BULLETIN

THE BRITISH ASSOCIATION OF PSYCHOTHERAPISTS

Number 17 July 1986

BULLETIN

of

The British Association of Psychotherapists

Subscription Enquiries:

Judith Lawrence, Secretary, 121 Hendon Lane, London, N3 3PR

BULLETIN

No. 17 July 1986

INTERPRETATION: FRESH INSIGHT OR CLICHÉ?

Patrick Casement

Presented at the sixth BAP Scientific Conference, Autumn 1985.

When we find ourselves using similar forms of interpretation with several different patients, it is probable that we are becoming stereotyped and repetitive. And when this repetition develops into cliché interpreting, it is likely to promote an intellectualisation of the analytic experience. How then can we recover that freshness of insight which alone can promote therapeutic change? This is the problem I wish to consider with you today.

Typical examples of cliché interpretation are: "You are really talking about me"; "You are seeing me as your mother"; "You are experiencing separation anxiety"; "You are rendering me impotent"; "You are experiencing castration anxiety"; "You are making envious attacks upon my understanding".

I haven't yet heard all of these statements rolled up into one single interpretation. That really would be a new event! But each separately is well on the way to becoming a cliché. Examples like these are common in the analytic literature which makes me wonder how frequently they may be used in the consulting room.

We cannot always avoid saying things like this to our patients. But, the effectiveness of such interpretations is dulled through over-use. Also, when these come to be regarded as universal truths we can lose touch with the individual. Therefore, when a stereotyped interpretation is foremost in our thinking it is often better to delay and to look for some neutral bridge that can lead towards subsequent interpretation. The patient will frequently lead us to insight that is more specific and often quite new.

I'll give just one brief example of this. I once pointed out to a patient a recurring theme that he, as a child and since, had become pre-occupied with protecting his penis against some expected hurt or threat. (The interpretation that I am not making is quite obvious here). He replied: "I am afraid of it being broken off." Let us notice how much more telling is his own description of castration anxiety. The threat was not just to the penis but to the excited penis. It cannot be thought of as being broken off unless it is erect.

However, I am not only thinking of the way in which actual interpretations become clichés because of their familar form. I am also

A revised version of this paper is to be published in *Free Associations 5.*

concerned with the stereotyped thinking that engenders this: for instance, the notion that everything in a session should be interpreted in terms of the transference, or in terms of the patient's current regression in the transference relationship. The danger then is that we will only notice what our theoretical assumptions prompt us to look for, and our pre-conceptions begin to be imposed upon what we see.

I came across a salutory warning of this when I was reading Anthropology at Cambridge. One book I had to read was about the symbolism of musical instruments. The author argued that every musical instrument is symbolically male or female. Having got carried away by the shape of violins and cellos he noticed that they are played on with long thin things called bows. These, he claimed, are phallic symbols. He then proceeded to go through the entire orchestra; and how could anyone argue with him?

He pointed out all those other long thin instruments that people are putting into their mouths; the shape of those wooden drum-sticks; and those drum-sticks with large woolly balls; and, what's more, these drum-sticks are beaten against the stretched skin of the drums, which (he tells us) represents the hymen. And what about those inviting hollows at the end of all the brass instruments; and the triangle, which is set ringing by a very small phallic symbol? And so on! After reading all of this, some joker had written in the margin: "If Sir Malcolm Sargeant knew what is really going on in front of him, and what he is waving around in his own hand, he would never conduct another concert!"

What I am trying to illustrate, in this absurd example of analytic interpretation, is that when basic assumptions are held to be beyond question our understanding can so easily be imposed upon what we see. Clinically, we must always be wary of this tendency, particularly as we are all inclined to relate to the familiar as if it were universally the same.

I would like to suggest that some of our stereotyped thinking and interpreting is due to a mistaken response to the patient's communications. This response could be described as a *transferential attitude to elements of the clinical situation* (Casement, 1985: 9-12). In ways similar to the processes of transference, we find ourselves responding to the patient in terms of our familiarity with analytic theory or other clinical experience. We then transfer, onto the patient, the understanding that we have gleaned from elsewhere. This is what I mean by cliché thinking.

I believe that we are most likely to engage in these repetitive forms of interpreting when we are feeling insecure about our clinical understanding. By prematurely imagining that we recognise what the patient is communicating, even if we don't, we can preserve the

appearance (at least to ourselves) of being competent. There is then a danger that we interpret on the basis of similarity rather than from a more genuine process of analytic discovery.

Let us remember, however, that the pitfalls of pre-conception are a hazard not only for the novice. A similar danger lies in wait for the experienced therapist. It is then the authority of experience that can tempt the practitioner to become lazy in his thinking — or too sure. It is often tempting to use short-cuts to insight, based upon what has already made sense with other patients.

The following vignette is taken from my own clinical work.

In a session, some time during the first year of analysis, a patient began to be distressed about her hair going grey. At first I thought I was hearing about vanity, particularly when I noticed that I could not see grey hairs. I tried looking closer, peering over the back of the couch, but I still couldn't see any grey. However, when I wondered about this shift in my position, from sitting normally in my chair to leaning towards the patient, I thought that I was being manoeuvred into getting physically closer to her. I therefore mistook this interaction to be evidence of some hysterical manipulation.

When I interpreted this, as the patient trying to get me to be closer to her, she became much more distressed. She began crying from deep inside herself. Only then did I recognise that the patient had been trying to tell me about her inside world, in which the scars of her childhood experiences made her feel that she was growing prematurely old. Part of the problem was that her emotional scars were not visible — and yet she needed me to be aware of them.

This re-orientation was only possible when I recognised that her response to my first interpretation was not due to resistance, as I had been tempted to think. Her increased distress contained an unconscious cue for me to listen to the deeper meaning in her communication. She needed me to be prepared to be in touch with the pain of her *internal* world.

In my initial failure to look beneath the surface appearance, I had become like her mother. The patient then felt left alone with her distress, as she had been as a child. Through a re-orientation of my listening, I was able to arrive at a quite different understanding of this sequence. Moreover, the patient was also able to discover that her capacity to cue the other person had not after all been lost to her for ever. That is how it had seemed to her after she had been badly burned at the age of eleven months. After that trauma her mother had seemed to be no longer able

to respond to her inner pain. She had concentrated instead on the healing of the external scars from the burning.

It is not easy for a patient to question, let alone to re-orientate, the therapist unless the patient is unusually tenacious — as with the patient I have just described. So, what happens if we let ourselves become dogmatic in our interpreting? One thing at least is certain; that we will become less receptive to correction from a patient.

Also let us wonder what is happening when our theoretical orientation becomes obtrusively evident in what we are saying to a patient. Are we imposing our theory upon what we are hearing? I think of this as 'jelly-moulding', giving a shape to clinical material that is not inherent to it.

The example I shall give, to illustrate this, just happens to be from the work of a Kleinian. But, I think that this style of interpreting would be more validly described as "caricature Kleinian". Similar caricatures of interpreting can be found in all schools of psychoanalysis.

At a recent clinical workshop I heard a case presentation given by a Latin American therapist who was visiting Europe. She is bilingual, in English and in the language of her mother-tongue. The patient she described is a man whom she had been seeing in three-times-a-week therapy. The sessions were reported in English but the therapy was being conducted in the patient's own language.

It was soon evident that this therapist's style of work is one of quite unusual sureness about her understanding of the patient. Then in one session that was described in detail the patient reported a dream. He said: "I had a dream last night in which my head was being squashed by someone sitting on my face."

What followed, after the patient had failed to free associate, was a product of the therapist's silent working over of this dream *in the context of her assumptions about the patient's state of regression in the therapy.* He was regarded as still at the breast. But, in the dream, where there should have been a mouth/breast relationship there is a face pressed against buttocks. The therapist was able to argue to herself that this must be derived from a distortion of the assumed feeding relationship. She therefore offered the following interpretation: "Because of your envy, you are unable to take in the good milk of my interpretations. Instead you take in my words as poisonous faeces."

The patient's response to this interpretation was to remain silent, and then to appear to change the subject. He eventually came out of his silence with the following statement: "I am going to the U.S.A. for my

holiday, but I don't speak English. This will make me very vulnerable because it means that I will have to be totally dependent on my wife to explain to me everything that is being said." What followed was an analysis of the patient's separation anxiety.

I should have said that this material was from sessions during the month prior to a summer break, so it was not surprising to hear the therapist refer to this when the patient had spoken about his summer holiday.

Now, at some level, both of these interpretations may have their own truth. But what if the patient is not simply regressed to an infant/breast relationship? What if the patient is also responding to the therapist's style of working? We might be hearing examples of *unconscious supervision* by the patient (Langs, 1978).

Let us go over the material once more, using trial identification with the patient to help us here to look at *the patient's view of the therapist* (Casement, 1985: 34-5). This can provide us with a different position from which to listen to this interaction.

The patient may be feeling battered by his over-sure therapist. If so, the dream might allude to the experience of not being allowed his own thoughts. Someone was squashing the patient's head — perhaps making thinking impossible. It could therefore be an unconscious prompt to the therapist to re-consider her dogmatic way of interpreting (Footnote 1).

The therapist, however, seems to be unaware of any prompting by the patient. She proceeds to interpret this dream no less dogmatically; and she regards the ensuing silence to be an acceptance of this interpretation by the patient. She also assumes that the change of subject has been determined by the impending holiday break.

Let us again trial-identify with the patient. Where does the notion of "poisonous faeces" come from in this session? Surely, not out of the patient's own thinking but from the therapist's theoretical orientation. Maybe, then, the patient's next statements are more directly related to this interpretation. As well as referring to the holiday break, the patient could be saying "I can't understand your language. If you can't use mine it could make me totally dependent upon you to explain to me what you are saying."

The communication here is, of course, bound to be over-determined — having several levels of meaning at the same time. We may also be hearing references to the transference, in that we know the therapist to be fluent in more than one language — and it is quite likely that the patient does too.

In my opinion, the interpretations given are super-imposed upon what the patient is saying; they do not develop from within the session

itself. Also, in passing, we might note that holiday breaks are one of the many common stimuli for cliché interpretations — particularly when everything is listened to for allusions to any interruption of the therapy.

Let us consider some other clinical phenomena that can trigger what I am calling a transferential attitude to familiar clinical experience.

Lateness may be an expression of resistance, or of some angry feelings towards the therapist. But it can be other things too. For instance, it is sometimes a token bid for the session to start in the patient's own time — not the therapist's. And that does not always have to be seen in terms of a wish to control the therapist. Patients quite often endeavour to "own" the analytic space, and the time of a session; and it is important that they can find ways to establish this as truly theirs. Too often, lateness is listened to only for its negative connotations.

This may also apply to *silence.* We encounter many different kinds of silence in the clinical setting. But some therapists are prone to fall back upon stereotyped thinking when they are anxiously trying to deal with prolonged silences. One of these stereotypes is to hold too strongly to the notion that the patient should always be left to speak first. But there are occasions when we need to recognise that *the patient has already started the session – with silence.* We are less likely to get into a sterile game of waiting if we learn to 'read' a patient's silence, and sometimes to respond tentatively to what we sense as the underlying communication conveyed in this. We will then be responding to the way in which the patient has actually begun the session. Silence does not always have to be withholding or resisting.

A similar stalemate sometimes develops around the issue of a patient's *anger.* Not infrequently we notice that a patient has difficulty in expressing anger — particularly in the session. It is then talked about as something that only happens outside the consulting room, or as something that seems not to happen at all because of the patient's inhibition of anger.

One therapist, whom I supervised, quite often interpreted *the absence of anger* in her patient's life — as paralleled in her relationship to the therapist. It was known that, throughout her life, the patient had been unable to give vent to her angry feelings; and this could be understood as an inhibition linked with her mother's frequent absences with cancer, and her eventual death when the patient was not yet four years old. Maybe she was afraid that her therapist would be harmed, even killed, by the murderous anger that still brooded in the patient's

unconscious; most particularly towards those she depended upon, and who were too often absent when she needed them.

Gradually the patient began to agree with her therapist that it would be a relief if she could let herself be angry in her sessions; and she had a lot to be angry about. The therapist was, of course, absent between sessions, and away for holidays. These absences were experienced by the patient as a desertion of her by the therapist, as by the mother who had often been away in hospital — and who then had died.

In supervision I began to hear details of how this therapist felt in response to the patient's frequent lateness and occasional missing of sessions, and her regular silences at the beginning of every session. I had, in fact, encouraged the therapist to make a point of starting every session on time with or without the patient. In this way she came to be most directly exposed to the impact of the patient's various kinds of absence. The therapist had then noticed that she felt badly treated by the patient. She sometimes felt abandoned; or she felt suspended in a state of not knowing where the patient was in a session, while she remained in prolonged silences; or not knowing what had happened to her patient, when she missed a session without telephoning.

Out of this monitoring of the therapist's responses, to these silences or absences, it began to become clear that we had been missing an important point. It was far from true that the patient was unable to express her anger in the sessions. She was doing this nearly all the time — *but it was not being recognised as anger.*

It began to be possible to re-think the communication conveyed in the unconscious interaction between this patient and her therapist; and it seemed possible that the therapist was being unconsciously tested to see if she could be aware of the murderous anger in this behaviour.

Surviving this silent aggression unwittingly, while speaking of the absence of the patient's anger in sessions, may therefore have been experienced by the patient as evidence that the therapist was actually afraid of her anger — and that she was unconsciously retreating from this by not letting herself be aware of it. This was exactly how adults had responded to her when she was a child. They too had not been able to cope with her angry feelings — around the time of her mother's death and after it. She had eventually been sent away to a children's home, when nobody felt able to manage this distressed child who also became very withdrawn. Important changes in the therapy grew out of this new awareness of the patient's anger having been, all along, *in the session* — even during her absences.

In this example we can see a shift from cliché thinking to fresh

insight. Silences and absence had been mistaken for resistance. But these could be understood quite differently once the therapist had begun to monitor her affective responses to the patient (King, 1978). It then became possible to see that the patient was 'communicating by impact' (Casement, 1985: Chapter 4). She was evoking in the therapist, by means of projective identification, a resonance to her own difficult feelings that she could not otherwise communicate. The therapist could thereby begin to recognise important aspects of the patient's own unmanageable experiences of being confronted by her mother's unexplained absence, not knowing where she was or what was happening to her. But a re-orientation in listening had been necessary before this understanding of the patient's non-verbal communication became possible.

Now, as an exercise in differentiating between clinically similar situations, I shall describe a case of my own in which I was also having to struggle with silences in a session.

A patient (whom I shall call Mrs D) would frequently fall into silences during which she was in evident distress. But with this patient, if I tried to interpret from my own reading of her distress (in the way I have just been suggesting) it didn't help. Equally, if I left her in silence *that* didn't help. Either way she experienced me as putting her under a pressure to speak; and I experienced myself as being double-bound. Whatever I did was wrong.

One day the patient stammered out of her silence: "I am sorry, but I can't help being difficult like this." She was now experiencing a pressure to apologise. But she was also prompting me to look at her distressed silence differently. I was hearing about something called "being difficult". I took this as an unconscious cue.

I was reminded by this that Mrs D's mother would often accuse her of "being difficult". She had previously told me that, when she was upset as a child, she could never speak to her mother about what she was feeling. Her mother regarded this reluctance to speak as perverse and would accuse her of "being difficult"; but, if she did then begin to speak about what she was feeling, her mother would turn away from her saying that she was "now being impossible". Her mother could not bear being made to feel upset, as a result of which the patient was made to feel that she was always in the wrong.

I had already been aware of this double-binding by the mother. But, in this session, I was able to hear the patient in a new way. I therefore replied: "Perhaps it is precisely this difficulty, in

communicating what you are feeling, that you need to convey to me now; but you expect me not to be prepared to stay with you, if I actually experience some of that difficulty, so you feel that you must apologise."

