THE ASSOCIATION

OF

PSYCHOTHERAPISTS

BULLETIN No. 2

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BULLETIN

No. 2 SEPTEMBER, 1960

OBITUARY

DR. KATHRYN COHEN, M.B., B.Ch., B.A.

The year 1960—Mental Health Year—began for us on January 1st with Kathryn Cohen's death. For those members of the Association who are not able to come to any of our meetings, this is a short attempt to describe the therapist we have lost.

Tall, with dramatic dark good looks, her soft voice dominated the scene when she spoke. No-one was a case history to her—not even after a day at St. George's, and anything up to 30 skin cases. Every patient was a person, each psychological reaction fraught with interest. She felt "in" to each individual, without losing objectivity; nor did this sympathy prevent her from being one of the most skilled medical hypnotists of our day. Preferring to use psychotherapy, she became one of our members in 1953. As well as her outstanding personality, her conviction that it was useless to divide disease into functional and organic will leave an indelible impression among us. She allowed no doctor to discuss a sick person without thinking of the unconscious factors at work, and no psychotherapist was ever left without reminder of the bodily expressions observable in any neurotic.

During her last two years she spent much time thinking about ways in which research into psychosomatic problems could be begun. Liaison between doctors and psychotherapists in a clinic designed expressly for such research and treatment was what she had hoped to see before she died. In endowing scholarships for our Association to train candidates who are already working with people and who wish to become psychotherapists, we are beginning with the foundations of such a project—the foundations being, of course, the psychotherapeutic staff.

TRAINING IN PSYCHOTHERAPY

KATHRYN COHEN MEMORIAL STUDENTSHIPS

Candidates wishing to apply for a grant towards an analysis prior to training as psychotherapists should write with curriculum vitae to the Hon. Secretary,

Association of Psychotherapists,
411 Upper Richmond Road,
Putney, S.W.15.

EDITORIAL

Training

Four months ago, the Kathryn Cohen Memorial Fund for the provision of scholarships in training for psychotherapy was founded. This has provided impetus for the Association to review its training programme for candidates. In this Bulletin we also take a critical look at our internal seminars and indicate plans for their future, as well as for the extension of the external seminars for social workers, probation officers, teachers in training colleges and those doing similar work.

All this has coincided with a request from the organisers of the World Mental Health Year for bodies active in the Mental Health field to make some contribution to the World Mental Health Year work, through their journals and teaching programmes. We therefore dedicate this issue of our Bulletin to that purpose.

Training for Psychotherapy

The flesh and blood of the training experience is not easy to convey to the reader. Miss Swainson's paper in this issue has succeeded in doing it. The fact that she has done so makes her contribution worthy of note, quite apart from any other merit it has.

Our Committee were divided, however, as to whether or not her paper should find a place in the Bulletin. On the one side, the honesty, sincerity and general " feel " of the paper were recognised as exceptional ; on the other hand, Miss Swainson was thought by some to lack the intellectual rigour of a defined theoretical framework, and to give a picture of trainees and trainer wandering around like babes in the wood of their own tangled unconscious processes.

Miss Swainson's paper is potent ; it has aroused considerable heat in those who have discussed it. The conflicting feelings reflect the dilemma that training for psychotherapy poses. On the one hand, it must be an intense personal experience for the trainee, and on the other hand it must equip him with theories and concepts which will enable him to evaluate critically what has happened to him, and to guide him, and allow him to build beyond his own personal experience when he comes to work with others.

We are a young Association, dealing with a young science. We are a little afraid that we may be dragged back into the subjective by the experiences we have in our work. Yet without these experiences, the work is nothing. It follows, then, that any training programme must emphasise the experiential qualities and at the same time demand the greatest possible intellectual rigour. It is sometimes felt that these demands are incompatible. At best, the outcome must always be a compromise. Hence the debate.

Miss Swainson offers her paper as a record of what has happened to her in the training field, and hopes that it will serve as a basis for discussion. What follows is a brief attempt to put forward some of our own thoughts and experiences on training, against the background the paper provides.

The Association has laid down its training requirements under four headings:

1. A satisfactory personal analysis.
2. Supervision of work with patients.
3. Wide experience of mental illness.
4. Academic qualification in a relevant field.

A possible way of looking at the personal elements of training, as opposed to the academic framework in which they operate, is to regard these elements in part as stemming from experience and change derived largely from the training analysis, and in part to see them as stemming from the process of establishing ways of communication between the trainee and the training field. Miss Swainson's paper shows that she is alert to the problems of communication. She is aware of the barriers imposed by the organisation of the trainee's personality ; of " blind spots " and the problems of emphasis arising from varying degrees of identification. She is also aware of another kind of barrier, often neglected, which arises out of the manner in which what can be called the actual communication process is organised in the trainer and trainee, respectively. The first set of problems can be tackled by the growth of insight from analysis and supervision, but the second set, namely those arising from the communication process, seems to be a more built-in function of the personality and less open to change. Miss Swainson mentions that one of her trainees had great difficulty in learning from verbal presentation, and that theories did not become real for her until she had identified them with her own introspective processes. By contrast, another proceeded by purely deductive methods which demanded little from intuition or introspection. It is essential to recognise that two different methods of communication are represented here. The respective trainees used them in dealing with their trainer, and will use them later with their patients. If the nature of these communication methods and the ways in which they differ from those of the trainer is not recognised, then the whole learning process can be distorted.

From both sides, therefore, it follows that the training process must be the outcome of very careful and sympathetic liaison between trainee and trainer. The training programme will lay down the broad principles and major areas to be covered, but the actual content and method of fulfilling the programme must be a highly individual business.

Miss Swainson worked under limitations which forced her into the triple rôle of analyst, lecturer and case work supervisor for each of her students. She questions the wisdom of this, although at the same time feeling that some advantages might come from the depth of knowledge that it gives the trainer about each student. From our experience, it seems likely that the problems arising from the closed circle of mutual transference will outweigh this, since a working group has a tendency to set in a form which its members find most tolerable. This in turn inhibits insight and development. Because of this, there is much to recommend that supervision is given by someone other than the analyst and that the first case is taken on in the later stages of the training analysis. The supervisor has a difficult job in any circumstances. He has to guide and at the same time give liberty to the trainee. The continuation of analysis during the process seems to be the best way of coming to terms with problems inherent in every supervision. Moreover, one process can stimulate the other and lead the student to new experiences. Seminars should preferably not include the analyst, nor ideally, the supervisor, but this is difficult to avoid in practice.

Miss Swainson mentions the idea that every trainee should be given a wide and eclectic experience of the various forms of therapy. In practice, during training and early professional life, the student tends to embrace one type of discipline or another. This may reflect his needs to have some comprehensive and systematically organised body of knowledge with which to operate in the face of the many uncertainties and anxieties that the illness of his patients must cause him. It may also stem from the function of the trainee's personality which selects the schema most appropriate to it. It is also inevitable that in his initial years of practice, the student will tend to mirror the theories and technique of his own analyst. It must be accepted that the ideally eclectic approach which selects from a wide choice that which is most appropriate to the needs of the patient, if it ever comes to exist, is the product of mature experience. In the light of this, it seems that training should offer the student a thorough grounding in the discipline of one of the major schools, and knowledge in varying degree of other areas in the field. It is important that his grounding in at least one discipline should be thorough and that he should speak with authority from this and so give himself a firm basis for reference and development.

