyst notices in response to his patient, in his 'counter-transference'. This is the most dynamic way in which the patient's voice reaches him".

"There will be stretches in the analytic work, when the analyst who combines free attention with free emotional responses does not register his feelings as a problem, because they are in accord with the meaning he understands. But often the emotions roused in him are much nearer to the heart of the matter than his reasoning, or, put it in other words, his unconscious perception of the patient's unconscious is more acute and in advance of his conscious conception of the situation". (Heimann, 1950). She adds that this approach to counter-transference is not without its danger. "It does not represent a screen for the analyst's shortcomings. "The analyst must in his own analysis have worked through his own conflicts and anxieties so that he does not impute to his patient what belongs to himself." (P. Heimann "On Counter-transference", paper read to the 16th International Psycho-Analytic Congress, Zurich, 1949)

Melanie Klein, as far as I can discern, said little about counter-transference in her writings. She conveys in the Narrative of a Child Analysis (1961), the sense that counter-transference refers to unresolved problems in the analyst, as when she says that she was aware of her positive counter-transference to Richard, and did not let it interfere with the work.

Wilfred Bion on Counter-Transference

Wilfred Bion, in "Learning from Experience" (1962) warns against viewing counter-transference only as a symtom of the analyst's unconscious motives, leaving the patient's contribution unexplained.

In 'Elements of Psycho-Analysis' (1963) he warns the analyst against making an interpretation "intended" to prove to the patient that the anxiety the analyst experiences, namely, that the situation is unknown and frightening, is not "so". This indicates, he states, that the analyst needs more analysis. Then, in 'Transformations', (1965) he notes how disturbed patients incessantly try and stimulate the analysts' unconscious and evoke his counter-transference because of a need "to evoke evidence of the existence of meaning".

Perhaps we can bring together the two perspectives on Counter-Transference by taking account of Donald Meltzer's differentiation between projective identification and intrusive identification. (See footnote on previous page). When the process the patient is involved in is primarily projective identification, it is more likely that the receptive analyst will receive and understand the communication; when it is intrusive identification the therapist has to do more work with him or herself to 'metabolise' the experience.

Discussion

The excerpts quoted above hopefully reflect central views on the subject. Freud conceptualised transference when studying unconscious manifestations in dreams and in the clinical situation. M. Klein and later Bion, Meltzer and others enlarged the concept and also developed Freud's views on Counter-Transference.

In summary, what we have is a view of an unconscious dynamic, conceptualised as transference and counter-transference, in a highly specialised dyadic relationship. At the same time, one aspect of it, namely transference, is considered to contribute to our object relationships throughout our lives. In the dyadic setting of psycho-analytic treatment, the manifestations of transference configurations provide the basic tool for the analysand to gain insight (or for the analyst to become aware of a need for more insight); but how can an understanding of these processes gained in analyst-analysand experiences be constructively or integratively drawn on outside the psycho-analytic situation, if at all? I think this is possible and that we can find encouragement from D. Meltzer and M. Harris in the following:

M. Harris, writing about alternative techniques in once-weekly treatment, states: "Here I am thinking of ways in which the analytically trained therapist may be able to use the observations he has been trained to make without consistently employing the psychoanalytic technique of interpreting in the transference. Observation of transference phenomena, which necessitates a sensitivity to one's own counter-transference, is a most valuable focus for assessing the quality and mode of a patient's relationships, and should never be neglected if we are trying to make an enabling

contact with an individual, rather than a case to which we are trying to apply our theories about psycho-pathology and personality development." (M. Harris, 1971).

D. Meltzer, in the introduction to his book on "The Psycho-Analytical Process", (1967), states: "If the latter's (the analyst's) only claim to special qualification is his capacity to deploy his 'organ of consciousness' inward to comprehend his counter-transference, the rest of the analytical 'work' is technical in the session and intellectual in response. With his technical and intellectual equipment, the analyst undertakes to perform in a special way, and to encourage his patient towards a similar performance, namely to utilize consciousness (of the derivatives of unconscious processes) for the purpose of verbal thought, as distinct from action. This amounts to an undertaking to 'contain' the infantile aspects of the mind and only to communicate ABOUT them"

"And so, to a greater or lesser degree, there is always in existence, if not always available for contact, a most-mature-level of the mind, which, because of its introjective identification with adult internal objects, may reasonably be termed the 'adult part' ..... The hope of the analyst is that this 'adult part' will gain increasing control over the 'organ of consciousness', and thus of behaviour, not only for the purpose of increasing co-operation but eventually for the development of a capacity for self-analysis." ..... "Until the analyst's experience is wide on the one hand and his character has been stablised by analytic treatment on the other, this structure of theory is continually toppling down under the stress of analytic work, its pain, confusion, worry, guilt, disappointment. The 'surfacing' to take stock, which occurs while the student is in analysis and while the young analyst is having supervision, must eventually be taken over by an autonomous process. To this function the conceptualisation of the analytic process can make a contribution — and thereby to the research capacity of the developing analyst. By this I mean his capacity to 'discover' psycho-analytic phenomena, beyond the verification of all he has been taught." But we must also remember the "dangers, namely the temptation to guard ourselves against the distress enumerated above by scotomization, by obsessional control, by docile dependence on and acquiescence in theory."