The patient then told me more about her fear of being upset in the presence of her mother. She had frequently been rejected by her mother, for expecting emotional help which was not forthcoming. To avoid this she would shut herself away in her bedroom, in despair of ever finding help with her distress.

Incidentally, this childhood history illustrates well how a failure to accept, or to deal with, the communication of distress leads to this becoming even more unmanageable (Bion, 1967: 114-16). Mrs D had to find out whether I could bear to be affected by her difficulty in communicating without me finding her "impossible". She also needed to discover whether I could recognise, and find ways of dealing with, her experience of being double-bound; and she had been able to communicate this by double-binding me.

I would now like to examine a particular problem of technique that confronts us all. There are some patients who use their familiarity with analytic theory as a defence against real insight. They have their own pre-conceptions. Therefore much of what we might normally be able to say to a patient, without it sounding stereotyped, is heard by the patient as nothing other than cliché. A typical response is the comment: "Oh, I thought you would say that." On the other hand, some patients seize upon any stereotyped interpretation to further their intellectualisation of the analytic process. By these means, real experience in the analysis can be warded off.

In the following example the patient was constantly ready to make a defensive use of any predictable insight.

Mrs E (as I shall call her) came to me for therapy when she was nearly thirty. She had a long history of depression, and now her second marriage was in a state of breakdown. She was analytically sophisticated, anticipating much of what I interpreted to her in the early months of therapy. (She had previously been in treatment with a psychiatrist who seems to have been prone to giving her 'wild' analytic interpretations).

This patient, born in a Mediterranean country, had been brought up as a Roman Catholic. She first married when she was seventeen. After three years her husband had left her, accusing her of frigidity. She felt guilty about sex without knowing why, and she told me that her head would become "filled with accusing nuns" if ever she began to enjoy sex.

After her first husband had left her she became promiscuous, and she began to think of herself as no better than a prostitute. Mrs E had subsequently married a much older man; but she had so often provoked him to jealousy, by flirting with other men, that he too was threatening to leave. She now felt that she could not stop herself being sexual towards any man who interested her.

Her history revealed an alarming degree of self-destructiveness. This included a car crash from which she had nearly died. Intermittently she had been actively pre-occupied with thoughts of suicide. She had also had two abortions.

Her relationships with each member of her family were difficult. From early adolescence her father used to beat her, or shut her up in her room, if she ever showed interest in boys. Her mother was also fiercely critical of her. She had a brother four years younger than herself of whom she was intensely jealous.

Much of the detail of her history lent itself readily to a familiar theoretical formulation. For example: I could postulate silently to myself that Mrs E had been oedipally attached to her father, particularly looking to him for love when her mother turned to the new baby; that she felt a fierce rivalry from her mother; also that her persecutory super-ego (an introjection of this critical mother) was later represented by the accusing nuns; and that she had come to experience her sexuality as bad — to be totally inhibited or punished lest it become uncontrollable. In addition there was evidence that she tried to deal with this self-destructively, or to get others to punish her, in relation to her sexual interest in men. This interaction may well have originated with her father.

However, this was all based on theory or on other clinical experience. It had not yet grown out of my analytic work with this patient. Some of it had been postulated by the patient herself, based on what she had read. She thus forestalled a deeper analytic experience. In addition, it was noticeable that Mrs E displayed an excited expectation that I would be interpreting her Oedipus Complex, as her psychiatrist used to do. I therefore chose to defer more interpretation of this.

Gradually the patient's own analytic pre-conceptions began to fade as I was not exciting her with sexual interpretations. The therapy moved into other areas, with my own theoretical formulations falling into the background of my thinking and listening; and I stopped looking for, or thinking that I saw, the most obvious things that my analytical training had led me to expect.

In the second year of this three-times-a-week therapy Mrs E told me a dream. She said: "I was in a bathroom with Kojak. There were many

baths — side by side in a row." She had no associations. After a while I commented: "I don't understand this dream yet, but I do wonder why there are many baths". (I was trying to help her to free associate without directing her to say more). Mrs E had no thoughts about this. After a while I added: "I wonder if there could be an unconscious metaphor here for some kind of frequency." (I was thinking aloud about this strange detail in the dream, knowing that I still could not interpret). She made nothing more of this so we left it.

In a session two weeks later she said: "I dreamed about Kojak again last night. He was with me in my parents" bedroom. He was being sexual with me and I was feeling very excited. We were about to get into bed to make love when I woke up". This time Mrs E freely offered associations to her dream. She recognised the bedroom because this had been in a house where they had lived when she was four. She remembered it well as her family had lived there for the year that her brother had been born. About Kojak, she said: "I really fancy that man. He sucks lollipops, like a child, and yet he is ever so sexy.

Here I felt, I should be especially careful not to pre-empt the patient. I therefore looked for a neutral way of providing *a half-way step to insight,* in order to keep the patient's options open. After a pause I offered the comment: "I notice that you have recently had *two* dreams about Kojak." (At least there was nothing directive about that!) Mrs E began to wonder about this: "I think it has something to do with his bald head. It fascinates and excites me — I can't think way."

Here I used a form of stereotyped response; but, fortunately, it did not lead to the intellectualising reply that it could have done. I said: "Perhaps Kojak is not the only person with a bald head who has fascinated or excited you."

"No", she replied, "I don't know *any* bald men — at least not intimately." After a pause she cried out, in alarm and disbelief: "My God! It can't be ... But, yes ... My father!" (Pause) "My father used to wear a wig. I only ever saw him without it once, when I was very little. He was asleep and it had slipped off. He was totally bald; and I had completely forgotten that until now."

Mrs E then poured out a memory that horrified and shocked her. She was in the bathroom with her father. She was four. Her father was playing with her, naked upon his lap, when her mother had come in. Her mother had started screaming, plunging her into the bath and washing her viciously all over. Her mother was screaming at her father (or was it at her?) while looking closely at her vagina.

What emerged in the following sessions was much else that related to this experience. Mrs E was convinced that her father had actually used

her sexually; and not only on this occasion but frequently before this too. (Perhaps that was what had been alluded to in the dream detail of the many baths. And, might the bald head also have been a derivative reference to some other nakedness of her father's body exposed to her?)

I learned that her parents' marriage had collapsed about that time. Her father, she was eventually told, had turned instead to prostitutes. Could that have been why she had later come to identify herself with prostitutes? And her father punishing her, as a teenager, for being sexual: had she been provoking her second husband to treat her in the same way?

Psychoanalytic theory, in this case, was discovered to be vividly borne out by clinical experience. But, for it to be clinically useful, it had to be re-discovered — not merely applied. It would have served only to increase the patient's defences against remembering, if I had anticipated this eruption of unconscious memory by interpreting earlier. Instead, I had to preserve the analytic space from my own pre-conceptions — and hers. Insight, when it was arrived at, was no cliché. It was discovered when the patient was emotionally ready for this; and she could only be ready when she felt analytically secure enough to remember.

What was then necessary in this therapy was a careful working through of this new insight in the transference. During this phase of the therapy, the patient was only gradually able to allow herself to realise that her manner of relating to me was also clearly sexual — as with any man who interested her. For a long time previously she had believed that it was only by her keeping all sexuality isolated from the therapeutic relationship that this had been kept safe. It therefore became an entirely new experience for her to discover that her sexuality could be acknowledged by me without being exploited, that it could be affirmed and not ignored or run away from. Only thus could she begin to see her sexuality as containable and therefore as benign; as neither bad nor destructive.

There are many occasions when we are inclined to fall into stereotyped ways of listening and interpreting. It is my hope, therefore, that this paper may stimulate us to recognise more readily when this is happening.

For instance, when we are listening for the transference, does everything said in a session always have to be related to the transference? When we are interpreting symbols, do they universally have the same meaning to every patient? When we are asked a question, should we always respond with silence (or with another question)? I believe that

these are some of the technical issues we should always be wondering about; for (in certain ways) our technique, like our interpreting, can just as easily become stereotyped and unhelpfully predictable.

I should stress, however, that there are (of course) occasions when a patient needs us to interpret promptly, as when emotional containment is an immediate issue. Then it really is important that we have the skill to interpret with sureness of understanding. But there are other times when we need to remain not-knowing, keeping the patient's options open by offering only a bridge to interpretation — as in some of the examples I have described.

We do not have to be so quick to use old insights when we can learn to tolerate longer exposure to what we do not yet understand. And, when we do think we recognise something familiar, we need still to be receptive to that which is different and new. Insight can then be found afresh, and interpretation can be more specifically personal. Discovering how to achieve this is, I believe, an essential art in psychotherapy.

It may also be an essential art in living. For instance, in his FOUR QUARTETS T.S. Eliot writes:

> There is ...
> At best, only a limited value
> In the knowledge derived from experience.
> The knowledge imposes a pattern, and falsifies,
> For the pattern is new in every moment
> And every moment is a new and shocking
> Valuation of all that we have been.
>
> (East Coker)

And later:

> ... Last season's fruit is eaten
> And the fullfed beast shall kick the empty pail.
> For last year's words belong to last year's language
> And next year's words await another voice.
>
> (Little Gidding)

In psychotherapy our task is to find, in the patient and in ourselves, that other voice.

NOTE:

1. This way of listening to clinical material has been extensively described by Langs in *The Listening Process* (Langs, 1978), and is central to all his writing since then.

REFERENCES

Bion, W.R. (1967). *Second Thoughts,* New York, Aronson.

Casement, P.J. (1985). *On Learning from the Patient,* London, Tavistock Publications.

Eliot, T.S. (1935). *Four Quartets. (1949) London, Faber & Faber.*

King, P. (1978). 'Affective Response of the Analyst to the Patient's Communications', *International Journal of Psycho-Analysis* 59: 329-34.

Langs, R.J. (1978). *The Listening Process,* New York, Aronson.

THE PSYCHOGENESIS OF GENDER IDENTITY

Elizabeth R. Moberly

This paper, presented at the Psychoanalytic Self Psychology Conference, New York 1985, represents a summary of the author's controversial views. Her conclusions are drawn from the author's extensive research and offer a challenge to traditional psychoanalytic concepts. We publish it as a stimulus to readers to clarify their own thinking on these fundamental issues.

In this presentation I wish to outline some of the conclusions reached in my two psychoanalytic studies. The first book is entitled *Psychogenesis* (Moberly, E. 1983) and is published by Routledge & Kegan Paul. This offers a detailed new formulation of the aetiology of transsexualism in both the male and the female, together with a completely new evaluation of the homosexual condition, again in both sexes. Both of these conditions are presented on a developmental perspective. The sequel to *Psychogenesis* recently published by Methuen and Tavistock, is entitled *The Psychology of Self and Other* (Moberly, E. 1985). This second book commences with a re-evaluation of basic Freudian concepts. I then develop the work of Dr. John Bowlby and Dr. Heinz Kohut, and on this basis I offer a new theory of developmental arrest and the possibilities of restoration. I use different languages in my two books. The data of *Psychogenesis* are entirely congenial to a self psychological approach, but it is only in *The Psychology of Self and Other* that I explicitly appropriate the language of self psychology, as I draw out the more general implications of my work in gender identity. What I shall attempt in this paper is to outline the major conclusions of my work and then draw them into a self psychological framework. I shall of necessity be brief, and I must refer the reader to my two books for full details of the position I outline.

Bowlby's studies of mourning in early childhood comment on three phases of response to the loss of a love-object: initial *protest*, which gives way to subsequent *despair*, and finally leads to *detachment*. Detachment is considered to be based on the repression of the child's need for his or her mother (Bowlby *et al.*, 1956). It is this attachment-need which persists as a dynamic force in the unconscious. The mourning reaction set in train by separation may be resolved sooner or later, and the ambivalence towards the love-object (experienced as hurtful) may be adequately worked through. However, I have suggested in

Psychogenesis that in many instances pathological mourning-responses may never be worked through. Repressed yearning for the loved object, and repressed reproaches against it, may persist throughout life. This unresolved twofold mourning-response entails the persistence of structures of ambivalence within the personality. An intense approach-avoidance conflict is implied. The attachment-need persists unfulfilled, and the defensive manoeuvre persists unresolved. I wish to emphasise the twofold character of Bowlby's model, since it is crucial for much of what I will say subsequently. Where I develop Bowlby's model is, firstly, in insisting that the mourning-responses of childhood are frequently not worked through, but persist into adult life. Secondly, and most crucially, that certain conditions are to be identified as derivatives of this unresolved mourning sequence — a sequence which is highly significant for the development of gender identity in particular.

To elucidate this, let me return to Bowlby's model. The child represses his or her attachment-need. This mechanism applies whether the love-source is the parent of the same sex or the parent of the opposite sex. However, when the defence happens to be vis-a-vis an object of the same sex, there is an additional complication. Relating to the parent of the same sex is important for the process of identification. If this particular attachment is disrupted, and the attachment-need is repressed, this in turn affects the identificatory process. Indeed, defensive detachment from the love-source implies not a mere absence of identification, but a defensive reaction against identification — in other words, *dis*identification. Freud (1917 [1915]) spoke of identification as a response to object-loss. By contrast, my view is that object-loss results in *dis*identification. The normal process of receiving love from, and hence identifying with, a love-source of the same sex, has been blocked by trauma in the early years of life — most typically, by early separation.

When this process occurs in early infancy, radical same-sex disidentification takes place. It becomes logical for a person to experience a sense of gender dislocation, and even to press for gender reassignment in accordance with this sense of self-awareness. This awareness is not imaginary or delusional, but marks an accurate and realistic representation of how it feels to be a person in whom the normal process of same-sex identification has been blocked from an early age. The demand for gender reassignment surgery is the logical culmination of this disidentificatory impulse.

In conclusion to Dr. Robert Stoller's position (1975), I believe that male transsexualism involves a defensive anti-masculinity. It is not the non-conflictual imprinting of femininity, but an aversive impulse from

the same sex, resulting in a genuine and radical absence of same-sex identification. Stoller speaks of an absent father who does not protect his son from the feminising effects of a close symbiosis with the mother. By contrast, it is my view that it is the father's absence that itself results in same-sex disidentification. This further indicates that transsexualism is not — despite appearances — cross-gender condition, but essentially a *same-sex developmental deficit.* The data I offer in *Psychogenesis* indicate a similar aetiology for transsexualism in both sexes. The young boy disidentifies from his father, the young girl disidentifies from her mother. I do not accept that core gender identity is safely established by the age of two and a half years (Money *et al.,* 1955). The future transsexual has as normal a same-sex identity as anyone else until disidentification takes place. My data indicate that gender identity is reversible by trauma that disrupts the identificatory attachment to the same-sex parent. The need for an identificatory attachment to a member of the same sex is repressed, and thus persists as a dynamic force in the unconscious.

The repression of the attachment need for the same-sex parent may not always result in radical disidentification. If the process of same-sex identification has proceeded somewhat further prior to disruption of attachment, the resultant psychodynamic structure is still one of same-sex ambivalence. But the sense of same-sex identity will be viable, even if incomplete. I refer here to the homosexual condition. I believe that transsexualism differs from homosexuality in degree, rather than in kind. This does not imply that transsexualism is a defensive rationalisation of homosexuality. Rather, the two conditions have a similar aetiology and a similar psychodynamic structure. They differ only in the degree to which same-sex identificatory growth has not taken place.

As we know, object-choice is a function of identity. I would say that same-sex object-choice is a function of incomplete same-sex identity. The repressed need for a same-sex attachment may emerge from repression, and seek further fulfilment. Since a normal and legitimate developmental need is involved, I wish to suggest that this is a developmentally realistic manoeuvre. I further wish to suggest a major re-evaluation of the homosexual condition on the basis of the data I present in *Psychogenesis.* My re-evaluation also applies to transsexualism.