There is a further important point emerging from Miss Swainson's article. Her trainees included many students and teachers. Thus, they all came from a homogeneous background which was predominantly middle class and intellectual. Miss Swainson recognises that wide clinical experience is necessary but has not yet been able to provide it for her trainees. She does not perhaps emphasise so strongly that it is also essential that the

therapist should have some grasp of the social background of his patient and know something of the varying stresses that different environments and occupations produce, together with the types of social behaviour with which varying levels of society demonstrate their stresses. The Association believes it important that the student obtains such experience by seeing as wide a range of patients as possible and perhaps also having some experience in group psychotherapy which will throw his own social ways and values into relief by contrast with those of others from different sections of the community.

There is a final point to make here. The Association believes that the knowledge of the techniques and underlying principles of Psychotherapy can branch into many areas of professional work. We encourage our members to be aware of the potentialities that the application of their special skills can have for social workers, personnel and probation officers, prison officers, and the like.

Homicidal Fear

We are most fortunate in being able to publish this case study by Miss Henrietta Meyer. She presents with great clarity the history of a patient whose homicidal fears and personal problems were greatly mitigated after E.C.T. and transorbital leucotomy had failed.

Most of us will have treated a patient with some of the features that Miss Meyer describes. The clear way in which she draws general conclusions from the presenting symptoms and from the behaviour during treatment should be of real help to those of us looking after patients with milder editions of the same disorder. In giving the details that she has chosen, Miss Meyer has illuminated very fundamental concepts through an important type of case.

Seminars for Social Workers

As recorded in the last issue of the Bulletin, a seminar for 15 psychiatric social workers, probation officers and child care officers was held in the autumn of 1958, the theme being Counselling in Social Work. A number of the participants in this course requested another series of seminars, to include more intensive casework discussion, and this was accordingly arranged for the spring of 1959 at the National Association for Mental Health, and conducted by Mrs. Seglow. They met for 12 consecutive weekly sessions. This group developed along certain definite channels. It began as a discussion of cases on the more formal lines of workers who were seeking advice and guidance on their approach to clients, their handling of relationships, their personal involvement or detachment, and their methods of interpretation. After three sessions, this led to a general feeling of disappointment because the needed

reassurance was not felt. The apprehension aroused in the participants by this "emptiness," as they called it, led to growing tension within the group which expressed itself in unwarranted hostility towards the group members themselves. They began to criticize each other, whilst at the beginning they had tended to blame themselves. We had now reached the stage where the awareness of tension led to transference problems both towards the group members and towards the conductor of the group. Unconscious trends began to emerge with which the group had to deal. This was done by the conductor either throwing in a controversial remark, or querying the silence itself. But the lead was left to the group, and as the members got to know each other as persons, no longer hiding behind the mask of social worker, they were gradually able to bring their personal problems, anxieties and conflicts into the group, and accept the other members, with their failures. During the last few sessions, they were thus able to experience the dynamic process of accepting each other, both as workers and individuals.

Seminars for Senior Members of Teachers' Training Colleges

In the Autumn of 1959 a course of Seminars was conducted on the application of psychological counselling methods for senior members of London training colleges.

INTERNAL SEMINARS FOR 1960-61

One of the objectives of the Association has always been the provision of opportunities for study and for the consideration of the different schools of thought in our profession. The Committee intends to implement this by offering Members, Associate Members and suitable non-Members a course of Learning Seminars during the year beginning this October.

We plan to have five seminars at fortnightly intervals during the autumn at which members will give papers on some basic Freudian concepts, illustrating them with case material. The Chairman will be an experienced Freudian analyst and the discussion will be open to everyone present.

After Christmas a series of papers will be given by Jungian members, with a leading Jungian analyst as Chairman. These may be followed by a few lecture-discussions on other psychotherapeutic techniques.

We hope that the members who join this experiment will come to the whole course. It will provide a means whereby both Freudians and Jungians can learn something of each other's language and ideas, as well as being a refresher course of our own sources. Some reading will be necessary and a bibliography will be sent out shortly.

We are all very busy, and it is not without due consideration that the Committee has decided to ask members to embark on a project, which will make additional demands on their time. However, for some years now there have been monthly conferences at which particular cases and individual analysts' methods of dealing with them have been discussed. We know that several members think that the time has come to review the theoretical aspects of our work and to study the connection between theory and practice.

It is essential that we do not slur over our differences and that the various approaches to psychotherapy are as clearly defined as possible. When the ground has been cleared it may well be that we shall discover some basic therapeutic concepts that we all share. We hope that as many members as can will take part in this attempt to achieve a fuller understanding of our work as psychotherapists.

Internal Seminar Programme

The Course will begin with Seminars on Freudian theory, with special reference to symptom formation and indications for therapy. Dr. R. A. MacDonald will take the chair.

October 11th.—Early Oral stage, with special reference to regression in therapy.

October 18th.—The Anal stage.

November 1st.—The Oedipal phase.

November 15*th.*—The Latency period.

November 29*th.*—Adolescence and the Genital phase.

The Seminars on Jungian theory and practice will be as follows:

January 17*th.*—The Structure and Dynamics of the Psyche.
The concepts of ego, shadow, Persona and the Self.
The four psychic functions.

January 31*st.*—The Function of the Archetypes in Consciousness and the Collective Unconscious.

February 14*th.*—The Healing Process in Jungian Analysis.
The complementary opposites and the inferior function.

February 28*th.*—The stages of growth to maturity.
Comparison of Analytical techniques for patients in the first and the second half of life.

March 14*th.*—Introversion and Extroversion in Health and Disease.

The Chairman for the Jungian Seminars. and the speakers, will be announced later.

To assist Association funds, a charge of four guineas is being made for the course of 10 Seminars. The applications of non-Members will also be considered, but numbers will be limited. Anyone interested in the course should write to the Hon. Secretary, 411 Upper Richmond Road, Putney, S.W.15.

LEARNING THE ART OF TRAINING

MARY SWAINSON, M.A., D.Phil.

Now that our Association has embarked on the training of psychotherapists, this paper is offered as a basis for preliminary discussion of the principles, ways and means involved in the process of training for adult clients. It does not set out to consider the initial selection of candidates, nor the final assessment of their fitness to practise, but is concerned solely with the art of training itself. After a brief survey of the methods operated by established training centres, I shall make my personal contribution by describing the trials, errors and insights of learning by experience on the pioneer fringe of such work. In conclusion, some of the fundamental questions arising in the course of training will be discussed, and it is hoped that members may feel stimulated to write to the Editor with comments and contributions from their own experience.

1. Existing Schools of Training in Psychotherapy.

There appears to be no universally recognised system of training psychotherapists for adult clients in this country, although a few

schools are experimenting in different ways. I am very grateful to all who contributed information from the following groups: —

(a) *Schools training medical and non-medical psychotherapists*
The Association of Psychotherapists, London.
The Open Way, London.
The Davidson Clinic, Edinburgh.

(b) *Schools training medical psychotherapists only*
The Tavistock Clinic, London.

(c) *Schools training psychiatrists* (who take a course in psychotherapy as part of their psychiatric training)
The Maudsley Institute of Psychiatry, London.
The Department of Psychiatry, University of Leeds.[1]

(d) *Schools training analysts, medical and non-medical*[2]
The Institute of Psycho-Analysis, London.
The Society of Analytical Psychology, London.