In M. Harris's paper, (1971), the emphasis tends to be on a capacity in the therapist to have a deeper understanding of interactions outside a psycho-analytic situation, while cautioning against the use of interpretations. While the quotation from D. Meltzer focuses on the existence in therapist and patient of a "most mature level of mind" and encourages the possibility of searching to find good, safe ways to contact it in psycho-analytic situations as well as in those where the therapist has a helping or facilitating role.

PRACTICE

I have for some years been engaged in working in both areas and would now like to illustrate the way in which I have tried to work with some of these issues in my own practice. The first example, which comes from analytic work, is intended to set the base-line as it were. The second example comes from a setting where a blurring of roles is built into the institutional framework and some effort was made to use this constructively; while the third comes from a consultancy assignment where there was an extremely limited opportunity for contact with the client and I tried to do the best I could.

Example from psycho-analytical therapy

The first example is drawn from the analytic psychotherapy with a professional man in his thirties who was being seen four times weekly in the context of his having 'broken down' and become unable to continue with his professional activities. Although highly intelligent, and frequently very articulate, it became increasingly usual for him to be almost unable to speak during most of his sessions. Often, he would struggle, utter sounds, even start sentences, but stop as if unable to continue. Over a period of several weeks, it gradually became possible to learn that this inhibition was related especially to the way in which he was frequently experiencing me. Thus he would arrive for his session, looking forward to it, and with a lot to say. Then, as he lay down on the couch he would begin to experience a frightening and even terrifying relationship to me. This was gradually elucidated as his experience that I required him to be "deferentially, optimistically, unhappy" as a condition for my accepting him. If he did not meet my requirements, he would be rejected, but also much more primitively, it felt to him that his identity, his self-hood, his very existence were at stake.

We were also able to learn the "reasons" for my "requirements" as he experienced and thought about them. His deference was required by me because I needed to feel powerful in relation to him. He had to be optimistic, so that I should not experience him as making demands on me to make him better, but he had to be unhappy in order to prove that he did need me and was dependent on me. He had to meet these contradictory requirements as the only way in which he had any hope of having a relationship with me. It was no surprise to learn that these elements of projective identification linked closely with significant aspects of his historical relationship with his parents (as he recalled the experience) and also to his distrust of relationships in general and of verbal exchange in particular ..... While the psycho-analytic setting and the beginnings of a verbal framework in which some of these experiences could be given new, more contained, meanings gave him occasional hope and relief, the intensity of the experience recurrently flooded the sessions, and made the level of adult co-operation at times very tenuous.

Once when this patient arrived ten minutes late for a session, owing apparently to accident rather than design on his part, he remained paralysed with fear for most of the rest of the session, at last saying he was convinced that I would be overwhelmed with disappointment and anger because of his lateness and that I would be totally committed to punishing and rejecting him. At other times, he simply felt certain that I had to control him in order to affirm my own identity — he felt that there was "some love" in this, but he desperately wished I could find a way to care about him, a way which also let him "be".

These were some aspects of the transference which unfolded and became unravelled as part of the work with this patient. In it, especially in the early sessions, I frequently felt overcome by a desperate feeling that I needed to do something to ease his anxiety, yet discovered that almost anything I said appeared to make things worse, leaving me feeling clumsy, stupid and guilty. Gradually I became more able to bear the experience

without 'having' to intervene, and then I became increasingly concerned to be able to be patient, with increasing evidence that if we could both stand it, this in itself led to some containing experiences and better contact.

This disturbed state of internal object relationships, which I am convinced was the primary basis for the phenomena which have been described, continued to surface in his relation to me, but also gradually after about a year of treatment what he called the "vortices" in his relationship to me began to give way to other forms of communication. Here is an example from a session near the holiday break.