In developing Bowlby's model, I wish to re-define homosexuality. It is usual to define homosexuality as the capacity for same-sex love. By contrast, I present homosexuality as a condition of same-sex ambivalence, where same-sex love is but one side of a twofold phenomenon, a twofold posychodynamic structure. Not only repressed

yearning for the loved object, but also repressed reproaches against it, have persisted. There *is* a problem in the homosexual condition, and that problem is the persistence of unresolved, often largely unconscious, animosity towards members of the same sex — an animosity that has persisted since defensive detachment took place in the early years of life. Same-sex animosity is a legitimate target for therapeutic endeavours. By contrast, same-sex *love* is seen to be a realistic developmental need. The need for a renewed same-sex attachment is not pathological or deviant, and it does not require cure. It only requires fulfilment, so as to further the normal developmental process. Increased opposite-sex contact can do nothing to resolve and fulfil same-sex developmental deficits. It was therefore illogical and counter-therapeutic for traditional therapy to promote increased opposite-sex contact for homosexuals. My data suggest that legitimate developmental needs for a same-sex attachment may not be bypassed, but must be done justice to. In order to maximise the value of the transference, therapy should be gender-specific: with a therapist of the same sex, focussing on same-sex relational needs, and — equally importantly — resolving the underlying ambivalence towards members of the same sex.

This is a very brief outline of my work in gender identity, which is presented in considerably more detail in *Psychogenesis*. I've stated that my data are congenial to a self-psychological approach, and I would now like to bring the specific transition to self psychology that I present in *The Psychology of Self and Other*.

I will commence this transition with a revision of the concept of defence, and from this my contribution to self psychology will be developed. Freud repeatedly insists that defence is directed against unwelcome instinctual impulses. Likewise, later writers such as Laplanche and Pontalis affirm that "the two poles of the conflict are invariably the ego and the instinct" (p. 105). This seems illogical. To return to Bowlby's formulations, detachment takes place vis-a-vis the *love-object* that is experienced as hurtful. The defence is directed against the love-object, and the attachment-need is protectively repressed in what is experienced as a situation of external danger. The need as such is in no way objectionable. This formulation is of major importance. Outstandingly, it indicates that the resolution of defence or repression is by itself inadequate. The goal must be the actual restoration of attachment, in a relationship that will fulfil those legitimate developmental needs that were left unmet when the attachment-need was repressed. It is not the attachment-need that is objectionable, but the unavailability of the love-object. Hence, repression should be replaced, not by "condemning judgment" (Freud, 1910 [1909]), but by a restored

attachment. The central issue at stake is not instinctual danger, but instinctual unfulfilment. The ego required the libido to withdraw *from the object.* The undoing of repression, in the absence of a restored attachment to the object, would therefore not resolve the problem, but merely provide a greater awareness of it.

The removal of repression must be complemented by developmental fulfilment. Repression in itself is not the problem, but only a hindrance to the solution of the problem. Even when repression is resolved, the problem as such remains — that is to say, the lack of fulfilment of attachment-needs. I wish to suggest that there is often a *realistic* element in the transference, to the extent that it involves the re-emergence of legitimate developmental needs. I further wish to suggest that, since the phase-specific fulfilment of these needs was checked, one aspect of the therapeutic task must be to resume the fulfilment of the developmental timetable.

I am certainly not advocating a "cure by love" in preference to a "cure by analysis". However, I wish to widen the scope of the analytic endeavour. The concept of transference implies "what is transferred". If an attachment-need emerges from repression, it may well be transferred to the person of the analyst. The conscious awareness of this fact will do nothing to remove or destroy the transference, nor should it do so. To 'remove' the transference of this unfulfilled need would be to reinstate the very problem that requires solution.

Transference can involve both repetition (of infantile conflict) *and* reinstatement (of unmet developmental needs). The concept of reinstatement is of outstanding importance. It stems directly from appraising Bowlby's data on the repression of an attachment-need in early infancy. And it implies that the rule of abstinence must give way to a new understanding of corrective emotional experience, defined specifically as the reinstatement and fulfilment of legitimate developmental needs through the medium of a renewed attachment. Interpretation remains central to the analytic endeavour — let me emphasise this — but it is no longer to be linked with the rule of abstinence in the treatment of developmentally affronted persons.

What I am saying is this: When an attachment-need was repressed in early years, and has persisted unfulfilled, the intense need for external objects — the need for a selfobject attachment — *is still a phase-appropriate.* To acknowledge such needs without gratification achieves very little, since — by definition — attachment-needs can only be fulfilled through the medium of an actual attachment and not otherwise. Object-libidinal fulfilment is the medium of intrapsychic structuralisation. The repression of an attachment-need checks the process of

intrapsychic structuralisation. But the re-emergence of the repressed — in the form of a selfobject transference — implies an inherent reparative potential, through which the normal developmental process may be resumed and continued. However, since the selfobject transference implies the reanimation and reinstatement of legitimate developmental needs, it is vital that such needs should be actually *fulfilled.* If we make childhood wishes conscious, but keep them frustrated and unsatisfied, we merely perpetuate the problem, albeit in a state of increased awareness. Repression was significant *only* as a hindrance to the fulfilment of attachment-needs. The undoing of repression is significant *only* as a preliminary to the fulfilment of attachment-needs.

My use of Bowlby's paradigm further implies that narcissistic and other developmental disorders *do* presuppose a repressed drive seeking fulfilment. This is not to reduce narcissism to the status of a neurosis, but to insist that drive-fulfilment is intrinsic to the structuralisation of the self. It is the early repression of the drive for attachment that checks intrapsychic structuralisation. Disintegration anxiety stems directly from the repression of the need for a structuralising attachment. On this analysis, the needs of a defective self *are* drive-wishes. Moreover, we do not have a contrast conflict solution with the establishment of self-cohesion. Defensive detachment — the protective repression of an attachment-need — is to be resolved, precisely in order to facilitate a renewed structuralising attachment, with all that this implies for the sense of self-esteem and personal identity.

Narcissistic and other developmental disorders also involve transference. I am unhappy about the distinction drawn between transference, and so-called pre-transference phenomena. I believe that this conceptualisation is incorrect, and I wish instead to contrast archaic forms of transference (or selfobject transference) with more mature forms of transference (or whole-object transference). The transference makes manifest the level of developmental progress — the level of intrapsychic structuralisation and the correlative capacity and need for objects. But at every level we see transference. The projection of a *lack* of internal structure is as transferential as is the projection of an intact structure. And, where intrapsychic structure is incomplete, the transference must of necessity be a selfobject transference, where the analyst is substituting for psychic structure. As Kohut described it (1977: 259), where there are "structural defects in the self", "selfobject transferences ... establish themselves on the basis of these defects". The analyst functions as an archaic prestructural oject. The function assigned to the analyst is of necessity exactly correlative with the degree of intrapsychic structuralisation and object-need in the analysand. It is

not right to label this as an "impersonal function" (Kohut 1978, I-506). On the contrary, this is the personal function appropriate to early developmental needs. The primitive needs involved are developmentally realistic, and there is genuinely a need for object replication — specifically, selfobject replication.

Moreover, the attachment is itself structuralising. I am not prepared to link "transmuting internalisation" with "optimal frustration". My data indicate that internalisation is *checked, not* enhanced, by object-loss. Decathexis does not *lead* to structure formation, but is the *consequence* of structure-formation. It is the fulfilment of object-libidinal needs that turns the object into an introject, and relinquishment of the object prior to such fulfilment checks structuralisation. It is an ongoing attachment to the prestructural selfobject — a continuing cathexis, not a decathexis — that promotes internalisation. Or, in other words, "transmuting internalisation" takes place *through the medium of* a selfobject transference.

It is, quite literally, the transference that helps to maintain the cohesiveness of the self. The selfobject transference marks the spontaneous reactivation of an early developmental stage. The admixture of aggressive elements in the transference does not imply distortion, but is merely a reminder that we face a twofold transference — of unresolved conflict, as well as of unfulfilled developmental needs. Conflict-resolution remains an essential therapeutic task, precisely in order to resolve all that hinders the further structuralisation of the self.

Dedifferentiation is a correlate of incomplete structuralisation, and marks the persisting realistic need for a selfobject. The need for a selfobject may be remobilised in any of the various forms of selfobject transference. I want to insist that where structuralisation is incomplete, it is not merely a *wish,* but a psychological *condition* of dependence that is involved. Developmental deficits imply that dependency is a structural characteristic of the patient's personality. I define dependence as a developmental state (of incomplete structuralisation) and a developmental need (the exactly correlative need for a structuralising attachment to a selfobject). It is vital to remember that the therapist does not create this state or need. The potential for transference lies in 'pre-analytically established internal factors in the analysand's personality structure' (Kohut 1977: 217). This implies that the possibility of developmental reactivation and reinstatement does not depend on the analyst. Early developmental affront need not be irreparable, precisely because there is an inherent reparative potential, in the form of the selfobject transference. The only choice for the therapist is whether or

not to co-operate with this inherent reparative capacity — by *accepting the role of selfobject* — or to continue to leave these developmental needs unfulfilled. The spontaneous activation of a selfobject transference indicates that the developmental opportunity is not past, but still accessible as a contemporary fact.

I define narcissism not as "the cathexis of the *self*" (Kohut, 1971), but as "the cathexis of *objects* in the service of structuralising the self" (1985: 50). I draw no antithesis between narcissism and object-love, but only distinguish between archaic and more mature forms of object-love. Instead of straightforwardly accepting the contrast of self psychology with a structural drive-defence model, I wish to assert that self psychology itself offers a *pre*structural drive-defence model. I do not translate "deficit" into "conflict" (Wallerstein, 1983), but I assert that conflict underlies deficit, and indeed was the original cause of deficit, at the point when the child protectively repressed his need for a structuralising attachment to the parental selfobject. More than this, I insist on a need for developmental realism. In conditions of incomplete structuralisation, the therapeutic function is to serve as a selfobject in lieu of structure and to promote further structuralisation. This is the only developmentally realistic therapeutic manoeuvre. Object choice is indeed a function of identity, both as regards gender identity deficits and more generally, in that the need for a selfobject is a function of incomplete structuralisation. Interpretation and conflict resolution continue to be vital, but are to take place within the matrix and context of the ongoing fulfilment of developmental needs, understood as the structuralising attachment to a selfobject. The logic of Bowlby's paradigm, of Kohut's data, and of my own work — as detailed in *Psychogenesis* and *The Psychology of Self and Other* — is to challenge psychoanalysis to accept developmental fulfilment as a central part of the therapeutic endeavour.

REFERENCES

Bowlby, J. (1973). *Separation, anxiety and anger.* London: Hogarth Press.

Bowlby, J. *et al.* (1956). "The effects of mother-child separation: a follow-up study". *British Journal of Medical Psychology,* 29: 211-47.

Freud, S. (1910[1909]). "Five lectures on psycho-analysis". S.E. XI.

Freud, S. (1917[1915]). "Mourning and melancholia". S.E. XIV.

Kohut, H. (1971). *The Analysis of the Self.* NY: International Universities.

Kohut, H. (1977). *The Restoration of the Self.* NY: International Universities.

Kohut, H. (1978). *The Search for the Self.* NY: International Universities.

Laplanche, J. & Pontalis, J-B. (1980). *The Language of Psycho-analysis.* London: Hogarth Press.

Moberly, E.R. (1983). *Psychogenesis* (The early development of gender identity). London, Boston, Melbourne: Routledge & Kegan Paul.

Moberly, E.R. (1985). *The Psychology of Self and Other.* London: Tavistock. (New York: Methuen).

Money, J. *et al.* (1955). "An examination of some basic sexual concepts: the evidence of human hermaphroditism". *Bulletin of the Johns Hopkins Hospital,* 97: 301-19.

Stoller, R.J. (1975). *The Transsexual Experiment.* London: Hogarth Press.

Wallerstein, R.S. (1983). "A Review and Overview". In *Reflections on Self Psychology,* eds.J.D. Lichtenberg & S. Kaplan. N.J.: Analytic Press, 1983.

TALION LAW: MANIFESTATION AND MANAGEMENT IN THE THERAPEUTIC RELATIONSHIP

Robert Fenton

Introduction

Talion law is depicted in the Bible as an eye for an eye and a tooth for a tooth. It is a deep and archaic impulse to exact revenge by taking pleasure in inflicting on others the hurt that has been experienced by oneself.

Fromm, writing about talion law, comments on how widespread is vengeful aggression, both among individuals and groups, and views the thirst for revenge as especially intense "in those who have an anxious, hoarding, or extremely narcissistic character. For them even a slight damage will arouse an intense craving for revenge" (Fromm, 1973).

Among other authors on this subject, Horney (1948) states that vindictiveness serves to provide a form of self protection against hostility within and without, to restore injured pride, to give a sensation of triumph, and to keep under repression feelings of hopelessness about one's life. Searles (1956) emphasises its unconscious use as a defense against the awareness of repressed grief and separation anxiety. Hence, the craving for revenge can be seen as multidetermined both in terms of the person's early development and in the defensive functions it serves in that person's adult personality.

The importance of understanding talionic impulses in the analytic context has been described clearly by Racker. "Every transference situation provokes a counter-transference situation, which arises out of the analyst's identification of himself with the analysand's (internal) objects. These counter-transference situations may be repressed or emotionally blocked but probably they cannot be avoided; certainly they should not be avoided if full understanding is to be achieved. These counter-transference reactions are governed by the laws of the general and individual unconscious. Among these the law of the talion is especially important. Thus, for example, every positive transference situation is answered by a positive counter-transference; to every negative transference there responds, in one part of the analyst, a negative counter-transference. It is of great importance that the analyst be conscious of this law, for awareness of it is fundamental to avoid 'drowning' in the counter-transference. If he is not aware of it he will not

be able to avoid entering into the vicious circle of the analysand's neurosis, which will hinder or even prevent the work of therapy". (Racker, 1968).

The Talionic Impulse – Illustrations in the Therapeutic Context

1) Winnicott, in a paper on the use of an object and relating through identifications, states that "interpreting by the analyst, if it is to have any effect, must be related to the patient's ability to place the analyst outside the area of subjective phenomena ... in our work it is necessary for us to be concerned with the development and establishment of the capacity to use objects and to recognize a patient's inability to use objects where this is a fact. At the point of development that is under survey the subject is creating the object in the sense of finding externality itself, and it has to be added that this experience depends on the object's capacity to survive. It is important that 'survive', in this context, means 'not retaliate'. (Winnicott 1974).

Similarly this is a point which has been made much of in relation to adolescence. The adolescent needs to test out the adult capacity to contain and survive the adolescent attack. The adolescent is making that attack as part of trying to find an identity that feels real. The adult survives by not collapsing or taking flight from a genuinely held viewpoint. The rigidly held position backed up only with retaliatory striking out conveys to the adolescent that there is no safety to test out and defy, because the adult cannot survive him.

2) In discussing the borderline patient, Masterson (1981) says that such patients internalise the talion impulse and act it out on themselves. He says that the borderline child is unable to express his hurt and rage, because of need for and fear of his parents, and instead attempts to master it by using the mechanism of identification with the aggressor. "He creates an internalised drama ... where the patient is both attacker and victim. He discharges the rage by attacking himself, fantasying revenge on the parents and the fulfilment of his talionic impulses by destroying their possession. This is at the same time a defense against the underlying talionic, homicidal urges toward the exploiting object. There is also a compensatory accompanying fantasy that if he dramatises this sorrowful state sufficiently the parents will provide the wished for response. This results in a failure to master the talionic impulse, which is destructively acted out on the self. Aggression is thus not free for release in self assertive, adaptive behaviour". (Masterson 1981).

Masterson views borderline patients as essentially focused on revenge, primarily wanting to get back at — not to get better. He sees the

critical crossroad in treatment when the patient must make a choice between getting back at or getting better. "He cannot have both. As long as his aggression is channeled into revenge it is not available to build psychic structure. He must give up the idea of revenge. That is, he must master the talionic impulse and free his agression to support his self image, rather than to attack it." (Masterson 1981).