Despite the natural biases (e.g., towards the clinical or educational aspects, lecture-courses or small-group tutorials) that are to be expected among schools exploring in a relatively new field, training requirements appear to fall into four general categories:

(a) A personal analysis of minimum length 250 hours (sometimes 400 hours). Some schools which train medicals do not mention analysis.

(b) Supervised casework, usually involving a weekly discussion with the supervisor who is (usually) not the trainee's analyst. The duration varies from 2 to 4 years as a minimum. Casework may begin at some point during the personal analysis, or after its completion. Further clinical experience (e.g., a period of observation and work in a clinic, or mental hospital, or attachment to a consultant psychotherapist) is stressed by some schools.

(c) Courses of lectures by experts, seminars, case-conferences and small-group discussions combined with reading and study, lasting for 2 to 4 years.[3] It is impossible to summarise these courses which vary more widely than any other aspect of training, reflecting the biases and different schools of thought in depth psychology, but, generally speaking, the content resolves into two parts: (i) Basic Theory and (ii) Psychotherapeutic Techniques.

(d) Some form of written work: a thesis, a paper to be read, or the presentation of a case-study. (This category is not universal.)

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[1] Since we are not concerned with training in psychiatry as such, I wrote to two schools only in this section.

[2] While stimulating and suggestive, the syllabuses of this group must be recognised as catering for wider, deeper and more intensive training than is essential (however desirable) for psychotherapists.

[3] In all except the full-time courses, meetings are held in the evenings, providing for people engaged in full-time employment. It is clear, however, that an increasing amount of their free time must be devoted to the work as the course proceeds.

Here, then, is a composite blue-print reflecting what has been found desirable—and practicable—mainly in large centres such as London and Edinburgh. Those of us who are managing as best we may in the provinces cannot hope to fulfil such conditions exactly, nor, I believe, should we attempt to centralise or to standardise training at this stage. The British tradition of education has always been its freedom to experiment and its emphasis on local responsibility and variation. So, perhaps, an account of the beginnings of learning to train by using what life offers may have its place in the total picture.

2. Learning by Experience.

In a large Midland city where, apart from two mental hospitals, psychotherapy is practically unobtainable, I run a " Psychological Service " for students, staff and teachers within the area served by the Institute of Education. The work is overwhelming, but as yet there is no paid assistant.[4] Therefore, when three properly qualified people, two of them senior lecturers in education from teacher training colleges, offered themselves in their free time for such training as I could give, I welcomed the opportunity. They were warned that the course would be biased in the direction of special problems of students and teachers, that we should work it out pragmatically as we went along, and that they would be used as guinea pigs. Training was given free as a part of the work (for which I am paid a fixed salary). In return, the trainees helped by taking, as supervised casework, clients who had been referred to the Service.

All three were middle-aged women with experience of marriage and children as well as professional work. The climate in which we work has always been that of a team in which four very different women contribute each from what she *is*. Indeed, one of the earliest lessons we learned was the impossibility of planning a uniform course with people who are so different in their psychological equipment, capacities and needs. To present a living picture of this experiment it is essential to give personal details for which *A*, *C* and *B's* husband have kindly given their permission.

Length of Training, Personal Analysis and Casework

After a long analysis some years ago, *A* came to me for a further course of personal psychotherapy from March, 1953, to February, 1956. Training began in January, 1955, before the end of her personal therapy. Her first client was a highly intelligent girl who, as a student, had been a client of mine, but I had been unable to go sufficiently deeply to avert the crash when she took her first post

[4] For two years a member of our Association worked as part-time private therapist in close association with me, and to her I referred cases that did not fall strictly within the Institute area. Her help was invaluable, but unfortunately she has now retired.

in a difficult school. *A*, however, had the right personality to deal with the case; after a regression to infancy the girl re-grew emotionally to the adolescent stage and resumed teaching, this time satisfactorily in a technical college. In 1956, *A* took another young woman teacher who had broken down with severe anxiety neurosis, finally returning her successfully to the profession. In the following year she had some experience of short-term therapy with two young men students from the university. After these four young people, and in view of the fact that she does a good deal of unofficial counselling with her own students, *A* asked for an older client who would provide experience of long-term therapy of a deeper kind. Fortunately, a middle-aged woman holding a senior clerical post in industry was available; her treatment, involving therapeutic painting at an increasingly deep level, lasted two years until a certain terminal stage was reached successfully, when she transferred to a male analyst in another city to work on her relationship with men. *A* has now started with the wife of a teacher who is a client of mine, so that we are working together on their marriage relationship. Since *A* is particularly interested in non-verbal techniques, during the summer terms of 1958 and 1959 she organised art therapy groups consisting of six members, mainly my own clients, some of whom had concluded their verbal therapy with me while others continued it alongside—an interesting co-operative project productive of much discussion and case-study. *A* is now taking the group fortnightly throughout the whole year.

B was still travelling weekly to London for a Jungian analysis when in January, 1955, her analyst suggested that she could start taking clients herself. My rôle in her case was less intimate than with *A* and *C*, whose therapist I had been. *B* needed me as a source of clients, as a friend with whom to discuss casework, and, primarily, as an established therapist to share responsibility and to give her confidence. She submitted weekly reports to me for discussion, but whenever she became held up by a personal problem I referred her to her own analyst. Her first case was the husband of one of my own clients, a married student with whom I could get no further until the husband had some help. I could not take the husband myself because (a) he was not eligible for the Service, and (b) it would not have been wise from the wife's point of view. The marriage was saved and we heard later that they had a second honeymoon. *B's* next case was a young man from one of my extra-mural classes; after him she began with a woman referred from the local Marriage Guidance Council, while *A* saw the husband for one diagnostic session. Unfortunately, however, in 1958 *B* became ill and died—a great loss to us personally and to the work.

C took a course of personal psychotherapy with me from August, 1956, to May, 1958, and then started training which still continues. After some preliminary theory, she began casework with an African suffering from anxiety neurosis (January to July, 1959)

followed by a most successful short-term case (September to November, 1959, with a few follow-up sessions since) and another similar one from December, 1959, to June, 1960. All these were male students who otherwise would have been refused since they applied from colleges outside the Institute area. After a few sessions with an ex-Child Guidance Clinic case (girl telephonist) which involved discussion with the psychiatric social worker, she has now started with the wife of a teacher client of mine so that, as with *A* and *B*, we can work together on the marriage relationship. Alongside this case she will shortly embark on another (a somewhat schizoid young woman ex-nurse, now shop assistant, referred through our adult education college) who, I think, will prove a tougher proposition. In selecting the first case or two for trainees I try to provide those that are not too difficult, gradually increasing the difficulty as their experience and confidence grows.

All the trainees' clients are first interviewed by me for one diagnostic session so that I can (a) see if the case is suitable, and (b) supervise it more effectively. Mine, too, is the initial responsibility for notifying the client's medical practitioner, and after this there may, or may not, be discussion between doctor and trainee. Most of the cases so far have been character disorders with few physical symptoms, but in *B's* second case there was excellent co-operation between her and a most understanding country family doctor who referred him to us in the first place.

Normally, in term time, each trainee has one session per week with her client followed by a weekly discussion of two hours with me which must include both casework and relevant theory. If there were more trainees, we could organise group discussions, case-conferences and seminars, but so far, in view of travel difficulties and their different requirements, the trainees have come separately. Some individual contact with *A* and *C* is essential anyway since, as their former therapist, it is my job to deal with any personal block that may be hampering the work.