Early on in the session he blamed me for blocking him from talking about what he was interested in and preventing him from making contact with his feelings. Towards the end of the session he talked of how much he would miss a female colleague who had supported him at work (he had by now gone back to work), and expressed the view that his anger with me had been because he had not known any other way to convey the feelings he experienced at that point. He stated that he attached great importance to his treatment in a way which sounded genuine rather than placating balm for the earlier 'attack' on me. We also became able via his dreams and associations to identify violent forces within himself partly representing a disturbed internal mother and partly a child enviously attacking the parents creative coming together.

Example from counselling practice

Helge had come to see me on an approximately fortnightly basis during the first term of the academic year. During the second term, she was away on a placement, and only three meetings had been practicable. The following account relates to the first three sessions in the third term:

At the first session, she spoke about her parents' recent visit from abroad to see her. She had taken a lot of trouble in showing them round and they were delighted with what they saw. However, it had been a strain for her. She had experienced her parents as being very demanding and critical in just the way she had described to me in previous sessions. She noticed that her habit of picking at herself increased. Her parents also noticed this and had said: "See how nervous you are! How can you manage to do the course here when you're so nervous!" She went on to speak about her uncertainty regarding her future career. She had previously spoken about her interest in tourism and had felt encouraged to consider this as a serious possibility, but now she was less sure. She did not feel confident that she would be able to deal with all the various types of tourists. We were both aware that she was discouraged by the fact that she had found it so draining to deal with her parents as tourists.

It was time to stop and as she rose to leave, she asked if I minded her asking me something a bit personal. I asked what she had in mind and she went on to ask why at the students and staff plenary meeting the previous week, I had remained seated when addressing the students. The question which was apparently reasonable, somehow had an undermining effect on me. Afterwards I found myself thinking

defensively that I have given careful thought to the way in which I would participate in that meeting, and in particular to what I would say to the students and how I would say it, specifically because of my concern about the extent to which my participation in this meeting might interfere with the development of the work with those students who were seeing me for counselling. I realised, on reflection, that there was a strong similarity between what might be called my counter-transference feeling, and the way she described herself feeling with her parents.

Our plan was to meet weekly this term, and Helge began the next session by referring to the placement she had been on the previous term. In particular she described in some detail her first few days in the setting, and how she had come to make what she thought was a good contact with one of the other people in the office and had been hurt when this person had told her that she, Helge, was "too serious". I sked if she could say more about how she felt about what had been said, and she replied that she felt sad; that the other person did not understand that "it's only part of me. I didn't know how to explain". I asked whether cultural differences regarding appropriate ways of behaving at work might have played a part and she replied: "No. When I worked in an office in Germany I was also criticised for the way I behaved. I was told that I was false because I was always smiling, even when there was nothing to smile about."

Privately I noted her firm rejection of my comment and was reminded of the way she had asked me her question at the end of the previous session, and decided to refer back to this by reminding her of her question at the end of our previous meeting and saying that I wondered whether there was any particular reason why she had asked. She replied that she had not liked my sitting down. She had not been able to see me. She does not like it when she cannot see the person who is speaking to her. She had already told me in the first term how she found it difficult to speak to people on the telephone. I said that it turned out that her question was a way of expressing a criticism of what I had done, and went on to reflect aloud that criticism was often a theme in our meeting. She said, "Yes, but how can I put it right?" I said, "I wonder whether you felt criticized by what I just said?" She laughed, said "Yes", quickly adding "I know I should see it not as a problem, but an opportunity."

I said that I saw what she meant. Also that in a certain sense whether one saw it as a problem or opportunity, it was in the same perspective: that of success — failure; and reminded her how her eagerness to ask the last questions in lectures had resulted in her being unable to ask any at all. I continued that perhaps we could also approach the problem as something on which to focus our interest with a view to understanding more about it. *She responded,* "I can't. It's difficult. I am very self-critical and very critical of others. How can I learn not to be?" *I said:* "Perhaps by experiencing somebody accepting you?" *She responded:* "My boyfriend does but I don't change ..... I remember something that happened at the end of last term. It was raining and we had just left with our suitcases from the house we'd been staying at. Pierre (her boyfriend) said after we had gone a little way that we should have given them some flowers. I said, 'No. We paid them, and it's raining and I'm getting wet.' He persisted, then the first shop we came to was closed and so was the next, and he said, 'Well, we tried, let's not go on, you are getting very wet'. Then I said 'No, WE WILL GET SOME FLOWERS.

AND I INSISTED'," She suddenly stopped the flow of her own words and said — "I'm just like my mother. I like to hurt people". She seemed surprised and hurt by her discovery, yet somehow more relaxed. *I said:* "Perhaps understanding that can also give you more of a choice about how you deal with such situations in the future?" She seemed to think for a moment, and said "Not with my mother." *I said:* "Perhaps that would be the most difficult, but it's more of a possibility with your boyfriend." She nodded in agreement. It was time to stop. On leaving she said, "It's good to have an hour to really think about these things."