Aspects of Jung's Model

As I wish to develop my subject in terms of Jungian concepts, I should like to outline some aspects of the conceptual model which Jung evolved, in an effort to order and present his findings.

In this model the psyche is divided into conscious aspects that are well organised and also into unconscious processes. The centre of consciousness, the organiser of the conscious aspects of the personality, he called the ego. For purposes of exposition, unconscious processes can be described in two layers, the repressed personal and the archetypal impersonal. The archetypal impersonal may be given image and representation in such cultural forms as myths and fairy tales. At this layer, the organisers are non ego and are called archetypes. However it has been cogently argued that the personal and collective unconscious in practice are indivisible since "nothing in the personal experience needs to be repressed unless the ego feels threatened by its archetypal power, and the archetypal activity which forms the individual's myth is determined by material supplied by the personal unconscious" (Williams 1963).

The archetype nearest the ego Jung called the shadow. This term includes both the personal shadow of each of us and the shadow of the society of which we are a part. It is important to realise that this term includes not only a complexity of personal problems and anxieties but also the person's neglected potentials.

Fordham (1965) has written on the importance of analysing childhood for the assimilation of the shadow, and many Jungians have been interested in the archetypal images and processes that can be found in childhood and in the analyst's counter-transference to the analysand's transference. If one remembers that transference can best be understood in relation to the person's developmental history then the study of transference fits in well with the study of psychological maturation in infancy and childhood. Hence the two lines of investigation have gone hand in hand (Fordham 1978).

Jung regarded early identifications between parents and children as critical in the child's subsequent development and he frequently commented therefore on the decisive importance of parents looking to their own emotional health. By identification Jung was not only talking

about more or less conscious imitation but rather the child becoming involved in living the unlived life and repressed psychopathology that is the parents' shadow.

The Shadow

In so far as the talion impulse is a part of the shadow of us all we have to consider how we can constructively transform its energies.

At a social level, we might hope that the cruel and vengeful streak in us can be managed and expressed through forceful support of ideals of justice and social causes and groups that have come to have a personal meaning to us.

At a personal level, Fromm offers some speculations as to why vengeance can be so deep seated and intense a passion. "Although man can often not defend himself against the harm others inflict upon him, in his wish for revenge he tries to wipe the slate clean by denying magically that the damage was ever done ... It is as if in his passion for vengeance he elevates himself to the role of God and of the angels of vengeance. The act of vengeance may be his greatest hour just because of this self elevation" (Fromm, 1973).

In Jungian terms one might say that by compulsive vengeance we avoid depressions but through becoming dangerously inflated. Hence it seems that the capacity to move beyond the talionic impulse involves an ego competence and development beyond the use of magic and omnipotent denial. It involves a freeing of the cruel aggression in the talionic response to be released in vigorous, self assertive, adaptive behaviour. To explain what I mean and to indicate the value in the shadow I should like to follow a frequently made distinction between non-assertive, aggressive, and assertive behaviour.

Behaving non assertively and passively means denying your ordinary entitlements through a failure to express feeling or by indicating wishes only in an indirect way. This means that the responsibility for making the decision is passed onto the other person. Also, it is likely to bring about undesirable consequences for yourself and the other person. For example, failure to communicate clearly about one's needs makes it less likely that they will be met and understood; and you may finish up feeling taken for granted and ignored. Then you may get angry and either worsen the situation by becoming provocative or else repress the anger and become depressed, guilty, anxious or prone to various psychosomatic complaints. The other person is not really helped by such non assertiveness either as he has to deduce what really is being asked for and he may feel unable to do so or guilty at being tempted to exploit this passiveness to his own advantage.

Similarly it may be of considerable use to the therapist to examine whether his behaviour with the patient is passive. For example, in a given session is his relative silence a non intrusive going along with the patient's need for creative space, or is he being knocked out by the patient's defensive need to keep feelings out of the situation, or is he in some retaliatory way not being present emotionally and withholding in a hostile, passive silence. Is he passively ceasing to communicate interpretations in order to punish the resistant patient?

To try to repress the shadow and simply behave as if it doesn't exist, even if that were possible, would not bring constructive results. On the other hand, obviously there can be damaging consequences from actively acting out the shadow. In my reading of Jung, he is certainly not suggesting that the shadow be allowed to run riot in such undeveloped forms as persistently aggressive behaviour. By aggressive behaviour I am meaning expressing wishes in a threatening, hostile, demanding and retaliatory manner. Disregarding the other persons needs in a ruthless manner, and not taking responsibility for the consequences, is obviously unpleasant for the recipient and likely to provoke a chain of retaliatory responses.

Again relating this to the therapeutic situation, we need to discriminate as to whether we are usefully stretching the patient's capacity to take on board upsetting insights or whether in fact we are angrily retaliating and disguising and rationalising this inappropriate action as honest anger, healthy clash and useful confrontation. If the latter is the case, then the outside world has confirmed and perpetuated the vicious circle of delusion in the patient's talionic inner world.

Assertive behaviour offers a use of emotional energy that is an alternative to acting out crudely or simply repressing aggression; or oscillating between these two opposite positions. A person behaving assertively expresses his rights and accepts responsibility for his own behaviour; and by a clear statement of his own position is likely to improve the chances that the other person will respond positively. Favourable consequences are also likely for the recipient who receives a clear and non manipulative communication rather than one that is merely hinted at. Also that person receives a request rather than an aggressive demand and hence does not feel so controlled, put down, or manipulated into taking responsibility for someone else's behaviour. If both people are behaving in this kind of way then their assertion will facilitate negotiation or a compromising of their differences.

It seems to me that appropriate assertion by the therapist means using the energy in his stirred up state to think about and interpret from what has been stirred up in him. In the therapeutic encounter the

infantile and child parts of the patient and the therapist are aroused. It is necessary that such should be the case but, because these infantile parts "are involved, the transference counter-transference relationship tends to be profoundly influenced by the dynamism of the talion law. The analyst in the transference counter-transference situation has therefore to struggle with the activation of talionic impulses in himself which would impel him to reward the good done to him by his patient and angrily punish the destructiveness". (Lambert, 1981). If he is able to understand his negative counter-transference and cope with his feelings in such a way as to be able to make a useful interpretation then he may achieve some breach in the patient's vicious circle of projected and reintrojected fear, hostility and vengefulness. This could lead to more trust and openness. "The critical point then is whether the analyst can master his own talionic feelings enough to become able to interpret in a concordant way the patient's inner drama into which he, as the analyst, has been drawn. At that point gratitude for such a non talionic response may promote further positive transference in the patient, to allow him to benefit from further analytic interpretation". (Lambert, 1981).

I have been indicating that this critical point is central to the therapy from the point of view of the patient's relationship to his inner objects. However it needs to be acknowledged just what hard work this is for the analyst. The breaking of the vicious circle may be a long and arduous process and it may occur only after some years or it may not happen at all.

At this point I would like to describe a cartoon that I saw on a childrens' television program. It was about a small mouse who was a dentist and a large fox who had a painfully decayed and disintegrated tooth. The mouse gives the fox an anaesthetic and then wanders about in the fox's mouth and takes out the tooth. The fox dreams of eating the mouse and later lightly mentions this in a casual comment to the mouse. That night the mouse tells his wife of the incident. She says the fox will eat him. He says that this is nonsense as he has been so helpful and kind to the fox and what reason could there be for the fox to eat him. She says that the fox will eat him simply because of being a fox. The next day the mouse is to fit a new tooth in the fox's mouth. The fox is feeling rather guilty about imagining eating the mouse but the idea of trying out his new tooth is more than he can resist. The mouse, while fitting the new tooth, is spreading some pain killer on all the teeth and asks the fox to clench his teeth to spread it evenly while the mouse moves out of the way. What has been spread is glue which holds the teeth together while the mouse escapes.

This cartoon leads me to the following thoughts:

i) There is not much likelihood of people changing quickly and it is unwise to expect or bank on them so doing. Even if you don't intend some comment as a persecution it may nonetheless be experienced as vindictive on your part. Quite often it is the non retaliatory response that is the most threatening initially because it challenges the power philosophy or paranoid world view of the patient.

ii) You need to be aware of how many and what range of patients you can work with at any one time. What are your own limits in respect to containing and working with vindictive attacks and the feelings of revenge that are inevitably stirred up in yourself?

iii) Take practical steps not to get in a position where your fear or rage at the patient will overstretch your capacity to contain, think about and harness your retaliatory feelings. For example, don't see potentially violent patients late at night when alone in the office, don't have your favourite fragile objects in your consulting room, don't try to work in a way that fosters development and exploration of the negative transference when the patient carries a knife or a gun. Practical steps are necessary, not efforts at heroic omnipotence.

iv) The need to be aware of the fox in oneself that is capable of grudging calculation in relation to the patient's growth, developing skills and enjoyment in life.

Conclusion

The concept of integrating the shadow refers to an internal, psychological acceptance of the rejected side of one's nature. In so far as such an integration is possible we release ourselves from the temptation to take up an attitude of innocent victim towards life and the tendency to project our own evil onto blaming our everyday associates. However this integration does not entail simply allowing the acting out of our talionic or other crude impulses. What the integration does mean is that the energy becomes available as a source of strength. Strength is needed to accept and grieve for our losses rather than trying to magically undo them, to be firm rather than provocative, and to be able to trust in the possibility of getting needs met through a relationship with others.

Paradoxically, the integration of the shadow element of revenge, and the transformation of its energy into reasonable assertiveness and strength actually consolidates rather than undermines our character. To acknowledge our talionic tendencies, and to integrate the emotions aroused by them, is to have the emotional energy of the talionic impulse available for deeper investigation of our patient's behaviour; instead of our being caught up in counter productive acting out. This makes available to the analyst the satisfactions to be obtained from understanding and discovering effective interpretations; and "the

patient may become more able to assimilate these interpretations not only because of their truth but out of the positive feelings set in motion by gratitude." (Lambert, 1981).

REFERENCES

Fordham, M. (1965). The Importance of Analysing Childhood for the Assimilation of the Shadow. Journal of Analytical Psychology, Vol.10, No.1.

Fordham, M. (1978). Jungian Psychotherapy, John Wiley & Sons Ltd, P.52.

Fromm, E. (1973). The Anatomy of Human Destructiveness, Penguin Books, Pp.365-366.

Horney, K. (1948). The Value of Vindictiveness. American Journal of Psychoanalysis, Vol.8.

Lambert, K. (1981). Analysis, Repair and Individuation, Academic Press, Pp.24, 26, 150.

Masterson, J. (1981). The Narcissistic and Borderline Personality Disorders, Brunner Mazel, Pp.187-188.

Racker, H. (1968). Transference and Counter Transference, Hogarth Press, P.137.

Searles, H. (1956). The Psychodynamics of Vengefulness, Psychiatry, Vol.19.

Williams, M. (1963). The Indivisibility of the Personal and Collective Unconscious, Journal of Analytical Psychology, Vol.8, No.1, P.49.

Winnicott, D. (1974). Playing and Reality, Penguin Books, Pp.102-107.

THE PREGNANT THERAPIST AND THE PATIENT WHO "COULD NOT JUST LOVE"

Cecilia Batten

"The Little Boy Lost" — William Blake (1789)
"Father, father! where are you going?
"O do not walk so fast.
"Speak, father, speak to your little boy,
"Or else I shall be lost."
The night was dark, no father was there;
The child was wet with dew;
The mire was deep, and the child did weep,
And away the vapour flew.

Introduction

The metaphor within this poem illustrates some of the crucial aspects of my patient's conflicts. I refer to the small child who experiences a feeling of abandonment by his parents, and how the emission of a body fluid, secretion, brings relief and comfort to his emotional pain.

I will try to describe the pronounced effect in the psychotherapeutic process, that the pathetic irony of having a pregnant therapist made, in a man-child who so desperately needed his father.

Brief Review Of The Literature About The Pregnant Therapist

Pregnancy in the therapist, however common it must be, seems to be a subject not very much explored in the literature. Many speculations could be drawn from this fact; do women therapists perhaps withdraw from professional commitments during pregnancy? Did they do their psychotherapeutic training after having completed their families? Or, perhaps they just did not write about their experience while pregnant. Most common of all, many therapists do not inform their patients of their pregnancy and plan their maternity leave in a way that patients are not given the chance of seeing their large abdomen. Although work on this subject appears as early as 1949 (Hannett),[12] it does seem to become more abundant towards the 1970's and 1980's. A sociological factor should be considered in this phenomenon, mainly that of women's possibilities to develop simultaneous professional and personal lives, with more freedom and social acceptance in later years. In 1969,[16] Lax compared female and male patients' reactions to her pregnancy, and uses the concept of the pregnant therapist as an "optimal projective

Presented as a qualifying paper for Associate Membership of the British Association of Psychotherapists, awarded "Lady Balogh" prize.

screen" if not a "blank one". Nadeson[17] describes "the relevance of the therapist's pregnancy in the therapeutic interaction", as well as discussing the therapist's and her colleagues' feelings and conflicts, but concludes that the therapist's pregnancy "may be an effective aspect of therapy".

Case Presentation

The patient presented himself for psychotherapy, having been referred to me by a colleague friend. His main symptoms were those of anxiety which manifested themselves in numerous ways, mainly in his inability to establish, or to formalise, relationships. He could not perform at job interviews, could not eat in restaurants, and suffered with episides of nervous diarrhoea. His immediate concern was his failure to get married to his longstanding fiancee owing to his overwhelming fear of intimacy.

He seemed to be a "good training case". Evidently he showed a wish to undergo psychotherapy, and he did not seem to present major technical difficulties.

In this paper I will try to explore the hypothesis mentioned at the beginning, but also to show how the psychotherapeutic relationship became not just a "recreative growth process" (Greenacre)[11] for the patient, but also a rich learning experience for the therapist.

The Patient

The patient was an attractive 24 year old man, highly intelligent and successful professionally. He was born of a British father and an Italian mother (the "Latin connection" to which I will refer later on in the paper). He has a sister one year older and two younger sisters, two and five years younger than himself. His mother also had one or two miscarriages in between the two younger sisters. The patient is now a physically sound person, but has a history of nocturnal enuresis until the age of 13 years. He also had an eye operation at two years old, and was circumcised in the first or second week of life. His father was a policeman, and his mother a housewife, both with a working class background. The patient's mother has a longstanding history of diabetes, and her pregnancies were complicated by that illness. She also gave the impression of having been constantly depressed during the patient's childhood. The patient had a very close, but emotionally and physically cramped relationship with his sisters. He had friends in the neighbourhood, and he was not carefully supervised in his free time. At home he was expected to be polite, respectful, and had a very strict, at times harsh, upbringing.

The father was an absent figure most of the time owing to his job. The maternal grandparents played a very important role in my patient's

childhood, especially his maternal grandmother who shared the mothering. The maternal grandmother seems to be a warm, caring Italian lady. The patient is fond of her and remembers her as the one who could and did take care of him in his enuretic days, changing his pyjamas and bed clothes, in contrast to his mother who neglected his physical needs. He went to a Catholic school for boys where he managed to achieve the levels required for his professional training. He had mastered his anxiety until some months before the beginning of therapy, when he began to have difficulties at interviews and, therefore could not achieve a job further up the professional hierarchy.

He left the parental home aged 18, suddenly, without much explanation to his parents. This was his way to overcome the intense anxiety about a phantasy regarding his mother's death once he had left his home. From then on, he engaged in numerous heterosexual affairs, short-lived and unsatisfactory. He eventually became involved with an Asian girl ten years his senior, but this relationship ended in the same explosive, painful style. At 23 he had completed his training in two correlated areas. He had then begun a relationship with the girl who would later become his fiancee. The patient had a number of male friends who became idealised at times. One of them is the referring agent with whom he has maintained an intense unilateral sadomasochistic relationship. That person is much senior to the patient professionally. His financial and living circumstances were, at the time of referral, of not much relevance, and his sort of job allowed him free time for his therapy.