As yet there has been no time for "further clinical experience", although *A* and *C*, in the course of training their own students, have had close dealings with Child Guidance Clinics, while *C*, qualified in Sociology and with experience of social casework, has met the mentally ill, psychopaths and inadequates. It is clear, however, that their practice, which has been largely with young and gifted students and teachers, needs to be balanced by less intelligent cases and some experience of gross abnormality. Later, when studying psychoses, we hope to visit the local mental hospitals.

Theory: Methods and Content

(a) *Methods*

It has not been practicable to invite expert speakers to address such a small group, although every advantage has been taken of

conferences on personality work, courses on counselling in London, a local course on the study of group relations, and our Inter-Professional Association for Mental Health. (Especially where trainees are few in number, I would stress the great importance of some group experience.) The bulk of the theory, therefore, has been my responsibility. Since one cannot lecture to two people, I prepare sets of duplicated notes with reading lists on the major topics; these we discuss, together with our reading, during the weekly session. (The inadequacy of a single tutor is obvious—and it is hard on the tutor—but what else can one do ?) It is about the presentation of relevant theory that I think we have learned most. *B* and *C* were great thinkers tending to make the link between theory and practice deductively. With them I found discussion of theory easy, casework more difficult. *B* had read so much that our sessions consisted largely in pooling ideas; from her I learned a good deal about the deeper aspects of Jungian dream analysis, whereas she needed my help when applying theory to areas with which she was unfamiliar, such as short-term therapy and interpretation of paintings. *C* read still more extensively; her test lay in the application of theory to casework. For example, although widely read on dream-theory, when faced with her first client's dreams she was liable to panic. My rôle was not so much to suggest interpretation as to give her enough confidence to realise that the understanding was there, and now she can interpret dreams with relatively little help. Her strongest functions are thinking and sensation, while the intuitive side is developing steadily in the form of immediate telepathy. So she needs, above all, practice in linking thought with feeling and with insight in personal relationship.

In the case of *A*, Froebel-trained, an artist by nature, with developed feeling, sensation and considerable intuition, the approach was rather different. Myself an introverted intuitive with the thinking function rigidly trained in an academic world, I blithely sketched out logical and tidy syllabuses, producing volumes of intellectually-presented notes which *B* and *C* skimmed readily. After a few weeks with *A*, however, we learned our lesson. Although, of course, she could comprehend the abstract material, it made no real impact on her unless she was ready to accept it as an essential part of a total pattern of experience. I soon realised that, as a University teacher, I had never fully understood what learning with one's whole self meant, and so I set out to learn to teach all over again. People of *A's* kind appear to work inductively; only when they meet the problem first in the living example is there sufficient incentive to study the relevant conceptual theory and to make generalisations. So, with *A*, the rule became: Experience first, books afterwards. Thus, only when we had both struggled with a psychopathic personality among her students, did we study the problem of psychopaths. In sessions with her, I learned to wait, as in therapy, for whatever topic was alive in her

at the moment; then was the time to introduce the appropriate material—all of which ideally needed to be held in readiness for use when required. It rarely was! This approach tests out the trainer far more than the presentation of a logical series of lectures irrespective of the "readiness" of the student, and in the end we came to a compromise. However, as a result of this meeting of opposite types, we both feel that, in learning together, we have achieved a degree of integration of insight, head, heart and practice rarely found in the academic world. In her casework she needed little help, indeed, she taught me much about art and feeling relationship. My contribution lay more in the field of conscious expression, communication, form and order. "This is what I felt and did," she would say. "Now tell me why I did it," and we would conceptualise the underlying reasons of which, perhaps, she had been only dimly aware. The main art of the trainer, as tutor, therefore, seems to lie in the ability to distinguish the varying talents of the trainees, and to provide help mainly on their weaker sides.

(b) *Content*

Allowing for variation with individuals and for the difficulty of condensing an organic pattern into a formal scheme, the syllabus so far has been as follows.[5] (The timing is that of *A* who has been the longest in training, *C* having run through it more quickly.)

YEAR I

(1) *General Principles and History of Psychotherapy and Counselling* (Individual and Group)

(2) *Main patterns of Mental Disturbance met with in student therapy:*

Hysteria
Anxiety Neurosis
Obsessional Neurosis
Inadequate personality

(Illustrated by (a) case studies of my former clients from whom permission was obtained after the end of treatment, and (b) by single interviews with current clients where possible.)

YEARS II AND III

(3) *Techniques of Psychotherapy*

(a) Introductory techniques useful for diagnosis and early interviews: Projection tests of all kinds.

(b) Relaxation treatment.

[5] There was no need for any general, social or developmental psychology, nor for principles of mental health, since all three trainees were themselves using these subjects in lectures to their respective students.

(c) Deeper techniques: Free association and amplification, dream analysis, active imagination, art therapy.
(d) Special application of these techniques to group work and to children. Child guidance and play therapy.

(From practical experience in the above techniques, trainees studied the main schools of psychotherapeutic knowledge in their reading.)

YEARS IV AND V

(4) *Further Patterns of Mental Disturbance*
   (a) Psychosomatic conditions (introduced when I had just completed a useful case of urticaria.)
   (b) Psychopaths. (Based on an actual case.)
   (c) Psychoses:
      (i) The difference between the genuine inner-world experience of the potential mystic (based on an actual case of one of *A's* students) and the psychotic state.
      (ii) Different forms of psychoses and their recognition. (We are just embarking on this section.)

(5) In the future we shall probably study some of the great myths and symbols.

Throughout this course, special topics have been written, read and discussed when requested. A random sample may illustrate the wide variety and levels required:

Conducting the first interview.
Homosexuality.
Masturbation phantasies.
Note on Primal Incest-Taboo.
The Tree as an Archetypal Symbol.

A voluminous correspondence on "How to tell what the client is feeling" requested by *C*, and contributed to by an interested friend (feeling type) not in training.

"What is vitality and what are its sources?" suggested by *A*. Beyond a useful but most explosive three-cornered discussion, we have made little headway so far with this topic, but is it not, perhaps, the most fundamental question of all training in psychotherapy?

Lastly, we are well aware of the lack of teaching on the medical side, and we have done nothing, as yet, about written papers or theses.

3. Questions for Trainers

Looking at established training schemes from the point of view of our own experience, here are some of the more thorny problems, as I see them, for discussion.

(a) Is personal analysis an essential part of training, or is some form of interpretative group experience sufficient? My own view is that, if we are training for individual psychotherapy, trainees must have experience themselves of a full personal analysis. As an *added* qualification for work in group therapy, experience of interpretative groups is, of course, most valuable.

(b) Is it preferable to complete one's personal analysis before training or to start casework at some intermediate point? If the latter, how can such a point be determined? (One trainer has suggested that not much can be taught until the trainee sits in a chair instead of lying on a couch—with all that this stands for.) Or is it entirely an individual matter, depending partly also on the next question?