During her session the following week, she told me she'd been crying since we last met. That it was upsetting knowing these things about herself. She'd also discussed some of it with her boyfriend, and asked "If he minds me changing. He said, he did in some ways. Though he also hoped I would not become too much like him because he likes me to be different." She went on to wonder how things would be next year particularly in relation to her boyfriend and her family. Also about her birthday. She'd like to do something different, and is exploring the possibility of hiring a boat. I listened, conveying interest in what she was telling me.

Example from Career Counselling

Mr G T, age 57, had eleven years experience with the Manufacturing Industry Training Board as Area Training Adviser. Previously, he was 17 years a Chief Executive Officer with a Building Society. For our meeting he prepared a seven page summary which detailed his work and experience to date and included four options for a possible course which he was considering:

1) Executive management position with a small company.

2) A step "backwards" to the Co-op movement as a development organiser and he had one particular organisation in view.

3) "Further education", particularly as part of the government's new training intitiative which provides young people with an insight into the very area in which he has extensive experience. He also mentioned that he had been invited to join the teaching staff of a College of Further Education on a part-time basis lecturing on his subject.

4) Developing his own business, although the "hassle" does not really appeal to him and he thought he might find it difficult to wait for the "obvious longer term benefits", when he has worked for salary all his life.

The "obstacles", which he had also summarised in advance, were "mainly age and a lack of specialised discipline". Although he could elaborate in great detail on his notes on aspects of his work which he had previously found satisfying, he did complain that he disliked "sacking people" and also that "whatever monumental progress you were able to make, existing commercial conditions were nearly always against you."

However, what he wanted from me was "a reassessment of my own opinion of myself, perhaps a guide towards the type of activity I should pursue in the future. Perhaps even a resurgence of a belief in myself, which I appear to have lost during my 11 years with the Training Board and the indifference it seems to have bred into me".

In fact I found that although he spoke at great length, reflecting his long summary, there seemed no motivation at all in him to actually get down to work. He seemed passive rather than depressed and I wondered whether he had found his work with the Board too easy, had not really been stretched, and perhaps had adapted to this way of life. These thoughts came from the 'feel' of our meeting. Thus working with him felt much more like a conversation than an exploration with somebody who was seriously and actively considering possibilities for the future. In the event, I decided to draw on my direct experience and told him that I thought that his experience in the Board had indeed got him into the habit of a comfortable way of life, with little energy and direction. I pointed out that this was also very much there in the atmosphere of the discussion between us. He seemed hurt, but did tell me that surprisingly enough other people had said the same thing to him. The rest of the interview focussed on trying to work through his sense of pain and shock and to encourage him to begin to think more constructively and actively about his future. I later heard that he had been surprised by our meeting. He had, however, discussed it with colleagues and according to my information was showing signs of becoming more active in his search.

Discussion

In all three examples I have tried to illustrate some aspects of the trasnference-counter-transference process involved. It seems to me that all three settings provide overlapping opportunities to tune into them. While the setting in the first case enhances by its very nature opportunities for transference manifestations, there are elements of this available for observation in all three. The therapist is not necessarily the only potential source of insight. The second example illustrates the possibility of encouraging a climate for discovery via communication and reflection in which the client can take an active part in the process of self-understanding. Here, the therapist's understanding of the transference-counter-transference helps him to facilitate this climate. The possibility of commenting directly on aspects of the apparently not-conscious aspects of the consultant-client relationship is discussed in the third example, even when there will be no opportunities for 'working through'. It was hoped to give the client some insight into the way his habitual mode of passivity and dependency was severely limiting the effectiveness of his career planning.

The conclusion which I draw from the before-said is that an insight into transference and counter-transference phenomena gained from experience in the psycho-analytic setting can be applied professionally in a wide variety of settings, if one gives careful attention to the people participating in the dyad and also the special conditions of the setting in which it takes place.

REFERENCES

Bion, W.R. (1962) 'Learning from Experience'. In: *Seven Servants.* Jason Aronson. 1977.

Bion, W.R. (1963) 'Elements of Psycho-Analysis'. In: *Seven Servants.* Jason Aronson. 1977.

Bion, W.R. (1965) 'Transformations'. In: *Seven Servants.* Jason Aronson. 1977.

Freud, S. (1895) *Studies on Hysteria. Standard Edition, 2.* London: Hogarth Press. 1955.

Freud, S. *(1900) The Interpretation of Dreams. Standard Edition, 4 and 5.* London: Hogarth Press. 1953

Freud, S. (1905) 'Fragment of an analysis of a case of hysteria'. *Standard Edition,* 7. London: Hogarth Press. 1953.