Clinical Material

The first interview took place as arranged; the patient was 2 minutes late. He immediately gave me the impression of being a determined, but easy-going sort of person. He was pleasant in appearance, dressed casually and carrying around his big motorbike helmet, and a bag. I could also feel how penetrating and seductive his attitude was towards me. During that interview he conveyed clearly his wishes of "finding an answer, why can't I be completely happy, why can't I establish deep relationships?" He did not ask for help, and he determined the relationship at a professional level, being quite conversant with psychotherapeutic methods, use of the couch, observance of times, and payment of fees. By the end of that meeting, to suit both of us, we had arranged to begin therapy after Easter.

I realised then, after he left, that I had been observing a "false self" in action. I had no idea how the real person was. I had a training case, I knew his personal history, but I realised that the initial thought of "no major technical difficulties" had not been well-grounded. I was

embarking on the treatment of a much more rigid, heavily defended patient than I first expected.

Six weeks later I invited him for a second preliminary interview in which the future of the therapy was going to be discussed, and where the patient was confronted with the therapist's pregnancy.

I am grateful to my supervisors and my analyst who guided me and held me in the very difficult process which began that day. The patient agreed to begin his therapy after Easter, as originally planned, but from this moment on he became hostile, menacing, provocative and uncontrollably angry with the therapist, who was no longer experienced as the colleague of that first meeting, but as the betraying mother who delivered a baby during his tender years.

The therapy formally began after Easter, the external setting was a consulting room at the therapist's home, three times a week, at a very reduced fee.

For the sake of simplicity, the therapy can be divided into different stages, coinciding with major external events within the therapeutic relationship. Needless to say, these stages overlap with each other and share numerous features.

Stage 1 — From the second preliminary interview to the birth of the therapist's baby.

Stage 2 — The birth of the therapist's baby to the patient's wedding.

Stage 3 — The patient's wedding to separation, in the 3rd summer of the therapy.

Stage 4 — Including separation and ending and therapist's move to a different part of Great Britain.

Stage 1

The patient and I were aware of the time being limited. He adopted a very structured way of presenting his material, whilst keeping his helmet (potty?) near by the couch. His behaviour was one of compliance and revealed a wish to satisfy me and his own concept of how psychotherapy should take place. He had a marked intellectual insight into the importance of his childhood experiences in the development and shaping of his personality. He had recollections of early memories which he could easily associate to the context of the sessions. Within the first month of therapy he took one of the available cushions in his arms in a very possessive way, whilst appearing to be regressed, adopting baby-like positions in the couch. He showed inability to express positive feelings towards me or the baby, except the occasional wish to be helpful and kind, which was just a reaction-formation from his aggressive

feelings, and the nearest he could come to actually caring for the therapist-mother. His transference was mainly a negative one, with overt verbal attacks on the therapist and her baby, usually coloured with denigrating sexual connotations. His constant intellectualisation, the splitting of the object, and the rejection of the transference, protected him by making my interpretations tangential to his intellectual mind, where they were projected to me once again, defeating any psychotherapeutic approach. My counter-transferential feelings oscillated during this period. I began by feeling rejected and sad. These feelings, I believe mirrored the loneliness and rejection experienced in his psychological emptiness. However, towards the end of this stage, I also experienced fear of his enormous curiosity about me, and his continuous threats to get to my obstetric notes. This, though quite possible in the professional city circle that he and I live in, could also be understood in terms of his voyeuristic projections on to me, of very early castration and separation anxieties at the time of his sisters' births. His curiosity about what was going on in the hospital while his mother was there, I understood as a way of defending himself against the anxiety of actually seeing the castrated woman. The patient only once missed a session during this Stage. He usually has vivid, detailed dreams which he remembers and brings to the sessions. A dream of this period, I hope, will illustrate the tone of the psychotherapeutic process.

He dreamt of himself and K.L. (a man) "getting married, or perhaps not" and his friend B. being the best man. He remembered jumping in and out repeatedly of a swimming pool at the wedding party. Also, fighting with B. under the water. The patient felt unwell during this session and he reported not being able to do any more work, feeling almost suffocated by the end of the session. The following day he talked a lot about water, and associated K.L. with his phantasies of what my husband looks like. He had a visual phantasy of being castrated, his testicles submerged in boiling water. He associated the idea of water with my amniotic fluid, and his constant wish to touch my, by then, large abdomen. I interpreted his thoughts and dreams as his attempts to get into the therapy, sometimes committed to it, sometimes not. Also, as an unconscious wish of getting inside my waters, and to fight with the baby for possession of me. Also, as fears of being punished and castrated for doing so, by a powerful successful father. Once again, he felt suffocated, short of breath, which I understood as an unconscious acceptance of the interpretation. Although there was no verbal acceptance of my interpretations during this period, he frequently expressed the internalisation of some concepts through physical equivalents, such as "short of breath", "irritation of his eyes", or the preverbal break-through

manifested as a strong wish to jump up and down in the room.

Just before the end of this period, which was going to be followed by six weeks' maternity leave, the patient's reconstructions of his early childhood became particularly marked, especially in relation to his fears of death, either his mother's or his own, when his mother was admitted in to hospital for eight weeks before the birth of his younger sister. One particular session he said, "Six weeks at 25 is painful; eight weeks at five was devastating". He was emotionally moved and cried on that occasion.

Having babies, being left alone, being frightened of dying, wanting to kill the new baby, wanting to be inside me and rejecting me, were the issues that governed this period. He also wanted to abandon the therapy altogether as a denial of any positive relationship ever existing with me. "If I manage to separate from you without destroying you, it will be the very first time that this happens to me".

As mentioned before, throughout these months he could cry only once. He acknowledged his great difficulty in letting his tears run freely, and how distressing it was to have to "hold on" to his tears, as his father or the teachers at school would never allow him to cry. In the child part of the self, sadness, depression or anger were not allowed to be expressed through the water in the eyes, and an alternative water was used, the urine, which poured every night on to the mattress/mother which became the container of so many feelings. In the sessions, the mattress/mother was me, the couch. The urine was now replaced by his offensive attacks, his fiery outbursts of temper and his constant sexual provocations.

Stage 2

There was a long six weeks gap in which the patient made no contact with me. The re-encounter was set by the patient on humorous terms, mainly teasing me about my slimline figure. At some point he began to describe his loneliness, his wish to be close to me and to the baby via a card during the break, and his inability to write to me. My interpretations of his ambivalent feelings of hate and love for me and for the baby, and the humorous way to acknowledge the absence of the baby in the room, seemed to help to re-establish some contact with him that I felt I had lost.

During the following months he went through a further process of identification with my baby. He too wanted "feeds on demand", asking for numerous changes of sessions, and arriving at the sessions very early. He also had clear recollections of some pleasurable experiences in the relationship with his mother. He began to experience warm feelings

towards me, whilst rejecting my male qualities projected on to some medical colleagues of his acquaintance. His father became less idealised, his absence from home and his careless attitude towards his family angrily criticised. The previous negative oedipal conflict coexisted and alternated with a more positive form.

His other major concern was primal-scene anxieties linked with memories of interrupting his parents' sexual intercourse and the noises coming from the parents' bedroom. He connected these thoughts with his own phantasies about the non-pregnant, sexually active therapist. This precipitated sexual longings which were immediately rejected and denigrated by him into pornographic, violent sexual obscenities. During this Stage the title of this paper arose "If I could just love ..."

A part of himself could understand and appreciate my interpretations of his having to destroy loving, positive feelings for me. He had to continue with his sadomasochistic attacks, urinating the mattress/therapist over and over again. My counter-transference throughout, with the exception of the latest months of the therapy, has always been ambivalent. His anger, his pornographic material, his invasive curiosity was experienced by me as frightening. (At this stage he was promiscuous and, amongst others, had a sexual partner, a girl who lived just the other side of the road from me). I also had tender and loving feelings for him. I was drawn into a position of a mother of a newborn baby, not just in my own life, but in the consulting room too.

He emotionally explored painful memories of murderous and sexual desires towards the other boys at school. He successfully revised the experience of primal-scene by engaging in exciting sexual phantasies (?memories) of sexual intercourse with his sister, leaving me, impotent, silent, overwhelmed and angry. My interpretation of a primal-scene in reverse was followed in the next session by a dream of the patient observing his idealised friend K. having intercourse with his wife. He realised how much his mother was absent — emotionally absent from him — and how he had to turn to his father or male teachers for love, with the eventual development of intense homosexual tendencies.

In contrast with the previous Stage, fewer dreams were reported during these months.

As part of the concrete state of mind that he was in at times, he had vivid visual, olfactory and auditory pseudo-hallucinations. At times he could see and hear my baby in the back garden, and he could smell and hear the passage of flatus which he was convinced came from myself. Why did he try so hard and why did he need to embarrass me? Why did he have to denigrate the very person whom he most needed to overcome his difficulties?

As a result of his successful ego splitting, it was during this time that the patient's outside life became exciting. He successfully mastered those anxiety-provoking situations and there was no further free floating anxiety.

His everyday relationships with women improved. He established a strong therapeutic alliance with me and he enjoyed working with one of his female colleagues. The matrimonial engagement between the patient and his previous fiancee was formalised and they got married just before the second summer break. His marriage was seen from one angle as an escape, mainly from his incestuous and homosexual phantasies. From another angle, was this the realisation of a profound wish to be in an intimate, exclusive relationship with a woman, channelling his previous sexual incontinence with a defined, satisfactory relationship?

Stage 3

His return from the summer break and honeymoon was triumphant. In reality, he had had a very interesting time, and is present life was satisfying and plentiful — a new house, a new socially desirable wife, and the exciting possibility of a new, more senior post soon becoming available at his place of work. He had contacted me a couple of days before beginning that term to confirm my new address. I had moved my consulting room to different premises. As previously, after a long break, he spent some sessions in a humorous way, giggling euphorically, denying any sad or angry feelings about having been separated from me, or about the change of consulting room. Nothing seemed relevant within the first few sessions. He proudly brought and showed me his wedding photographs.

The therapy continued in this tone, until he began to disclose his sexual fantasies which he freely associated with having "regular" boring sex. I said that I wondered whether he found regularity a feminine attribute, to which he had to submit (as in potty training) and that he turned the tables, wanting his wife to submit to his sexual wishes. He agreed about submission; that was the exciting aspect of his sexual relationship at this time. His behaviour within the sessions was controlled, less aggressive, but his ability for self exploration was reduced. He lived in a permanent state of exhaustion, headaches and hunger. At times, he felt guilty and depressed, and shameful about his sexual activities with his wife. Throughout this Stage a lot of the memories of his enuretic years became very important to him. He was preoccupied with not letting coins fall out of his pockets on to the couch. I made interpretations of fears of "spending a penny" on the couch and his anxiety about how I would handle such a situation. His wish was soon fulfilled. He dropped a pound coin on the couch just before he left a

session. My interpretation of having to experience the mother/me on a wet bed was shamefully accepted. The concreteness of lying for prolonged periods on a wet mattress/mother seemed to have helped him to be in touch with his primary process functioning. His shame was the beginning of a new era within the therapy. The symbolic understanding of his "spending not a penny, but a pound"! on the couch brought about a remorseful attitude in which the mothering qualities of the maternal grandmother/me were reconsidered in a very positive way.

Whilst this process was taking place, he found out that one of his colleagues at work was also in therapy with me. His immediate reaction was the successful seduction approach this time trying to seduce his psychotherapeutic sister. His transference of a positive nature now, suffered a narcissistic shock. He was, this time, symbolically presented with another sibling. The material then became repetitious with feelings of being "stuck". Around that time he became markedly agitated and warned me that he might masturbate during the session. I became despondent, his material was repetitive and I felt that no further progress was possible. Holding, in the Winnicotian[20] sense, was my major counter transference feeling for many sessions, as interpretative work proved to be experienced by the patient as very intrusive. Simultaneously, he made quite definite gestures of wanting to leave therapy after the summer break, which made me sad and aware of my wish to keep this patient/child pampered, ignoring his attempts for independence. He was feeling mainly deprived, focusing these feelings on the environmental deprivation and poverty of his early years. Once again, he was deprived of his mother/grandmother/therapist's affection for the sake of his "sister". His overwhelming anger took the form of "confusion", namely a dissociative state of mind in which he mixed up the time of his sessions, arriving at the consulting rooms at times when he was not expected.

The only two dreams reported during these months seemed to have the "healing" qualities described by Winnicot[18]. Both dreams were reported in the two sessions before the Easter break.

He had previously had a very depressing session. He had felt that he could not achieve any more in therapy, that that was his luck, and a general feeling of being unwanted and no good. On the second session of the week he reported a very vivid dream the night before. He even woke up and apologised to his wife for having hurt her. He had actually dreamt that he was pulling angrily with two of his fingers at the nipple of the breast, wanting to stretch it and to hurt it. The nipple began to stretch and became longer and longer. He felt that it could break. He woke up terrified. His wife comforted him that he had not hurt her and

that it had all been a dream. He felt that the dream just expressed how he felt; he was in his angry, fighting mood. He had, that morning, already argued with one of his junior female colleagues and had felt like hitting or raping women as in a film he had seen the night before. I said that I wondered whether the dream was a reversal of the weaning experience, the omnipotent denial of the breast separating from the baby by pulling, and the nipple stretching up to the point in which it could break; not surprisingly, he was in such an angry mood with the withdrawing breast encountered in the woman/colleague therapist who was leaving him during the Easter break. He saw clearly the weaning aspects of his anxiety and he associated this with the birth of one of his sisters and the separation from an ex girlfriend. The following day he reported another dream "I was crying on my mother's lap, feeling her belly on my head. She managed to comfort me. I was kneeling with my head on her lap, she was sitting on a chair". He felt more optimistic this time. He felt that he could be close to me, or to his mother, through his tears, that the mother/therapist could help. "If I can cry in my dreams, I'll soon be able to cry in here".

These dreams seem to reconcile the two parts of the self, the two parts of the object that had been split off for a long time. A sense of emergence from a regressed, unapproachable state was experienced after these dreams.

In his external life he was able to control his explosive temper and he became more confident at work. He also made enquiries about further professional training.

Stage 4

The beginning of this period is rather confusing and very much juxtaposed with the previous one. It began when the patient announced his wish to leave therapy. This coincided with my telling him that I was moving to another area of Great Britain. His decision was soon modified and he stayed in therapy until the last session that I could offer him.

The main issue preoccupying him during this time were those of wanting to father a child and wanting to achieve his professional goal in the way of a senior position. This was a period of great emotional and mental productivity. New material appeared, associated mainly with the masturbatory activities of the past linked to his sexual experiences of the present. The monthly disappointment of his wife's menstruation provoked in him enormous frustration, as well as a wish to be grown up and fully potent like his father. His transference to me had now paternal and maternal qualities. Whilst I was seen and admired as the successful

professional "moving to a better job", the child part of his self resented the abandonment. He spent most of his sessions trying to work things through by himself, trying to do without my help, assuming my absence. He denied my presence, and denied my departure until a month before ending. At some stage he talked about his parents-in-law going away, to a journey around the world. "We'll have to be in charge, we will have to look after my brother-in-law who has fits and can get very ill at times". He could accept my interpretation about his fears of our own separation and whether he felt competent enough to look after the child part of himself who was capable of fits of anger, and who is experienced as dependent and needy. By now, my interpretations were acceptable to him. During this period he was appointed to the so much sought-after job, after a successful interview. Before the interview he could understand how his phantasy and reality thoughts were entangled and how in phantasy at the interview he wanted to test his superior's affection for him and to compete for his love with his sisters/colleagues.