(c) Should the trainee's own analyst carry out training in casework, or should there be a separate supervisor who is in close consultation with the analyst? There seems to be something to be said on both sides. In our experience, I had no choice with two out of my three, and in my view, for what it is worth, the trainee does need her own analyst in her first one or two cases. Initial errors are nearly always due to blind spots transferred onto the casework, and the analyst knows what these are. Moreover, the elements of her own analysis are bound to be relevant to the trainee's methods. Training, in fact, is a continuation and application of personal analysis—after the "withdrawal" it initiates the "true return" to the outer world—and, in selecting the first critical cases, it is the analyst who knows best what the trainee's strong points and difficulties are likely to be. On the other hand, the trainee may find adjustment to the new relationship too difficult; from the trainer's point of view, too, the swift change of rôles from analyst to supervisor and tutor, and finally to colleague and friend, may precipitate problems of counter-transference, as I know to my cost, which may react on the trainee. In such a case, it is easier if the trainee has completed her analysis before training or has a separate supervisor. Perhaps a useful compromise might be that, after the first year or so of casework supervised by her own analyst, the trainee should go on to a fresh supervisor, or join a casework discussion group, so as to learn different ideas and methods.

(d) What form should the supervision take? Surely so much depends on the quality of the relationship that the situation may be left fairly fluid. However, allowing for variation in personality, I have tended to take a more responsible line for the first year or two, choosing the clients by initial interview, reading and discussing

case-notes made weekly by the trainee. After this, I consider it a sign of maturity when memory replaces formal note-taking, "supervision" changes to an equal exchange of views, and trainees take fuller responsibility for their own clients. Real humility is required on both sides; the set-up is not authoritarian —we learn together. Therefore, it is desirable that the relationship, at least to start with, should be as free from ambivalence as possible; yet if mutual involvements should occur and can be worked through in real-life situations, this, in itself, is a profound training and achievement for both.

(e) What essential considerations govern the choice of training cases? The trainee's first need, surely, is confidence. For an initial case, I would suggest one that is not right on the trainee's own major problem, but relates to some phase of growth which has been passed through yet deeply understood. Ideally, it can well be a relatively short-term case, yet one with sufficient challenge to be handled with a real sense of achievement. I have found that a similar personality type, if available, is often more congenial; later on, the more difficult opposite type can be attempted. Similarly, with regard to the psychopathology, one of my trainees could take hysterics in her stride whereas the other two felt safer with anxiety types; I aimed, therefore, where practicable, to start them with the known and preferred, and later to offer the "dark other."

(f) What should be the content of the theory courses? Most trainees will start with a sound knowledge of general and social psychology and probably also of the psychology of development and the basic principles of mental health. If any of these aspects are lacking, may one suggest that they should be studied as preliminary groundwork? The actual training course could then consist of principles of depth psychology, including a study of the main patterns of disturbance and the appropriate psychotherapeutic techniques. (For non-medical trainees, courses on the relevant aspects of anatomy and physiology, and also on psychiatry, as given in one school, would be valuable.) With regard to principles, syllabuses from various schools tend to show specialisation, often exclusively, in psycho-analytic, Jungian or other disciplines. For an eclectic training in general psychotherapy, would it be too much to suggest a broad introduction to all systems of psychotherapeutic theory, with later specialisation in one branch? On the side of techniques, the comment of a tutor engaged in training young psychiatrists in psychotherapy is most relevant. "Is there", he asks, "agreement about fundamental principles? I am sure that some people in this field want a technique that is a defence against the needs of the patient. Others are prepared to recognise that healing is a function of a personal relationship, however much it is guided by scientific knowledge." Should we not introduce trainees

to a wide variety of current methods—clinical, pastoral, educational—so that each can find and develop the particular blend suited to the gifts and limitations of his own personality?

(g) How can we achieve integration of theory and practice? Sound principles can be taught in lectures and seminars, but the main art of the tutor-trainer will be to ensure that there is a reciprocal flow between principles and casework. It is here that typological differences may be met; the trainer must help the theorists to apply general ideas to very diverse human beings, whereas the opposite types need ordered knowledge to make a pattern of their fluid feelings and hunches. This raises the question of which should come first, the theory or the concrete situation? It has been suggested that a minimum reading list guaranteeing an L.C.M. of knowledge should have been covered before casework begins, together with certain information of a practical nature such as "Handling the first interview", essential techniques, etc. On the other hand, in the case of the trainee who will not read, is there not something to be said for learning to swim in the water, and for the high degree of incentive in searching for the necessary information induced by finding himself "in a tight spot" with his client? Perhaps a skilful alternation is needed. It is here that case conferences and small groups consisting of mixed types can be most valuable; it is a fascinating experience to see how we all educate each other. For example, in discussing "How to tell what the client is feeling": intuitives know, but do not know how they know; thinkers observe overt clues; those with developed feeling "feel into" the client, whereas some sensation types say, "I get it in my body." Here, within the group, insight, head, heart and body work as a team; it only remains for each member to internalise and develop the function in which he is weakest.

As an educationist, I would stress one basic principle: any form of education fails if it does not practise what it preaches. If, then, we want our trainees to become whole persons so that they, in their turn, can help others towards wholeness, must we not provide for the integration of practice and theory through the use of all their four functions *in the immediate situation of the training experience?* As far as possible, *the course itself should be an integrated whole*—not rigidly planned but rather a living organism in which all are free to experiment, change and become what they are.

HOMICIDAL FEAR

HENRIETTA H. MEYER, Ph.D.

For the purpose of this paper "Homicidal Fear" will be solely concerned with one particular factor, namely with some mothers' fear of impulsive harming or even killing their children.

In the field of maternal psychopathology this is not at all an uncommon symptom, often attributed to parent-child hostility. The basic principles underlying the conflict situation are frequently the outcome of an unhappy or uncared-for childhood and a non-overt hostility towards their own mothers.

The homicidal fear is not roused by symptomatic child's behaviour patterns, but by anxiety-provoking tendencies emerging from the mother's disturbed mind. The intrinsic clinical characteristics are anxiety states, and neurotic depression combined with obsessive compulsive trends. The majority of these women are in fact of an obsessive-compulsive nature, and are, as a rule, suffering from mental illnesses in which sustained depression is the predominant feature. Their compulsive attitude forms an integral part of the problem and can be regarded as a safety valve for mastering this particular fear. These mothers are undoubtedly aware that their children's lives are threatened by impulses they fundamentally reject: thus their passive attitude avoids the risk of allowing such dangerous phantasies to be materialized. A submissive and mild behaviour in their day-to-day relationships with others forms a striking contrast to a vortex of violent and tormenting thoughts. Furthermore, experience has proved that these women are in general genuinely devoted to their offspring: and that no sacrifice is too great when the children's health or welfare is endangered. E. J. Anthony holds the viewpoint that such behavioral attitude is "in part their solace." "Between the impulse thought and the act," he writes, "there is a 'gap' and the more isolated the thought, the more immersed it is in surrounding mildness and submission, the wider the 'gap' appeared to be."* The writer, who applied group psychotherapy with some mothers of this type, divided them into two main groups—those who were more depressed and those who were more obsessional. The more depressed ones revealed stronger guilt feeling and showed as a compensation successful endeavours at making their children happy. The more obsessional ones posed under the mask of the perfect housewife and mother. They were mild and submissive in family and social relationships. They made a sharp line of demarcation between their homicidal thoughts and the severe chastisement of their children when they deserved punishment.

* S. H. Foulkes and E. J. Anthony. "Group Psychotherapy" (pp. 188-191). Penguin Books A370.

The following clinical material has been chosen to illustrate some of the aspects relevant to homicidal fears and their symptomatology.