Freud, S. (1910) 'The Future Prospects of Psycho-Analytic Therapy'. *Vol. XI. Standard Edition.* Hogarth Press. 1957.

Freud, S. (1912) 'The Dynamics of Transference'. *Standard Edition,* 12. London: Hogarth Press. 1958.

Freud, S. (1912) 'Observations on Transference Love'. *Standard Edition,* 12. London: Hogarth Press. 1958.

Harris, M. (1971) 'The Place of Once Weekly Treatment in the Work of an Analytically Trained Psychotherapist'. *J. Child Psychotherapy, Vol. 3.*

Heiman, P. (1950) 'On Countertransference'. *Int. J. Psycho-Anal. Vol. 31.*

Klein, M. (1927) *Symposium on Child Analysis. The Writings of M. Klein. Vol. 1* London: Hogarth Press. 1975.

Klein, M. (1946) 'Notes on Some Schizoid Mechanism'. *The Writings of M. Kelin. Vol. 3.* London: Hogarth Press. 1980.

Klein, M. (1952) 'The Origins of Transference'. *The Writings of M. Klein. Vol. 3.* London: Hogarth Press. 1980.

Klein, M. (1957) 'Envy and Gratitude'. *The Writings of M. Klein. Vol. 3.* London: Hogarth Press. 1980.

Klein, M. (1961) *The Narrative of a Child Analysis.* London: Hogarth Press.

Meltzer, D. (1967) *The Psycho-Analytical Process.* Heinemann Medical Books.

Meltzer, D. et al (1982) The Conceptual Distinction Between Projective Identification (Klein) and Container — Contained (Bion), *J. Child Psychotherapy, Vol. 8.*

OBITUARY: CLARE WINNICOTT

Margret Tonnesmann

Clare Winnicott, OBE, was a committed friend of the British Association of Psychotherapists and in particular its Freudian Training Course. She took an active part in it as training therapist, supervisor, lecturer and clinical seminar leader. Our students were always most appreciative of her lectures on "Donald Winnicott's Contributions to Psycho-Analysis" and also her clinical seminars and they repeatedly asked for more. It was Clare's warmth, her spontaneity and her fine sense of instantly understanding the other's feelings of the moment which made it such a pleasure to be with her. Whether she felt gaily, angry or was thoughtful she always radiated a delightful glow of being alive and she was a fierce advocate of every human being's right to be themselves, no matter what. When she retired from her distinguished work in Child Care and after Donald's death she devoted much of her time to clinical psycho-analysis and also to the task of making some of his so far unpublished papers available. Her clinical work was in the Winnicott tradition but she also brought her own individual style to it.

Over many years she suffered from a painful illness. With admirable courage she faced her pains and made them an integral part of herself which could be talked about with ease and yet, as she once remarked, she had made up her mind not to let her illness interfere with her life.

Clare phoned me at the beginning of February, shortly before the start of her lecture course to tell me that she was not sure whether she would be able to give the full course but she was very keen to se the students at least a few evenings as she liked teaching our students so much. Her doctor had put pressure on her to have yet another admission to hospital where she had been so often over the last years for further often painful treatment.

The students were not aware of the seriousness of Clare's illness as she was as lively and interesting as ever. On the third evening she discussed Donald's paper on "Fear of Breakdown" and on the fourth evening she presented her own clinic work to show its clinical application. This was her last lecture. Two days later she went into hospital and was heavily sedated to relieve her from the pain. She died on the 17th April 1984.

When I returned from my holidays I had a number of phone calls from parents of Donald Winnicott's child patients (and there must be many more who contacted other colleagues). They had read the obituary in the Times and just wanted to talk about Clare. A few only knew her from having talked to her on the phone and that many years ago, but they had appreciated her understanding approach to them.

Both Clare and Donald will stay vividly alive in the memory of many who knew them. Their untiring efforts to share with all those who were keen to learn from them their unique ways of understanding the feelings involved in the child's communications and also understanding the child in the adult without ever reducing him to a child will hopefully benefit many patients and clients in the therapists' consulting rooms and the various areas of mental health work.

BOOK REVIEWS

PSYCHOLOGY AND PSYCHOTHERAPY — CURRENT TRENDS AND ISSUES

Edited by David Pilgrim

Routledge & Kegan Paul. 1983. Pp. 236. £7.95 – paperback

For a long time psychologists have been craving scientific status and few have accepted that psychology might be an art. Psychologists who are psychotherapists are just beginning to break free from this dilemma. They can now openly declare that they are *not* scientists and do not have to justify this. This thought-provoking collection of readings begins to reflect the resultant freedom from having dropped their defences on having worked through much of this conflict.