Encouraged by his professional achievement, he concentrated in his sexual relationship with his wife and the search for a baby. Sexual intercourse became "creative" and his previous careless sexual attitude disappeared. Sexual intercourse was his way to achieve the closest relationship ever. In his sexual excitement he could maintain the denial of the mother/therapist departure. By becoming himself a parent, he was desperately trying to be the mother/me, "therapy started with a baby, it should finish with a baby".

The patient felt unable to cope with their inability to conceive. His anger provoked a return of his perverse feelings which were acted out and he allowed his homosexual phantasies to be enacted in the matrimonial relationship. His wish to be physically close to the woman/wife was overriden by his temporary loss of sexual identity during those sexual experiences. His body image was consciously altered, he could actually experience the duality of his own, useless, enuretic phallus with the powerful, fun-giving one held by his phallic wife/mother.

At the time of writing this paper these activities mentioned before have ceased as they proved to be unsatisfactory, only provoking an emotionally wider gap in the couple. There seems to be now some new enthusiasm to create a child. In that context, creativity has taken place within the professional life. He is heavily involved in the development of new facilities at work, and organising academic meetings. He has, in this way, allowed the positive aspects of the female elements of his personality to find an expression. The split-off female element of this, undoubtedly male patient, was then showing at different levels a

creative, caring, nurturing aspect against a frustrated, infertile, empty aspect (mainly projected on to the patient's wife). But was his wife the only person invested with these qualities? Not so. They were transferred on to me as well — "You are going to a very cold, very wet, barren part of the country" he said to me two months before ending therapy. He seemed to be concerned about his responsibility in this happening, as if in phantasy he had omnipotently managed to make me wet and cold, as the mattress/mother of his childhood. This massive projection served to the purpose of his defenses, protecting him from deep anxieties of disintegration once I had gone. The imminence of final separation from the patient precipitated numerous counter transferential feelings in me. This was indeed a terminable situation. I could realise that much ground-work had been done together with the patient, but I felt unhappy about leaving him in a situation of partial awareness of difficulties but many areas unresolved. Practical issues like continuing therapy with a colleague were rejected. I was aware of causing my patient great tension. There was no option. One of his responses was a bombardment with dreams. It would be impossible to quote all of them. Was this a break through? He also had a recurrence of a childhood memory reported much earlier in the therapy. In it "the light comes from a window at my grandmother's house. I have terrible earache. I am in bed. I can almost see myself flying out of the window into space. My grandmother's flat was high up in a block of Council flats. I spent quite a lot of time at her house when my mother was in hospital for my younger sister's birth" (patient approximately four years old). This memory, with its luminous, plastic quality and the visual self-representation as a child, may be what Freud[3] described as a "screen-memory". Although the memory is related to the time of the birth of his youngest sister, four years younger, it seemed also to convey some preverbal memories of the birth of the sister only two years younger. The birth of that sister had been at home. Was he perhaps describing the mother in bed with labour pains and the baby flying from high up the birth canal on to the bed? How much had he actually seen and heard at that tender age when his sister's birth took place? These are unanswered questions, but the castration threat of the oedipal phase (birth of the younger sister and time of screen memory) seems to be exacerbated by hypothetical memories of the pre-oedipal preverbal trauma of the sister who came next after him.

In the last two weeks of therapy the patient reported two major events that clouded the feelings belonging to the termination of therapy. His wife had become pregnant, and his mother-in-law had had a mastectomy. These two events provoked anxiety, joy, anger, desolation

and euphoria in him. He could not experience any feelings towards me, although he was intellectually grateful, and aware of having become "able, generally more able, to enjoy life" which he believes has been the major achievement of the therapy. It was a very sad, painful process for me, as his impossibility to cry made me wonder whether I was to cry for him; as if I had been left with his tears, the mother-me, once again having to be wet, as part of the not yet resolved conflicts of his personality.

He expressed his wish to contact me in the future to ask for advice regarding a colleague therapist with whom to have further individual therapy at a later date.

Discussion

A colleague once referred to "the equivalent to pregnancy in the male psychoanalyst". This comment shows some of the difficulty that colleagues, especially men, have in understanding the transference-counter transference situation of the pregnant therapist and her patient. In my opinion, this experience has no male equivalent, not even the reverse, that of the pregnant patient and her therapist, has such a transferential effect in the extraordinary psychoanalytical dyad. I base this opinion on my own experience as a pregnant therapist, as a pregnant analysand, and as having had pregnant patients in therapy. Although in all these situations "the baby" is in the consulting room, the patients's "baby" is only available to the therapist very much as the child part of the self, or as a defense, but ultimately, exclusively available at the patient's wish. The therapist's still unborn "baby", together with her, are always there, transferred permanently for numerous months with a massive amount of emotions belonging to the transference neurosis. Owing to these circumstances, the therapist and her baby became particularly vulnerable. Counter-transference feelings charged with protective anxiety towards the baby are not uncommon. (Fortunately for me, this was my third pregnancy, and I felt quite confident about motherhood). Through primary identification with the therapist's baby "the lost prenatal unity with the mother, the feeling of security that goes with it", and the universal longing for the prenatal state (Klein)[15] seems to be reached by the patient "ipso facto" in the therapy. These phantasies and anxieties of going back to the mother's womb have also been described by Freud[8], "temporal regression to infancy, to a time when the subject was in his mother's womb". The patient's psycho-pathology, the very issue of my foreign accent (the "Latin connection" mentioned before), added to my unplanned pregnancy at the beginning of the therapy, provoked a sudden, intense regression and "the gulf separating the therapist from the child in the patient" (Balint)[2] was

bridged. Temporarily speaking within the therapy, a very early re-enactment of pre-oedipal and preverbal conflicts was encountered.

As we all know, the concept of transference has numerous definitions. For Freud it was at the beginning of his work a resistance, and later a powerful therapeutic tool. In 1905[4] he refers to transference as the central factor in the therapeutic process. He says too "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".

Klein[14] — "A concept of transference is rooted in the earliest stages of development, and in deep layers of the mind interpreting these by which the unconscious elements of that transference are used. The patient is bound to deal with conflict and anxieties re-experienced towards the analyst by the same methods he used in the past".

In the case of my patient, there was no subtle, progressive development of these unconscious elements of the transference, but an immediate abrupt emotional bond as a result of the analytical situation being a re-experience of his feelings for the pregnant mother/therapist, with a real growing baby within the room, "a quick arrival at the deprivation trauma" (Winnicot)[19] in the second interview.

A divergent point arises. Should one have started the therapy in this situation? The fact is that there was only a confirmation of pregnancy after the first meeting with the patient. One could have not gone ahead with the therapy, but would that not have been a rejection of him, the already existing child? At a subsequent meeting in which the pregnancy and its implications were discussed with the patient, he wanted to start his treatment in spite of the limitations with which we were going to be faced in months to come. From then on, a very clear older-brother/mother bond was established, a primary loving-hateful transference.

Much has been written about bed-wetting and urethral eroticisation. Freud, in his "3 essays on the theory of sexuality" (1905)[5] and in the "case history of Dora" (1905)[6] interprets infantile enuresis as an equivalent to masturbation, "nocturnal enuresis corresponds to noctural emission". He also suggests the existence of certain character traits associated with urethral eroticism (Character and Anal Eroticism, 1908)[7]. Abraham[1], in "the narcissistic evaluation of excretory process in dreams and neurosis" talks of childhood phantasies of omnipotence that may accompany the act of urinating, the feeling of "possessing great and even unlimited power to create or destroy every object". "Urethral sensations are closely related to infantile impulses of love, while urine appears as the instrument of a sadistic attack". Klein[13],

stresses "the importance of aggressive and destructive phantasies by urine. These urethral sadistic phantasies bring about disturbances of sexual potency in the male".

How did these concepts apply to my patient? As briefly mentioned before, he had a prolonged history of nocturnal enuresis which began after the birth of one of his sisters, and which concluded with puberty. His fiery outbursts of temper and his offensive vocabulary seem to be part of it. There was, of course, his promiscuity and his compulsive masturbation. This all seemed to be part of his character and the therapy seemed to illustrate some of these hypotheses.

To consider now the theme of homosexuality, I will begin by a basic psychoanalytical concept, that of human bisexuality. Freud[9] in 1930 admitted that "the theory of bisexuality is still surrounded by many obscurities and cannot but feel a serious impediment for psychoanalysis". But by 1937 in "Analysis, Terminable and Interminable" Freud[10] states "it is the attitude, proper to the opposite sex, which has succumbed to repression (penis envy in women, feminine attitude in men)". For Winnicot[21], the bisexuality of the individual is naturally loaded on the side of his or her anatomy, "most males become men, most females become women", whereas environment and culture play a part in the determination of male and female identification. In this paper I have been concerned with the splitting of female and male elements and the effect of this type of dissociation in the production of anxiety-neurosis symptoms. The female elements of this patient's self were heavily defended behind his apparent "macho-like" behaviour, his chauvinistic petulant manner, all products of his cultural upbringing. Unresolved negative oedipal conflictual feelings towards an idealised father and a rejecting mother unconsciously operated in this man, disturbing his object choice, facilitating his homosexual phantasies. As foreseen, this area of conflict could not be explored over quite long periods, his promiscuous heterosexual activities being a successful defence against his homosexual impulses.

It would be nice to try to integrate these theoretical hypotheses by applying them in the case of my patient. But, unfortunately, presenting clinical material will not successfully reconstruct the whole atmosphere of the psychotherapeutic situation, but I hope it has facilitated the clarification of some of the concepts. The silences, the volume of the patient's voice and numerous other para-verbal communications experienced by me cannot be communicated in my presentation. These aspects of unverbalised transference are, as we all know, constantly present in the psychotherapeutic process but are extremely difficult to reproduce in writing.

Summary

The psychotherapeutic work with my first training case gave me an opportunity to learn about the issues which I have described, whilst it gave him a better understanding of his conflicts and relief of some distressing symptoms. The very issue of the therapist's foreign accent, added to her unplanned pregnancy just before the beginning of therapy, provoked a phenomenon which I have described as an acceleration of the transference neurosis. This facilitated within the therapy, a very early re-experiencing of preoedipal preverbal conflicts as a result of sudden intense regression and a quick arrival at the deprivation trauma.

Another important subject of this therapy has been the exploration of oedipal erotisation of urination. This led to prolonged enuresis in latency. Unconscious equivalents of it appear to have been compulsive masturbation during adolescence and promiscuity during adult life. Besides, the psychotherapy of this case brought to light the way in which the patient turned successfully towards the peripheral father during his mother's pregnancies; and has subsequently sought a father substitute (Catholic father, hierarchical figure) to replace this absent figure, forming an alternative, intense relationship with him, lately resulting in homosexual phantasies and conflicts.

REFERENCES

1. **Abraham, K.** (1927). "The Narcissistic Evaluation of Excretory Processes in Dreams and Neurosis". Selected Papers on Psychoanalysis Ch XVII. Int. Psychanal. Lib.
2. **Balint, M.** (1968). "Bridging the Gulf". The Basic Fault Ch. 26. Tavistock Pub.
3. **Freud, S.** (1899). "Screen Memories". S.E.III. London. Hogarth Press.
4. **Freud, S.** (1905). "Fragment of an Analysis of a Case of Hysteria". S.E.VII. London. Hogarth Press.
5. **Freud, S.** (1905). "3 Essays on the Theory of Sexuality". S.E.VII. London. Hogarth Press.
6. **Freud, S.** (1905). "Clinical History of Dora". S.E.VII. London. Hogarth Press.
7. **Freud, S.** (1908). "Character and Anal Eroticism". S.E.IX. London. Hogarth Press.
8. **Freud, S.** (1926). "Inhibitions, Symptoms and Anxiety VII". S.E.XX. London. Hogarth Press.

9. **Freud, S.** (1930). "Civilisation and its Discontents". P106. S.E.XXI. London. Hogarth Press.

10. **Freud, S.** (1937). "Analysis Terminable and Interminable". S.E.XXIII. London. Hogarth Press.

11. **Greenacre, P.** (1968). "Psychoanalytical Process, Transference and Acting Out". Emotional Growth Ch. 39. International University Press, Inc. New York.

12. **Hannett, F.** (1949). "Transference Reactions to an Event in the Life of the Analyst". Psychoanal. Review *36.* 69-81.

13. **Klein, M.** (1932). "Early Stages of the Oedipus Conflict and of Super Ego Formation". The Writings of M. Klein II Ch. VIII. London. Hogarth Press 1975.

14. **Klein, M.** (1952). "The Origins of Transference". Chapter IV. The Writings of M. Klein III. London. Hogarth Press 1975.

15. **Klein, M.** (1957). "Envy and Gratitude". Chapter X. The Writings of M. Klein III. London. Hogarth Press 1975.

16. **Lax, R.F.** (1969). "Some Considerations about Transference and Counter-Transference Manifestations worked by the Analyst's Pregnancy". Int. J. Psychanal. *50.* 363.

17. **Nadeson, C.** (1974). "The Pregnant Therapist". Am. J. Psych. 131: 10.

18. **Winnicot, D.W.** (1958). "Hate in the Counter-Transference". Collected Papers: Through Paediatrics to Psychoanalysis Ch. XV. Tavistock Pub.

19. **Winnicot, D.W.** (1965). "Psychotherapy of Character Disorders". The Maturational Process and the Facilitating Environment Ch. 19.

20. **Winnicot, D.W.** (1971). "Mirror Role of Mother and Family in Child Development". Playing and Reality. Tavistock Pub.

21. **Winnicot, D.W.** (1971). "The Split-Off Male and Female Elements to be Found in Men and Women". Playing and Reality. Tavistock Pub.

THE "MOUTH" THAT ROARED A CLINICAL ILLUSTRATION OF A PSYCHOTIC TRANSFERENCE

Sybilla Madigan

This paper is based on 18 months work with a young man, Mr M. When I starting seeing this patient I was not only unaware of the degree of disturbance we were to encounter but I also did not know that I would be leaving the country soon afterwards and would have to terminate my work with him after only a year and a half. Our time together was divided into three stages and fall loosely under the headings of:

1. Containment
2. Elucidation of history and its effect on the patient.
3. The repetitions and re-enactments in the transference.

The main themes that emerged were the patient's internalization of a psychotic father, his "identification with the aggressor" and the psychotic transference that developed very rapidly in the treatment.

I would like to stress that this relatively short therapy has really only allowed us to touch the outlines of his personality, the narcissistic and manic defenses he employs and his borderline structure with its implications of a fragmented and weakened ego. His words, that it felt like the opening of a Pandora's Box, with the accompanying anxieties about what more we were to find, are very apt. Much of the working through of the immensely rich and complicated material that has emerged will have to be left for the future.

But let me start from the beginning.

Mr M's referral letter described him as a young man with an arrested adolescent development and unworked through oedipal problems. He complained of being an obsessive thinker who needed to find himself and learn to establish relationships, particularly with women. He was then 26, the only son of a professional man and a mother who had only recently started working. The parents had just divorced. By first accounts, the father seemed to be a very disturbed schizoid personality — described by the patient as a mad and passionate man, alternately domineering, dogmatic, arrogant and physically violent towards both wife and son when not the charismatic poetry-writing dreamer living in a world of philosophical thought and fantasies. To Mr M clearly a fascinating figure, as was apparent from the vibrancy of his voice and the glow in his eyes when talking about him. Very

Presented as a qualifying paper for Associate Membership of the British Association of Psychotherapists, awarded "Lady Balogh" prize.

different to the mixture of sadness and anger that he conveyed when describing mother. A servile and depressed woman, silently and masochistically suffering her difficult husband. Mr M thought of her as intellectually inferior, his image of women, and felt contempt and resentment for her inability to protect him against father's violence and injustices. Yet, up until his adolescence, he "had loved her too much!" They appeared to have had a boundaryless, collusive relationship with shared complaints about father during their daily tea-drinking sessions that were often interrupted by father's angry appearances. But Mr M's loyalties were divided, he felt "crucified between two poles, the ground they battled on."