The patient, whom I shall call Mary, was 26 years old when she was referred to The Marlborough Day Hospital, London (September, 1950). Mary was seen by me in 265 interviews from September, 1956, to March, 1960. Her husband was also seen by me in 16 interviews, from October, 1956, to March, 1960.

She was the only daughter of middle-class parents with bourgeois standards. Her father, a civil servant at the Ministry of Pensions, was an energetic man with various interests : amateur dramatics, journalism, and cricket. He was a kind man, who was genuinely concerned with the upbringing of his three children. Although he was very considerate, he was strict on matters of routine and manners. Mary, being the only girl, and the middle between an older and younger brother, considered herself his favourite. She was very attached to her father, who showed particularly ambitious tendencies towards her scholastic achievements. When Mary was ten years old, he suddenly died at the age of 39 years of bronchial trouble as a result of having been gassed during the First World War. Mary was very distressed when he passed away. Her mother, now 59 years old, is in good health apart from phlebitis. She is a placid person with rather flat emotions. She used to be more lenient with the children than the father, but inconsistent in handling them. In bringing up her babies she was easily impatient, and regardless of their tender age she used to smack them for wetting their napkins before the regular elimination could be expected. The parents' marriage seemed to have been quite a happy one. " Mother was," as Mary puts it, " not a deep thinker." When Mary was about 16 years old, her mother married again. The second husband, an easy-going man, was Chief Fire Brigade Officer at an aircraft factory. He died two years ago of kidney disease. Although Mary did not dislike her stepfather, she was reluctant to accept him. Since she had grown into womanhood, she had become closer to her mother. They used to go out together and were often thought to be sisters. These outings came to an end after the mother's second marriage. The stepfather started to live in their house before the marriage took place and during this period mother became pregnant, a fact of which Mary felt very ashamed before her friends and neighbours.

Besides her own two brothers Mary has one half-sister. She never got on well with her older brother, who used to tantalize her, especially after her father's death. Of the younger brother, a quiet and gentle person, and of her stepsister she has always been very fond.

At school Mary was regarded as being a very capable pupil. She was never keen, but succeeded in being nearly always top of

her form in the elementary school and continued to be well above the average in her attainments at the girls' grammar school she attended. She never felt confident about her intellectual abilities and has always been scared of examinations. During the war, when her school was evacuated, she was so scared of parting with her mother that she preferred to leave school altogether. She was quite a good mixer and had some close friends, and with one of them her friendship has been maintained to the present day.

Mary had never had any special training. She started her first job as a clerk, aged 15. She has always been successful in earning her living, but reactions to her work manifested symptoms of inner disturbance. She was constantly haunted by the fear that her work was not up to standard, ignoring the promotions she had received.

As a young child she did not show any particular interest in sex. She started menstruation at 11 years. Having been completely unprepared for it, she was extremely frightened at the sudden loss of blood and associated it with death. It took her a long time to confide in her mother, from whom she received rather scanty information, which, however, satisfied her for the time being. Her menses are normal; she feels depressed just before and during the first days of menstruation. Mary has always liked to mix with the opposite sex, and had many boy friends. At 17, she started her first love affair during which sexplay took place and once almost led to heterosexual intercourse. This incident made her feel ashamed and resulted in a depressive bout.

When she was 22 years old, Mary married Dick, four years her senior. They had met at a dancing club. "It did not take me long to love him. He attracted me by being witty and by his extraordinary physical strength. It was a love match. Dick was my world, and I thought married life was just wonderful." The betrothal was a happy one and so was the marriage at the onset. But soon sexual dissatisfaction and difficulties emerged, partly due to a disturbance of her sexual capacity and partly as a result of unfavourable living conditions in the house of her in-laws. Mary was frightened of her "highly critical" mother in law whose life values differed vastly from those in which Mary had been brought up. Constant friction between the two women increased Mary's unsureness of herself. At the age of 25 she gave birth to her first child—a boy—and three years later she was confined with her second child—a girl. Mary was happy about and during the pregnancies, but soon after she became tense and apathetic. She felt often depressed and did not want to have any responsibilities. Both births were easy and normal ones. There were no abortions.

Mary had her first nervous breakdown when she was about 22. She was persecuted by the thought that she would never be success-

ful in life. She attended the Psychiatric Outpatient Department of a London Mental Hospital once a month and was treated by psychotherapeutic methods. She was diagnosed an obsessional neurotic with recurrent depressive features. After her first baby's birth awful thoughts that she might hurt or kill her little son and her husband harassed her incessantly. She was admitted to the hospital and responded well to E.C.T. There was, however, no lasting improvement, and a few months later a Transorbital Leucotomy was performed. A change for the better lasted for eleven months only; then Mary was in hospital for a further six months. After a short spell of well-being, another relapse led to a further admission as an in-patient. E.C.T. treatment was again applied. Mary discharged herself after four weeks. While at home, she made a suicidal attempt by trying to gas herself. She was detected by her mother-in-law, whereupon she was re-admitted to hospital for three weeks. At her discharge she was referred to The Marlborough Day Hospital, London. There was no history of previous mental or nervous illness in her family.

When Mary started psychotherapy with me, she presented severe symptoms of depression and in particular domestic apathy. During the initial stage of treatment Mary talked a great deal of her late father, revealing a strong and positive fixation towards him. The material obtained in this early phase indicated that marked Oedipus feelings had largely contributed to the deteriorating relationship with her husband. Indeed, her choice of Dick arose from discovering in him personality characteristics similar to those of her late father, a fact of which she was entirely unaware. It became clear also that at a time when she felt more and more lonely and frustrated by her mother's second marriage, the desire to materialize her longing phantasies about her father grew more intense and found temporary satisfaction in a marriage with Dick. When Mary talked about her father she liked to mention that she was his favourite. She revived memories of various activities she had shared with him, i.e., playing chess, studying for the 11+ examination, learning pieces of poetry for the purpose of reciting them in his club, etc. Although she was flattered by being singled out by him, she enjoyed at the same time showing a certain resistance, or ignoring his demands, thus getting an additional amount of attention. This negative attention-seeking had partly emerged from her strange feeling of "being left out" which she had first experienced at the age of almost three years when her younger brother was born. The confinement took place at home. Mary dimly knew that something out of the ordinary had happened in the parental bedroom. Being left by herself, she felt utterly lonely and frightened. Since then, feelings of loneliness were apparent.

Already during the first months of her marriage, she showed with her husband similar behaviour patterns to those she had

exhibited with her father. On the one hand, she wanted to be quite close to him and tried to maintain a "togetherness" of which she was no longer sure. On the other hand, she felt small and helpless towards him and totally inadequate to be his wife. A great deal of her matrimonial quarrels arose from her neglectfulness and lack of punctuality which finally developed into a domestic apathy. Her attitude evoked strong reactions in Dick. Although he showed sympathy towards his wife's illness, he was far too insecure within himself to play "the indulgent father" Mary wanted him to be. He comes from a family with a particularly strong solidarity. Under the leadership of an authoritative father, all the members of the family were engrossed in hobbies, working as a team. As to the social structure in Mary's family, there was also a distinct patriarchal trend, but her father was less domineering and her mother less co-operative than was the case with her in-laws To be confronted with Dick's efficient family unit made Mary extremely self-critical and conscious of her shortcomings. She felt despairingly helpless about her inadequacy and a fear grew within her that her children might have inherited her "badness." The devaluation of herself led to suicidal and homicidal tendencies. In addition, she was without any religious faith and overwhelmed with fear of death. This was only one of many fears: the strongest of all being of killing her offspring. The relationship between Mary and her children indicated strong positive feelings towards them. Nevertheless, her own state of infantile dependence interfered at times unfavourably in her handling of them. Mary's own immaturity and dependency easily emerged, and were mainly directed towards her husband, and later towards me. This revealed the outcome of an overpowering unconscious problem with her own parents.