The contributors to this book are from the Psychology and Psychotherapy Association (PPA). They are a radical, small, atypical group of psychologists — mainly personal construct and dynamic theorists — who each have something interesting to ask and say.

When one moves away from the comparative safety of a 'scientific', medical model, the prospect is daunting, to say the least. As David Pilgrim states in his Introduction, it is far easier to buffer yourself against people's anguish by placing 'advice, pills, tests or statutory procedures' between yourself and them, than to deal with the uncertainties of what professional status one can maintain as a psychotherapist: 'Is private or State funded friendship being offered or is psychotherapy something over and above this?'

Collectively, these theorists seem to accept that psychotherapy cannot be considered a 'scientific undertaking' and is more a 'moral enterprise' (Szasz). There is, it seems, a vested interest in not pursuing research which could prove one's own ineptitude. They agree that while theory has its importance, therapy, finally, centres on a personal relationship which cannot be standardised or reduced to jargon or techniques. As Bill Barnes remarks there is no *one* theory or answer. Each patient has to find his own answer. In personal life there is no 'scientific truth'; the importance lies in reconstructing a *personal past* that is meaningful to the patient. Thus, absolute objectivity is impossible in psychotherapy and it *cannot* be 'scientific' if one is a participant observer. However, as David Smail asks, if we are not scientists, what can we as therapists offer over and above spouses, mothers, lovers, best friends or barmaids?

I think the answer is clear. The most we can hope to offer is an unequal, non-intrusive but caring involvement: we can offer a degree of objectivity. In my own life, my years and years of analysis have not made me conflict free, but merely, I hope, somewhat more objective. Moreoever, Carkhuff and Berenson (1967) found in their research that the most effective therapist qualities were: '(1) accurate empathy, (2) non-possessive warmth and (3) genuineness': that is, qualities suggesting a sympathetic and natural objectivity and not a cold, detached scientific approach.

The book is divided into two parts. The first, dealing with 'Theory and Practice', is intent on freeing psychotherapists from their constraining 'scientific' chains. The second part deals with 'Politics', and is concerned with freeing psychotherapists (especially psychologists working in the NHS) from the accepted models of hospitals, doctors (particularly psychiatrists), and nurses. These all want instant solutions and are frightened by the prospect of understanding, or thinking up strategies or looking at the prevailing system. They want the safety of clear-cut answers, of *seeing* results, and cannot tolerate the threat and uncertainty of relating and spending time with patients.

The PPA group go a long way towards showing us that patients are not enemies to be subdued and overcome, that they actually 'have a right to be right', and that our mental health organizations are not equipped to deal with psychotherapeutic values which are in direct opposition to their institutional ethos.

I learned much from this whole collection of readings. If I had to select *one* paper to recommend above the others, it would be hard but I think I would choose Paul O'Reilly's moving, personal account of his own life experience and journey into family therapy. His honest revelations clearly bear out Fairbairn's remark, quoted by Llewelyn and Osborne in chapter 11, here: 'I can't think what could motivate any of us to become psychotherapists if we hadn't got problems of our own'.

Judy Cooper

REFERENCES

Carkhuff, R.R. & Berenson, B.G. (1967) *Beyond Counselling and Therapy.* New York: Holt, Rinehart and Winston.

BOUNDARY AND SPACE: AN INTRODUCTION TO THE WORK OF D. W. WINNICOTT

By Madeleine Davis and David Wallbridge

Penguin. 1983. Pp. 191. £3.95 – paperback.

This book is, as the title suggests, an introduction to those not familiar with the work of Winnicott. It is also the first attempt to set out systematically the development of his own thinking and his theories of emotional development. Although it includes reference to and quotations from much of Winnicott's published and so far unpublished papers, it is written primarily for those in allied helping professions rather than psychoanalysts and psychotherapists. Consequently it may be somewhat of a disappointment to those who were looking for description, discussion and explanation of Winnicott's psychoanalytic techniques, particularly with adults. Any examples are drawn from his work with children

Davis and Wallbridge begin briefly by placing Winnicott in the context of his family background and tracing the development of his interest in medicine, paediatrics and finally psychoanalysis.

There follows the main body of the book in which the authors unfold his theory of emotional development. As they had access to all of Winnicott's writings, they draw liberally and extensively quoting much that is as yet unpublished as well as much that is already familiar to us. Firstly his theories of intra-psychic development are described; then the child's relationship with outer reality; finally the theories of the importance of the part played by the environment in the emotional growth of the child, wherein Winnicott's enormous contribution is clearly described.