In school he initially did well but then felt more and more unable to fulfil father's academic expectations. Nevertheless he finished with 5 'A' levels but his disappointment was intense when this effort was ignored by father. His early school years he had enjoyed but later in public school he lost his "leadership role" and only regained it after much isolation and loneliness by proving his "superiority, the stoic who could survive any challenge". (Standing still for 45 minutes while others poured milk all over him.) He often felt misunderstood and hurt by masters one of whom described him as vicious and dangerous. He continued on to University trying to read physics but failed and took history instead. There he seemed to have had what he described as a breakdown caused by "a period of intense self-analysis, incessant and obsessive thinking to solve philosophical questions and the problems of the universe." He felt "quite mad then but became involved with a guru who saved him through meditation but also paralysed his mind. All creativity ceased, his motivation and zest for life, his superior qualities and leadership role lost." He felt dead and described hallucinatory episodes.

This led to two unsuccessful attempts at therapy as an out-patient which he found unhelpful. Both therapists were men. Until then his contact with women had been intermittent and only platonic. He felt his sexuality to be dangerous and destructive to women. His last failure with a girl led to the recognition of his complete inability to form relationships. This was then compounded by the disappointments he suffered on having job applications repeatedly turned down, not for lack of aptitude but for personality difficulties. Just before he started his therapy with me he had found employment in a bank.

1st Stage

For his first interview with me he arrived late and by taxi, slightly harassed and out of breath with his eyes quickly darting back and forth

to take in me and my surroundings. My first impression: a man full of extremes, even in his appearance. In reality he is a smallish man but his aura of intensity and repressed violence made him appear larger. I knew he was only 26, his physical movements confirmed the "arrested adolescent" yet, conversely, the whole appearance gave the impression of a troubled prematurely aged man.

Initially he talked intelligently and with awareness of his difficulties but, as the hour progressed, his need to charm and seduce me became quite apparent. He gave me his "potted history" and I began to get a feeling of deep chaos and confusion, covered up by grandiose descriptions and colourful speech. But it was not until after I had agreed to take him on that a very schizoid borderline personality emerged. A manic man, full of denied depression and an omnipotent view of himself. Our very first therapy session set the tone for what happened in the next 6 months.

He sat on the couch with his legs tucked underneath him and in a threatening and challenging 40 minutes rage, demanded by agreement to "no talk of emotions, only intellectual answers, this was purely a matter of the mind, an intellectual exercise. He was no patient and wanted no therapist, only answers". My interventions, talking about his anxieties in this setting and desire for attention and a special, different relationship, went unheard and his demands for me to step outside my role increased. Only towards the end, when I pointed to my being a woman and his fear and excitement in my presence, did his anger subside. Yet, he was unable to sustain this and left the session 5 minutes early.

In Fairbain's (1944) terms, I seemed immediately to have become the provocative mother, the exciting and rejecting object. The anxiety and frustration it evoked in him, he could only tolerate by his angry and contemptuous attacks on me. The material that followed was a clear indication that he had adopted father's phallic aggression to cope with his threatened self. It seemed a mirror of the parental relationship.

The sessions were taken up with descriptions of his aggressive, arrogant father so full of contempt for his passive wife and lack of interest in his son, their spartan household and Mr M's hate for what they had done to him and his own hate and contempt for the world and me. (Just another inferior woman who hid behind her profession with talk of emotions. He will destroy me with his mind). His language became more and more florid, his physical behaviour more taunting, his sitting on the couch, looking down on me in a challenging way, designed to test and intimidate me.

I confronted him with his behaviour, pointed to the similarities of

his stories and what was happening in the transference: his blatant flouting of all analytic rules, his refusal to lie on the couch, his identification and imitation of his contemptuous father, his seeing my role as therapist as an equivalent of his passive mother, his anger about this as well as his great excitement at being in the same room with a woman. All this seemed hardly to register. His manic flow of words never ceased. He began to describe visions and fantasies that were thinly disguised sexual references to our male-female positions.

His language and behaviour were not only expressions of his excitement, but there to attract my admiration for his performances, poetic speech and colourful descriptions; his grandiose narcissistic self. I had become his externalised admiring self while he retained the father representation inside him. This way he could control me, the excitement I created in him and deny my separateness. My presence had rapidly reactivated his early instinctual relationship to a possibly confusing, tantalising mother. His lack of knowledge on how to relate to me, a woman, seemed intense. His anxiety turned into sadistic sexualized fantasies with him either as the brutalizing, domineering male who would rape a submissive female (me), or himself as the victim of a castrating penetrating female. The conflict between his hate, fear and distrust and his desire for women seemed constantly present in the transference. My interpretations of his eroticising of our relationship, his delusions about the analytic situation, his excited feelings, brought vigorous denials yet were followed every time by further evidence of his bewildered state. "You are only the local whore anyway, men going in and out by the hour, paying you, a medieval wench! If you had any sense, you would look out, I am going to damage you. My passions are murderous if let loose. I am a mini-god with a storm in my pocket". It was the threatening tone of voice and the hollow laughter that would follow my interpretations that indicated the psychotic element rather than the adolescent. He seemed unconscious of his aggression and denigration of me and when I faced him with it, his only perception of himself was as a concerned, caring and victimised personality. His splits and the projection of his anger onto me was clear in his paranoid complaints that I was threatening him with my words, wanted to humiliate and break him.

But despite my constant comments about his anxieties and my elucidations of his behaviour in the sessions, he continued. Nothing seemed to have any impact on him and I began to seriously question whether we could continue, whether he was reachable and containable. Frequently, he put me into the role of the persecuting father, at other times I was the uncaring, stupid mother, but, more often, I became the

butt of his angry and mad attacks. He would complain about the "ineptness of my puny interpretations, the emptiness of my words, he wanted to shoot me, people, kill amongst crowds. The stupid masses with their vacant, weak faces, their insensitivity, just followers, victims. He wanted to scream: respond! Did they not hear he was destined to be a legend, he was far removed from the vermin-like state the rest of us lived in? Why should he join the contemptible human race?"

When I told him that I thought he talked about his parents and what he felt they had done to him, and that they could not hear his cries as now he felt I could not hear them, he laughed sarcastically. Then told me about two budgerigars he had as a child, General Ullyses Grant and Helen of Troy, a beautiful ferocious female, he loved them so much, he took them in his hands gently and squeezed and squeezed them ... while looking at me threateningly.

Only my counter-transference feelings of resentment, anger and invasion helped me to cope with my growing doubts whether I was strong enough to withstand his assaults and gave me an understanding of the degree of fear and confusion he suffered underneath his manic defense.

He was alternately threatening me with his violence, reading his poetry, WAGNERIAN "Götterdämmerung" like epics or "entertaining" me with his grandoise, often catastrophic stories. His language was so extravagant, his metaphors so obtuse that understanding and recalling a session became often difficult. His sense of others' inferiority and his superiority seemed total. It became more and more apparent that he could often not differentiate between fantasy and reality. His delusions about destroying mankind were split off parts of his aggression that he was entirely out of touch with. It was evident from our sessions that he was incapable of forming any relationships in the outside world and that his internal world was bordering on the psychotic. Fortunately for both of us the madness of the sessions was sometimes relieved by flashes of humour. I began to refer to him as Jesus Christ, (following accounts of his having walked on water during a recent holiday), he playfully responded "just call me J.C.". These were occasions of contact.

Often, though, I felt confused and overwhelmed by his flood of words, my efforts to stop them and point to his defensive use of them to keep me at a distance, he ignored. I was struggling with his attempts to involve me in his internal chaos and his lack of boundaries.

Rosenfeld (1978) says: "Generally the borderline patient is capable of differentiating the self from external objects and internal experience from external perception. But reality testing is lost in the transference

regression and confusion occurs as to what is inside and what is outside in the patient's experience of interacting with the therapist. It is as if the patient maintained the sense of being different from the therapist at all other times but currently he and the therapist were exchanging their personalities. This is a frightening experience because there is a breakdown of ego-boundaries and a loss of reality-testing which interferes with the patient's capacity to distinguish the projected self and object images from the therapist as a real person".

My work lay mainly in trying to ground his delusions, to put him in touch with his split-off contempt and envy, to help him to differentiate; to contain his adolescent, but more often borderline, psychotic behaviour. It felt to me like a painful deflating of his grandiose narcissistic self. Initially he sadistically attacked me when he felt "detected" or "read" and arrived late or not at all for sessions as my punishment. But slowly he seemed to gain a feeling of relief and even appreciation of my efforts to understand him. As his omnipotence began to diminish slightly, we were able to do much work on his desperate need to control, on his performing for me, on his need to be "exceptional and outstanding". He "despised the mundane world". He was still sitting on the couch making occasional attempts to lie down, which caused him panic and further loss of reality. But he was able to tell me that he needed to see me to feel my warmth. If he would lie down, I would become "a goddess, a classic marble statue, by its very nature rock-like and he would brake up hitting against it. It would be solitary confinement and he would lose all motivation to come here. It would all be anger, hate and lust on one side, isolation, purposelessness and despair on the other". He was grateful for my acceptance of his fears and agreed with my comment that for him, it was like the loss of mother's warm, accepting face when he was an infant and would leave him having to face his emotions and fantasies alone, before he was strong enough to cope with such unsettling feelings.

He began describing his "tripartite personality" as his arrogance, his contempt and his dream-state, his world of unreality, as ways of dealing with his sense of insignificance and the panic he meets with in his external life. He linked much of this to his relationship with father whose love and attention he had so desired. It became clearer that he had identified with his weak and timid mother and that his omnipotent behaviour was an imitation of the powerful, envied father and that the mirroring and introjection of the father's pathological personality was to compensate for his lack of introjection of a healthy object and the development of a strong ego. During this period of regression, he seemed to be contained enough to then begin to feel some sense of

awareness and pain at his lack of integration and lack of self. His responses to me changed from envy (his anger at me, a female, being able to make helpful interpretations) and competition and his wish to destroy me or anything positive that may evolve from his therapy to feelings of appreciation and some hope for the future.

These internal adjustments were followed by his first full sexual relationship with a woman. The discovery that his sexuality was not damaging to either of them and that it was a "shared experience" was very important. Again, his identification with the phallic, narcissistic personality of father seemed to have left him with the fantasy that his penis could only be used as a weapon. Before the affair he described his sexual feelings as 100% sexual, complete, obsessive infatuation, he would only rape and hurt a girl, use her submissiveness. He had referred to father's violent sexual assaults on what appeared to him as a helpless mother. After clarification of this, he was then able to admit his deep terrror of intercourse. "Man, although penetrating the woman, in fact with his desire becomes the equivalent of a female vagina in his vulnerability, the woman then becomes the penetrator, the emotional raper". He accepted my links of his experience of therapy as putting him in the same vulnerable position of being penetrated and raped by me. The end of this first affair due to external circumstances coincided with the first summer break. He was defensive and resistant to any interpretations and links in the transference. Angry and disappointed with me he characteristically missed the last session.

Despite my fear that he may disappear, he returned after the break looking well. He seemed to have digested some of the work of the previous months, was less manic, more open and prepared to let me have a glimpse of "his intimate self". He showed genuine vulnerability and sadness when referring to my absence during the break and with much insight admitted: "that the real struggle here is to unite the fragmented parts of myself".

2nd Stage

The next stage began in marked contrast to our initiation period. Mr M had settled on the couch , attended regularly and punctually. We entered a period of "reasonableness" where a good working alliance was established and I could begin to interpret some of the material brought to the sessions rather than having to continuously confront him with his bizarre behaviour. His anxiety level and tension had dropped as his trust and desire for co-operation and understanding began to develop.

We entered the world of his childhood, his reminiscences and impressions of his parents who seemed deeply involved in their own

private destructive drama. Mr M was a captive audience, alternately dazzled, frightened, overwhelmed and confused by what appears to have been a blatantly exhibitionistic father who demanded complete obedience, submission and attention from his wife and son. In Mr M's eyes, when in the grip of the idealized version of father, he was "a heroic figure, god-like, the sage who talked to me not in terms of Britain, sometimes Europe, but mostly the world. The world was his playground, he the leader, poetically and symbolically, and I was to be the active representative of it, that was my purpose and cause. The prince waiting for his kingdom".

Father's rapid switches from these ravings — the "heroic orator" to violent, threatening, then withdrawn depressed man left Mr M in a bewildered, often paralysed state of mind. The father's personality had become so unreadable that Mr M's only defense appeared to have been a retreat into a child's world of fantasy and mysticism to be compatible with father's grandiose, intellectually and philosophically unattainable world. Mr M had obviously retained this defensive structure. It was now repeated in the therapy and in his relationship with me. His competition was evident, but when his intellectualizations fizzled out, or he felt my contributions were more "meaningful" he would take flight into fantasy and revert to a world of primary process thinking. I could then not record or comprehend his line of thought.

But what was most striking was my feeling of having been subjected by Mr M, over all our time together, to the same experiences he now so vividly recounted of his past. This at least gave me some verification of the material that at times sounded too bizarre to be true, both prior to and after the holiday. In all this, mother continuously appeared as the victimised, persecuted figure and Mr M vacillated between identification with her and with the powerful, dynamic father. During these accounts of the past, it became more and more obvious how Mr M needed to violently reject these disturbing internalized figures "to find himself". My interpretations were attempts to get him to see the split in his feelings, that this hated, despised and feared figure was also the admired, loved father of yesterday's session. How he needed to expel the positive as well as the negative aspects of his parents and was left with an empty inside, no self, and how these feelings now seemed to be present in his perception of me. He acknowledged it in his constant references to there being "less" of him the more he talked. The introjection of a split and fragmented object seemed obvious.

All this material he presented to me with his usual verbosity, a peculiar mixture of madness and gift for language. Sometimes I found it impressive in its eloquence but mostly difficult to follow and wondered

about the distancing effect it had. When I shared this with him and that it must have been how his father talked to him and that it must have had the same confusing effect on him, he confirmed this by describing the special power and different meaning words had in their communications and how he now suffered by being continuously misunderstood by others. Needless to say he felt it was their loss and lack of imagination and creativity, but his language became less ornate and our communication simpler and more straightforward.

It was during this time, 9 months into the treatment, that he suddenly told me of the birth and death within 6 days (due to a hole in the heart) of two siblings, one born approximately 18 months after his own birth, the other 6 years later. He had no memories, further information or associations to this except that he had been staying with relatives where he had been happier than at home and that mother had been described to him later as very depressed. I assume that part of his omnipotence and grandiosity is a result of his imagined powers of destruction. What it also infers is a separation, a traumatic loss in Mr M's life before he had been able to establish object constancy. Whether the flight to father, the identification with a powerful male figure started then, before his own ego had sufficiently developed, is unclear. It seemed that the almost obsessional insistence on father's importance and the omission of mother in the material was a desperate attempt to defend against the underlying problematic mother-son relationship.

But the material about father continued, a mixture of adulation and outbursts of rage. Having been unable to challenge him, he imitated him, seeing this as impressive and potent, particularly in relation to me and our sessions. His "insights" seemed remarkable, but I began to question the validity of them. I felt his co-operation was too ready and his acceptance of my interpretations too quick. There seemed some genuine strengthening of his ego-functions, but were we losing sight of his instinctual life at the expense of "ego building"? To what degree were his intellectualizations a normal stage of adolescent ego development (A. Freud, 1936) and to what degree a defense against the libidinal instincts awakened in his contact with me? I carefully began to interpret his recent "hard work" and efforts at insight as a possible need to comply with me, to be accepted and respected by me; I felt he had become my co-therapist, certainly a potent male, but what was happening to the child within him?