The early phase of treatment was mainly devoted to loosening her unconscious identification of her husband with her late father, and to the consequences of this identification. The valid material obtained in these early interviews centred around feelings of guilt about her domestic negligence and unreliability which—as she realized—had contributed to her deteriorating matrimonial life. She began to understand that by wasting her time with gossiping and reading inferior magazines she increased her guilt feelings and the impending unpleasant home atmosphere. We planned together her daily duties, went through her housekeeping money, and discussed at length her inability to be punctual. This was the crucial point. Apart from her lack of time awareness, the inner unconscious resistance was brought to the light. Her domestic improvement not only gave her a certain satisfaction but had a favourable effect on her matrimonial relationship. For a considerable time, Mary had recurring dreams in which her "togetherness" with Dick was emphasized. This fervent wish had been partly transferred to the conscious level. When she had relapses with bouts

of depression they were of a less egocentric type than they used to be, and she did not feel so utterly defenceless when invaded by them. Nevertheless, the homicidal fear continued to appal her.

During the following phase of exploratory discussions the outstanding psychotherapeutic problem was that of ventilating her feelings about her relationship with her mother. Certain facts and reactions deduced from her comments disclosed a repressed hostility which was quelled by a conscious loving attachment and manifested in a specific attitude of unresolved ambivalence. In order to make one understand how this unconscious hostility contributed to the very complicated mechanism of homicidal fear, it seems necessary to recall some incidents in which her mother's attitude evoked traumatic patterns in Mary. I have already commented on the birth of the younger brother, on the loss of the father, and on her first menstruation. In her early adolescence, she came home one day just in time to see her mother being carried on a stretcher into a waiting ambulance. Neighbours told her that her mother had had a hæmorrhage. For a few hours Mary was alone in the house, tormented by the fear that her mother was going to die. A week later, her mother returned with a baby boy, explaining to her three children that she had offered a home to this infant because his mother was unable to keep him. A few weeks later, Mary overheard a conversation between her mother and paternal relations who urged her to offer her illegitimate son for adoption. Although the mother was aware that Mary had overheard this conversation, she did not discuss the matter with her daughter. Some months later, mother had to telephone an adoption society. Since she was not familiar with the dialling system, Mary had to put the call through and to deliver the message. Again not a word was said about it afterwards. Mary felt very ashamed and could hardly make herself face the outside world. When her mother became pregnant, prior to her second marriage, she hardly discussed her pregnancy with her children who had to accept the *fait accompli*.

There was no doubt about the detrimental effect which these incidents had on Mary. The unconsidered way in which she was confronted by such frightening situations obviously accounts for the early onset of her depression and loneliness.

In this connection I should like to refer to Mrs. Klein's theory of the "Predisposition to depression." Mrs. Klein postulates that the infant has to find a way of realizing that the "bad object" and "the good object" are, in fact, the two main objects for forming "the whole object." If the infant fails to integrate the "good" and "bad" objects in his ego, then a predisposition emerges and this depressive position is bound to give rise to depressive feelings throughout his life. If the child encounters the fear that his hate and aggression are stronger than his capacity for

love, a permanent loss of the love object is unavoidable. "I consider the depressive state," to quote Mrs. Klein, "as being the result of a mixture of paranoid anxiety and of those anxiety-contents, distressed feelings and defences which are connected with the impending loss of the whole loved object . . . . In my view, wherever a state of depression exists, be it in the normal, the neurotic, in manic-depressive or in mixed cases, there is always in this specific grouping of anxieties, distressed feelings and different varieties of these defences, which I have called the depressive position." *

In Mary's case the predisposition to depression has undoubtedly been established during infancy. According to various comments, some of them casually made by Mary, it became evident that her mother was unable to give her children sufficient security in the love relationship to have prevented them from developing fear and anxiety. Furthermore, the mother never displayed strong maternal feelings towards her children but showed a certain detached maternal domination, combined with a lack of overt affection. Mary recalled some instances of her childhood during which she badly wanted her mother. Nevertheless, the mother's immediate response did not arouse feelings of affection and security in her, but "a gap" between her mother and her. Although Mary's feelings of sexual attraction towards her father have also to be taken into account, it became evident that the mother did not function in the usual way, by giving sufficient comfort and affection to her children. Though she was not the bearer of authority in the house, nor unapproachable, the outgoing and incoming emotional feelings of the children were far more directed towards the father than to her.

Before the barrier of repressed hostility towards her mother was broken down in Mary, she had applied the typical mechanism of denial, thus producing exaggerated positive feelings and denying any negative ones towards her mother. Through the abundance of material provided by Mary, a burden of guilt, loneliness and tension was lifted and opened new channels for reaching the deeper causes of her disturbance. It was obvious that, on the one hand, her ego was far too undeveloped to break down the barriers behind which inner fears were hidden, and, on the other hand, it was encouraging that parts of her ego, though impoverished, had not been so intensely damaged as to block her co-operation. Her genuine feelings towards her mother were finally brought to consciousness. Step by step a variety of interacting symptoms, related to this situation of conflict, were dealt with. The differentiated facets of love and hate were slowly and reluctantly inserted like the small stones of a mosaic which require careful selection before

* M. Klein (1953). "Love, Hate and Reparation"—The Hogart Press, London.

they are fitted. On the surface Mary tried to control her aggressive drive and it took some time before an uncontrolled outbreak of anger aided the discharge of repressed aggression. These aggressive discharges were the equivalent of a young child's tantrum. Apart from weeping and shouting, she stamped her feet and raised her fists as if to destroy an invisible foe. The first experience of such an outburst was rather painful to her and resulted in ambivalent feelings of guilt and release. Eventually, she began to understand that these aggressive drives were indicative of a love similar to the biting, sucking and laughing of the infant when he is establishing an attachment to his mother's breast. The liberation of the helpless child in Mary prepared the way for the maturing of her ego and for the strengthening of her personality. Furthermore, her affection relations with her family, the outside world, and last but not least with her own self were loosely re-formed. This was a distressing experience for her. Since she felt so terrified of the perils of her destructive impulses, she considered herself an outcast of society, unworthy to mix with others. Her only support was provided by a strong transference to me which she held onto tenaciously. In the transference situation positive and negative reactions were encountered and dealt with. Negative transference situations were met by Mary with strong feelings of guilt and with a fear of losing me, the good object. Situations as these helped her to recognise that her ambivalent reactions of love and hate did not interfere with her attachment to me but proved to be beneficial in the process of integration. Mary rarely expressed hostile feelings towards me overtly. Nevertheless, there were a good many phantasies in which she belittled me or felt frustrated by me, thus revealing the underlying love and hate. It was obvious that she identified me with a good parent whom she needed to lean on. Possessive and greedy demands, characteristic of a young child, were closely connected with her dependency. She would, for example, raise an important point at the moment her session had come to an end, or return under some pretext after a short interval, ignoring my next appointment. By trying to obtain additional attention, she wished to satisfy her greed, manifesting a child-like inability to abandon a wish fulfilment. In addition, she wanted to find out what kind of punishment would be imposed on her in exchange for the trouble she had inflicted upon me.