The last section of the book is the one from which it takes its main title, Boundary and Space. These concepts are defined and the important relationship between them examined in the successful development of the normal child.

This book is, perhaps, most quotations from Winnicott himself, with linking narrative by Davis and Wallbridge: indeed much of the explanatory part of the text is Winnicott himself. It achieves what it sets out to do, being a clear introduction to his theory of emotional development, but it also whets the appetite and leaves the reader wanting to read more of Winnicott for himself.

Hazel Danbury

PSYCHOANALYSIS: THE IMPOSSIBLE PROFESSION

By Janet Malcolm

Pan Books. 1982. Pp. 174. £1.95 – paperback

In this highly entertaining and thought-provoking book, Janet Malcolm takes us on a journey through psychoanalysis, its theory and application to treatment; it is written by a layman to make the subject understandable to laymen and in this aim it more than succeeds. Her vivid style makes it equally engrossing to those already steeped in the subject.

The book describes a number of sessions the writer has with a New York Freudian analyst "Aaron Green" which in some senses parallels an analysis itself; they discuss and question together the process of analysis and its supporting theories.

Interspersed between the sessions are chapters bringing the theory into focus for the reader, with many references and quotations from Freud et al. After the basis of the theory is established, Malcolm looks critically at the later theories of, for example, Winnicott, Kohut & Kernberg.

"Aaron Green" eschews all but classical Freudian theory, techniques and interpretations; any deviation, he considers, results in its not being psychoanalysis. He forcefully maintains this position with well reasoned and very persuasive arguments in response to Janet Malcolm's sympathetic, knowledgeable, if sometimes rather cynical questioning.

Although one may not always agree with the conclusions reached in this book, it nevertheless must present to the lay reader an accurate glimpse into the world of psychoanalysis: to the professional it makes us stop and re-examine our ideas, theoretical framework as well as the ways in which we carry out our work and the rationale for this. Perhaps there are few who would agree with the rigid definition given to psychoanalysis, but equally there must be few who could put down this stimulating and lively book having once begun reading it.

Hazel Danbury

DEPRESSION: THE WAY OUT OF YOUR PRISON

By Dorothy Rowe

Routledge & Kegan Paul. 1983. Pp. 242. £3.95 – paperback.

Therapy with depressed patients is a little like the art of walking the tightrope. If the balance of interpretation veers too much to the side of explaining current feelings in terms of previous experiences, and thus towards sympathy and acceptance, the therapy will risk an expensive prolongation through the failure to foster what have come to be known as 'independent coping skills'. If, on the other hand, the balance veers too much to the other side, with the therapist providing too frequent comments about such alternative coping patterns, the working alliance may be threatened by the depressive's oversensitivity to criticism. In individual therapy one is fortunately able to monitor this balance minute by minute as feedback from the patient is continuously available. But when one is attempting the same task through a book one cannot tailor the message to suit the individual needs of each reader, and the balance is therefore even more difficult to achieve.

Dorothy Rowe has bravely attempted this task. That her book is aimed primarily as a therapeutic message rather than a description of a disorder emerges immediately in the subtitle 'The way out of your prison'; and at frequent intervals throughout, she addresses her readers in the second person singular, often generalising about how 'we' feel in a way that occasionally risks sounding like a Sunday-school teacher (for example when she reminds us that Pride is the deadliest of the seven sins). But what she is saying is clear and not untrue; and she says it in a way which is vivid and easy for a wide range of readers to understand and find interesting. Quoting from poetry, biography, religious teachings and case histories of her own patients (she is head of the North Lincolnshire Department of Clinical Psychology), interspersed with some delightfully apposite cartoons, she presents a sequence of nine chapters which chart the escape roots from depression: their titles include 'Inside the prison', ' Why I won't leave the prison', 'Suppose I did want to leave the prison what would I do?', 'Suppose I decide not to change', and 'The prison vanishes'. This sample of chapter headings is enough to show that, in the circus acrobat terms outlined earlier, she leans towards the moral exhortatory rather than the explanatory side of the therapeutic tightrope. There is, for example, no chapter called 'If other people have managed to avoid this prison how did I get here?'