Moreover, Mary used her complaints about the persisting homicidal fears as a medium for arousing resistance in the transference situation, and as an attempt to curtail the treatment progress. As stated, Mary was diagnosed as an obsessional neurotic. The chief characteristics of the obsessional, aggressiveness and self-will, were hidden behind a mask of timidity, inhibition and dependence. Compulsive actions such as making sure that the gas was turned off, and that the doors were properly locked, were carried out. Nevertheless, the morbid impulse to do serious harm to children

and husband remained irrational. While the compulsive actions served as a safety valve and did not worry her unduly, the destructive impulses aroused acute fear.

The question now arises of how it was possible to deal with these impulses. When Mary experienced the fear for the first time, she stated that she was frightened of the impulse to kill her children and her husband. In all further complaints she continued to mention her husband, too. These evil thoughts originally emerged when Mary was in a severe state of emotional distress. Bottled-up emotions of long standing, and hostile feelings towards her mother-in-law had aggravated her basic disturbance. Moreover, the sexual relations with her husband had deteriorated due to an inner resistance on her part. Both facts implied some loss in her interpersonal and physical relationship and indicated signs of regression as well as of repression. Hence Mary, having experienced love deprivation in her early childhood, broke down under a second disappointing maternal experience, namely the unfavourable attitude of a domineering mother-in-law to whom her husband was strongly fixated. Mary did not dare to bring her hostile tendencies into the open, but instead began to show antagonism in her sexual relations with Dick. She resented his physical strength, one of the outstanding qualities which had aroused her love for him, and which was also a quality he shared with her late father, who was endowed with remarkable physical strength and passion. For Dick, satisfying sexual relations with his wife were compensation for her inefficiency in running the house. The fact that Mary's sexual responsiveness decreased with the man of her choice after a comparatively short period of married life goes back to two significant factors: Mary's reactions to the unsolved Oedipal aspects (her father's sexual relations with his wife, the sibling rivalry, and her penis envy), and depressive disturbances which were apparently based on a childhood neurosis. The following episode impresses me as an important manifestation of a long-lasting and deeply rooted mental disturbance. While Mary's father was still alive the family spent a holiday at a seaside resort, when one day Mary stole away from the family gathering and went to watch the sea from a lonely spot. "For no apparent reason I felt very sad and had to go away." No doubt, this sudden depressive reaction in a child of eight was associated with an early ego frustration, love deprivation, and loneliness.

As in many obsessional cases, Mary's depression can be traced back to a conflict in which the obsessional fear has resulted from aggressive, forbidden impulses, which are, therefore, both repressed and active. They are repressed out of fear of the consequences and they are active because the self is urgently demanding satisfaction. This urge for satisfaction remained on an unrealistic level. It coincided with another obsessional phenomenon: the craving for omnipotence. Inflated phantasies concerned with the

magic of omnipotence often rule the inner world of the obsessional neurotic. In Mary's case, showing elements both of self-will and omnipotence, these impulsive urges were brought to the conscious level in her aggressive discharges; even the impulse to kill—although in a very modified way—was acted out. An exaggerated self-will and a disproportionate longing for omnipotence are often met in the young child and in obsessionals who have been pampered and spoiled as small children. The latter who have not outgrown it have usually retained a low frustration level. As stated, Mary was both a spoiled and a deprived child. To endure frustration is still not easy for her. Moreover, it explains the primitive ego functions. Living in an unrestricted world of omnipotence is the compensation for feeling small and worthless, and for being compelled to obey the powerful superiors.

When we are investigating the external cause for an internal omnipotence, Mary's relationship to her husband ought to be considered. Dick is rather a tense, evasive and insensitive personality who is easily inclined to lose him temper. He is a trustworthy person with a high sense of duty ; his kindness and warmth are hidden behind a stern persona. His lack of sensuality was the crucial point in Mary's emotional and physical relations with him. At times, when her tender feelings towards him came to the fore, his ambivalent response, sometimes abrupt, sometimes aggressive or sometimes even completely unreactive, made her feel profoundly rejected. Besides, there were the environmental difficulties which were troublesome. All this resulted in an aversion to sexual intercourse, although she never refused it. She saw in Dick an authority whom she feared. She did not dare to speak her mind or to contradict him, and could only respond by apathy and a refusal to share responsibilities. This provoked in him feelings of anger and a desire to retaliate.

The therapeutic task now was to dissolve the stern father/daughter relationship existing between husband and wife. Mary was most reluctant to give up a defence mechanism she habitually employed. In a state of acute disturbance she was torn between the acceptance of help and the rejection of it. This became apparent in a marked fluctuation between co-operation and resistance in the therapeutic relationship. There were sessions during which she made the conscious effort to withdraw, similar to the attitude she had adopted when differences between her and Dick ensued. She eventually learnt that by behaving like that she excluded me from an important part of her life, just as she had excluded her husband. This behaviour pattern gave rise to guilt and anxiety. She felt guilty because she thought she had let me down and hampered the therapeutic progress, and she was frightened that she never would grow up and become a person in her own right.

She also gained insight into the main factors which encouraged

her to retreat into an irrational world with a false sense of omnipotence, dominated by the threatening impulse to kill her children and husband, which was the only condition in which she could demonstrate power, thus revenging her powerlessness. She experienced the same feelings of impotence and resentment in her interpersonal relations as she did in what she regarded as the intrusion and aggressiveness of the sexual act. She complained about her husband's violence and lack of consideration. Although she was orgastically potent in sexual intercourse, she never expressed great satisfaction in sexual activities with a husband she consciously loved.

The exploration of Mary's sexual problems revealed long-standing distress over her dependence and deceitful submissiveness. She did not allow herself to show self-will and aggressiveness in everyday life. Repression had transferred them into her inner world where they became dominant factors.

It seems that Mary's sexual disturbance was one of the root symptoms which caused her homicidal fears. Although one generally speaks of a mother's impulse to kill her children, experience has taught me that this impulse is in fact frequently connected with the husband and also directed towards him as a result of resentment or even hate. Since Mary was unable to show a face-to-face opposition towards her husband, she covered her inability behind a mask of passivity and feelings of hate which were rooted in her experience of the negative side of her mother in infancy. These feelings of unworthiness were compensated for by one outstanding achievement in life : the birth of her two children, and this had given rise to feelings of superiority towards her husband. The impulse to kill her own children was traceable to the omnipotent feeling that she had the power of life and death over the man who was their father. To threaten with such destructive impulses is a revenge for having to endure the aggressive act in sexual intercourse. It also indicates that she is no longer content to remain passive. By killing her husband in phantasy she acquires power over him, and destroys his masculine power.

The relationship between herself and Dick was changed from a father/daughter to a husband/wife pattern. Mary's need for love and affection found more adequate satisfaction. Being no more dominated by inner destructive impulses, she was better equipped to cope with recurrence of depression. After the disintegrated parts of her ego had been dealt with, signs of maturity became apparent.

The exploration of Mary's unconscious mind enabled her to understand the strength of love and hate. A new approach to herself enabled her to maintain fuller interpersonal contacts with others.

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