This tilt to her balance suggests that the author's perspective is essentially that of the Cognitive Therapists, for although this volume is not intended as an academic work, its quality and the list of references reveal that she is well versed in the current theoretical literature. The main focus of Cognitive Therapy is upon changing the depressive's tendency to react to everything with negative thoughts, particularly with pessimistic predictions and self devaluations. Critics of this perspective, whether psychoanalysts or sociologists, have sought not to deny but to elaborate it, by broadening the aetiological focus to include the factors which gave rise to, and which maintain, this

tendency to negative cognitions. At various points Dr Rowe gives convincing examples of how important attachments (and thus by implication the perspective of John Bowlby), can be in causing and preventing depression. But she is determined to lean to the same side of the tightrope: commenting on Brown and Harris' finding that a significant factor in depression was lack of a confiding relationship, she writes "It was not just that they had no one who would listen; it was that they had no one they could trust enough to confide in". The moral onus is placed again on the depressed person for not being trusting enough. But one important thing to remember about the depressed women in that study is that in their lives there *were* actually people who were unusually *un*sympathetic and who by not listening were contributing to the womens' depression. The message from that study was that the moral onus should not fall so heavily on the depressed but be shared by those around them. But Dr Rowe does not have time here to address the patients' relatives or their National Health doctors in the second person singular, although she does devote some space to describing how they may feel about the patient. This last could be very helpful to any depressed reader who has not been discouraged by the first 100 pages giving him an overwhelming sense of his own culpability. Given the range of personality types afflicted by depression there will be some who will have responded with a positive transference to the elaboration of their cognitive and behaviourial shortcomings, but many may fail to persist.

But despite its being written in the second person, the book should not be judged only in terms of its potential impact on depressed readers. As a way of conveying the experience of depression to those fortunate enough never to have suffered it, the initial descriptions of the prison succeed impressively. In this way the book may well have an impact, despite itself, upon factors on the other side of the tightrope. For those of us who have previously failed to see how our way of reacting to our depressed friends can serve to increase their depression this book may contribute to improving our capacity to listen helpfully. Perhaps this paradox can best be illustrated by the picture on the book's cover. It shows a man in seven stages of sitting; ignoring, then noticing and picking up a key, finally rising to unlock his prison. But he is doing it alone. There is no friend or counsellor who helps him reach out. Perhaps the impact of this book will be less on those readers who resemble the cartoon man than upon those who have been waiting for the script to play the role of this invisible liberator.

Tirril Harris

REFERENCES

Brown, G. & Harris, T. (1978) *Social Origins of Depression.* Tavistock Publications.

LISTENING PERSPECTIVES IN PSYCHOTHERAPY

Lawrence E. Hedges

Jason Aronson, NY. 1983. Pp. 239.$25.00.

This volume provides an impressive integration of the original contributions of Freud and the major new developments in psychoanalytical theory and technique. The focus around which this broad sweep of psychoanalytical thinking and practice is organised is in what Lawrence Hedges calls the therapist's 'listening perspective'. As Hedges points out, we hear what we are prepared or able to hear and he proceeds to open our ears. Only by informed understanding can we be truly empathic and make an appropriate choice of the treatment approach we should use with a particular patient.

Hedges uses 'listening' in the broadest sense of the word to include all forms of information received by the therapist as well as any of the therapist's responses to his patient. He distinguishes four distinctly different 'listening perspectives' which broadly correspond to four major phases of emotional growth or nodal points of self or object differentiation and to the familiar traditional diagnostic classifications: psychotic, borderline, narcissistic and neurotic. He likens the different psychotherapeutic approaches to each of these to the progressive parenting responses through a child's development from a subjective world of part-objects to the differentiated self of the child who has attained object constancy, becomes subject to those conflictual experiences with others which are the heir to the oedipus complex.

It is of course important not only to remember that these phases overlap but that the way in which earlier stages have been experienced and resolved affects the pattern of subsequent stages — a fact which led Balint to use a geological term, the 'basic fault', when trying to describe the affect of earlier mis-alignments on later stages of development.

The virtues of this book are its thoroughly modern interactional, post Einsteinian perspective, its clarity and freedom from narrow sectarianism, which allows him to bring together the observation of a wide range of psychoanalytic writers on the topics he discusses. Although reality may depend on the eyes of the beholder or the ears of the listener, I find it thrilling as well as re-assuring that so many clinicians have observed very similar phenomena even if their theoretical structures may differ. Perhaps reality is after all not as fickle as it is made out to be. Certainly every psychotherapist will be able to see, hear and understand more clearly with the aid of this book which should prove profitable reading for all.

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Papers particularly from members of the Association are welcomed and should be sent to the Editor, Mrs Denise Taylor, at 78a Compayne Gardens, London NW6 3RU.

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James, H.M. (1960) Premature ego development: some observations upon disturbances in the first three months of life. International Journal of Psycho-Analysis, 41: 288-295.

References for books should include the author's name and initials, year of publication in brackets, title of book, place of publication and name of publisher, e.g.

Winnicott, D.W. (1971) Playing and Reality, London, Tavistock.

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