His response was immediate. The breakdown of his intellectualizations was followed by regression. He talked about the child inside him he did not know and whose needs and excesses he feared. He gave examples of being "so wild, unmanageable, so

dangerous and uncontrollable" that he had apparently caused another child's concussion by pushing him off a couch. Whether this was a screen memory of the siblings' death and whether what now followed was an unconscious repeat to kill me off is unclear, it was certainly a "realization" of his description of himself. In Balint's (1968) terms he seemed to have entered a stage of "malignant regression". For session after session he regaled me angrily with demands for extra time, a "special setting", even a demand for hospitalization should I not comply. He had 10 days of outstanding holidays and wanted to spend them in my company. The only way he could get through to this child in him was to regress and regrow in my presence, with my undivided attention. I was to be his mother and father and provide the childhood he felt deprived of. His voice was high-pitched and bordering on the hysterical and I felt the persistence of these demands for my adjustments were an indication of the psychotic transference he had entered. I attempted to appeal to his ego to tell him what he was doing. I explained that I felt whatever extra time I gave him would not be enough as his wish was to become my sole infant and me the totally dedicated mother who would only exist for him. This was all unheard and swallowed up by further intense requests. I persisted with my interpretations. I also acknowledged the difficulties he had in accepting the limitations of our setting and pointed to his need to be so extraordinary, exceptional and special that he would even "act mad" to get what he wanted, and linked it to his father. But my thoughts turned to the boundaryless attention mother had possibly provided early in their relationship. His hallucinations of an ever-flowing breast, his fantasy that he could have, say and do all.

I think at this point Mr M experienced therapy, the limitations of the analytic situation and me, as the destructive, ungiving mother, as a repetition of an earlier very frustrating event, possibly connected with the loss of mother when the first sibling was born. My attempts at interpretation were useless. As was to be expected, my "inflexibility" was a blow to his narcissism and was followed by rage. He missed sessions, came late, sulked and slammed doors and continued to complain bitterly about my rejection of him. Not only had I become a bad breast, but he projected all his own hate and disillusionment into me. He was the victim of my sadistic attacks, he always knew I was determined to destroy him. "Our love affair was over". It was the intensity of his repressed rage at the end of each session when I told him it was time, that I found far more frightening than his verbalized anger. His potential for serious acting out was very present. He seemed unreachable and heading for a psychotic breakdown. I interpreted this

to him and his wish to have me responsible. Then I would have to look after him and in his fantasy we would merge and perhaps revert to an idealized period that was free of pain and conflict for him.

The next session he changed tactics, he informed me he had decided to survive, (part of his pressure had been veiled suicide threats) that he had "plotted my destruction". We now had the total identification with the aggressor.

There followed an onslaught of material so dense and obscure that I could barely follow. My efforts to make sense of it became more and more difficult, then useless. The verbiage exhausted me, the intensity with which it was delivered overwhelmed me, the analagies were incomprehensible.

This continued for several sessions. In one memorable session it had lasted for 25 minutes, then he stopped, repeated his intention to survive, wondered what all his anger had been about and went to sleep for the rest of the session. I felt confused, tongue-tied, aware that I had trouble formulating any thoughts. It was only after this session, on examining my counter-transference feelings, that I realised that he had quite successfully paralysed me. It reminded me of his early complaints that father had made him progressively more stupid and uncreative and now I understand the connection. It was a repeat and re-enactment of his own experience of the mad father. He was trying to paralyse me, drive me crazy, in the same way he felt father had paralysed him. The pleasure and satisfaction involved in trying to eliminate me by the same process that father so "dazzling" used, obliterate with words, was then followed by his withdrawal into sleep. Again a re-enactment of father's withdrawals after periods of intense involvement. He missed the next session — I felt bad. When he re-appeared and continued in the same vein, I repeatedly interpreted my experience to him and added the reconstructive links to father. He was thoughtful, but reluctant to give up so "powerful a game".

3rd Stage

From underneath this so often arrogant, omnipotent, angry and contemptuous young man with his constant need to devalue and destroy both our efforts at understanding, now emerged a vulnerable, shy and fragile child with a fragmented and impaired ego. Mr M was in touch with that part of himself more frequently now. His desperate need for love and warmth from me now allowed us to examine the motives for his defenses and his resistances more openly as they emerged in the transference.

His time keeping and attendance had been erratic, an indication of

his ambivalent feelings towards the possibility of change. There seemed a constant battle between his healthy, sane, motivated self and the omnipotent, destructive self which he idealized and which he felt was threatened by therapy. He complained that his sense of superiority would be taken away from him and he "would end up just another impoverished, mediocre creature". So in the transference I now alternated between being the persecutor (father) who does not allow him to "stay great" by interpreting his behaviour and, when in touch with his healthy self, his "mirror" who shows him what he does not want to see. He would talk of the "outsider, the manipulator" of whom he was the victim and by whom he was manipulated into unacceptable behaviour, i.e. his lateness, his contempt for others, his bizarre attention-seeking behaviour at work. (Standing on his head on his desk! Luckily for me all this was now reduced to verbalizations in the sessions).

My interpretations centred for a long period around his disowning and splitting off his destructive parts and his reluctance to accept these parts as belonging to himself. I needed to show him that all this mirrored his home situation and his experience that father did gain attention and total control over the family in this way, and that he had internalized much of this father, was repeating it with me and in his external life. To him it seemed the road to success. I continued that he equated strength with aggression (father) and weakness with vulnerability (mother), that I believed he felt truly neglected and unloved as a child, but was trying to gain this love now by his mad behaviour when in reality he was confusing and frightening people; his experience of father.

The whole theme of his introjection of disturbing objects became very alive. His need for excitement, the constant presentation of material, the arguments and panic states in his outside life, the dramatization of, I believe, very difficult life experiences, all this contributed to the picture of a man who only felt "alive" when in a state of conflict with all his surroundings. The irregular comings and goings with me, the self-accusations and guilt feelings it produced all seemed to point to a masochistic need to feel confused, paranoid, hopeless and finally worthless — his constant complaints. It also assured my on-going role as persecutor and protected him from experiencing me as a containing, helpful maternal figure. In the sessions he became more manic, he seemed madly to grab at subjects to keep his confused state going and it seemed clear that he wanted to create the same chaotic state in me. At times he did. I felt disturbed, intruded upon, overwhelmed but I also felt that he was now bringing me his primal object relationships. I was experiencing what it must have been like for my patient to grow up in an environment that seemed boundaryless,

invasive and overstimulating where he not only had to cope with his own infantile psychotic projections but those of his parents as well. I stayed away from all content interpretations and tried to show what I was experiencing; that I felt that he was now trying to confuse me, make me lose my boundaries, reflecting his internal chaos. I tried to clarify his feelings, how he needed to molest himself to keep this state of panic going, how this seemed to have been the form of communication at home.

I felt that his identification and internalization of the father's exhibitionistic behaviour was his escape and defense against a depressed and confused mother who could not contain or provide for the needs of her child. I gently suggested this to him. I also felt that his constant demands for more time, the greed with which he sometimes took in interpretations (when not dismissing them as "totally off the wall") were an example of the boundaryless atmosphere that must have prevailed at home and were an expression of his pain about the analytic situation that now reflected his home deprivations. After these interpretations, his time-keeping and missing of sessions improved. He was much calmer, became quite reflective and accessible.

Only when the Easter break approached and he was faced with his dependence and need for me, did he revert quickly to the "grandiose genius". His often so insightful and interesting observations were again strictly for effect, for me to admire him. When I suggested to him that this was his defense against his growing attachment to me, he was able to voice his resentment at his dependence and the envy he felt that I was the one who "held all the goodies", the sane parts that he wanted and I deprived him of, his needed nourishment.

The final sessions oscillated between his need for me and his rage. His rage won. He would talk in great detail about the contempt and hate he felt for the world (wanting to machine gun the crowds in Oxford Street and splatter the walls with their brains and guts!). I interpreted his contempt and hate for me and the ease with which he switched to anger as a protection against feeling upset and depressed. He agreed with my comment, but still left kicking the walls outside my flat and slamming doors. Again the introjection of father's phallic aggression would prevent him from feeling separation anxieties.

It is interesting to note that when, shortly afterwards, he went on his own pre-arranged holiday, he could talk very openly and movingly about his love for me and his wish to take me along. And, in fact, he had a very enjoyable holiday, coping better with friends and surroundings. When he was leaving me, he could retain me as a positive internalized figure. The anxiety only arose when I was the one leaving. He even

tolerated losing three games of chess in a row, in his words "once an unbearably traumatic thought", but recognised now that they were "only games after all". What struck me repeatedly after all breaks was how "intact" and "sane" he returned when I had expected further fragmentation. It seemed that in my absence, with me as the representative of the disturbing parents, he could put himself together again. This he later substantiated with accounts of going off to boarding school, getting in touch with what he felt to be "himself" there, feeling good and real, and then, on returning to the parental home and the old conflicts, having a breakdown.

We have done much work around his experience of me as the destroyer and persecutor, the combined negative parental transference and his reaction to it expressed in his need to undermine his therapy and my efforts to help in retalliation. Throughout this difficult time our work on the positive transference has persisted and sustained us through all the agonies and uncertainties we both experienced. His perception of me as a separate person has become more differentiated and his ability to feel and express some concern has increased. It seems to have helped him to make the move to a house he now shares with three others and live there quite peacefully.

But perhaps my most important counter-transference feelings occurred very recently. We seemed to be drowning in his never-ceasing material. I felt strongly that I had had enough and I realised that again he had seduced me into responding to content, his pathological search for involvement that then created excitement and was a very effective defense against me as a holding maternal figure, an experience alien to him. In several sessions when his "material" began to flow, I developed an intense headache, practically forcing me to stop thinking and just be with him. When I finally used this and told him that I thought he was tired of intellectualising and really wanted the more maternal part of me which would allow us both to attend to his emotions, he was startled and silenced.

He acknowledged his fear of that, but also talked of his deep need for love and his desperate feeling that nothing would ever be enough for him. At this point I had intense pains in my womb and could only understand this as a direct psychosomatic manifestation of the need he talked about and of the extent of his deprivation of a holding, caring mother.

He then brought a dream that clarifies and confirms much of the preceeding material. In fact, he brought 6 dreams in one session (never having brought any before); five of them involving powerful super-ego figures he identified and then merged with to deal with the threat they

posed. In his associations — himself and father.

I will quote the triangular one that included mother and portrays the oedipal struggle very clearly, yet I feel, on a deeper level, it points to Mr M's fears that a mother cannot "hold" him and that the merger with father, even a mad, psychotic father, was still preferable to a rejecting, depressed fragile mother.

The dream: A gorilla is being pursued by hunters. Mr M is the "hero" hunter. The gorilla approaches, does not attack. He and Mr M face each other and then they merge. He becomes the gorilla being chased. He takes refuge in a building, it is hollow inside. He climbs up the walls. A "particular" hunter pursues him, lifts his rifle to shoot. The gorilla desperately tried to find a hold, there is none. He slides down, merges with the hunter.

Mr M's association were on the oedipal level; wanting to get into mother's body — the building, the punitive father, the plesurable sliding down representing an orgiastic emission. But he also stressed the merger with the father/gorilla/hunter after the absence of "holds" in the building/mother, and referred to a previously mentioned fantasy — "if father ever dies I see myself in his grave". He then told me he felt all "his splitting" occurred very early; that he turned himself into a "hero" knowing he was fake.

I think much of Mr M's turmoil lately has to do with the emergence of the maternal transference, in his eyes still eroticised, but with his dawning awareness of the implications of real depression and pain. There were frequent and quick mood changes now, from the fantastic self, to the insignificant, hopeless and frightened part of him. Silences were now possible, completely absent in the first year. We were able to look at the frantic activity in both mind and body that he needed to maintain to discharge and deny the emergence of depression. After a particularly isolated and "deadly" weekend he would come and "dump" his desperate feelings onto me. He would describe how he had felt but not experience it in the session with me present, that close emotional contact was still too threatening. Then he would leave, with me carrying the hopelessness and depression and feeling that during those period my sole function was to be the container. He would disappear for a session or two. I interpreted that he was testing out my strength to hold his depressive feelings, "the scab on his face" as he put it. If I was strong enough to carry and accept what he considered the "weak and bad bits" of himself, could he then begin to allow himself to feel and face them?

Was this the beginning of the breakdown of his omnipotent personality? The questions that remain in my mind: Did the flight to

father, as holder of all the valued attributes, including mother, represent the power of the psychotic model in the light of an unintegrated ego that was unable to grow and develop in the presence of a possibly ineffective mother who was not capable of seeing Mr M's needs as separate from herself? He has told me that any expression of his feelings would immediately be swallowed up by her "pain and sadness", that "the emotional impact of their interchanges was so intense, simply overwhelming". It would bring him to breaking point, he had to smash something not to smash her. Was the aggressive defence necessary to disguise his vulnerability and fear of annihilation?

Rosenfeld (1964) says: "In narcissistic object relations, defenses against any recognition of separateness between self and object play a predominant part. Awareness of separation would lead to feelings of dependence on an object and therefore to anxiety. Dependence on an object implies love for, and recognition of, the object, which leads to aggression, anxiety and pain because of the inevitable frustrations and their consequences". In Mr M's case, with possible mutual incorporation (mother/son) and blurring of boundaries, this must have been particularly confusing and I think points to his fear of repeating a similar relationship with me in the transference. I think his excessive "dependency needs" during his "regression" reflect his incapacity to really depend on anyone because of his distrust of early internalized objects (mother).

I find Kernberg's (1975) description of narcissistic disturbances particularly helpful in understanding the dynamics of Mr M's involvement with father: "In cases where the self has developed pathological identificatory processes to such an extent that it is modelled predominantly on a pathogenic internalized object, while important aspects of the self (as related to such an object) have been projected onto object representations and external objects. This refers to individuals who in their intrapsychic life of object relations and in their external life, identify with an object and love an object standing for their present or past self".

Mr M's fears that "there is nothing of himself", it will be him in the grave when father dies seems to confirm this. Also the difficulties in separating and owning his aggressive instincts as well as the more positive aspects of his personality. On a later developmental level, the homosexual elements of this identification would also serve as a defense against oedipal rivalry. This Mr M has referred to periferally only. (Feeling sexually excited but also repulsed by father). Kernberg talks of the efforts of a patient to hold onto his grandiose self as a defense against the feared relationship with a hated, sadistically perceived mother

image. I think this has been Mr M's struggle.

Since having written this paper, I had to tell Mr M that I was leaving the United Kingdom at the end of the year and would have to stop seeing him in December. I think his response, the disbelief, anger, disappointment and despair to this, to him, deeply disturbing news best illustrates the changes that have taken place in Mr M during the course of his therapy with me. The sessions were tense, with him struggling with his volatile emotions. I feared that his anger at the "deep sense of betrayal" he experienced would be uncontrollable, but he was able to contain it and put his distress into words. "You scrape me out of your womb like my mother scraped me out of her womb. I feel sick, dead, you are dead for me". He lay on the couch motionless and stiff, conveying his accusation that I had killed him. My reminding him of our having been together for 18 months, the age he was when, through the birth of his sister (who died), he was separated from his mother, re-activated powerful memories of him being "dumped" with relatives, the loss of mother and his inability to find his way back to her. "I remember her as girlish, young and pretty, womanly and femine before. She taught me to use the potty. I understood that very quickly. She was very pleased. Then I had to use the toilet, it was out in the corridor, cold, dusty and cob-webbed, a dark, frightening place".

Later he felt one side of her face to be paralysed with a crooked smile, the split physical representation of his perception of the changes and her depression. He nodded sadly to my link of my "death" representing her "death" for him at the time. His pain was intense. "I am threatened, you are destroying my peace, I cannot bear it, I want to laugh, I want to get up, be active, I feel inhibited lying here".

I interpreted his wanting to laugh, be active as his escape from the pain, the defensive protection he had erected to cope with the loss of mother at the time. He then told me he wanted to curl into a ball, but could not do that because of what it represented, "the foetal position". He could not show me such vulnerability. He struggled.

When I answered that I felt his sadness inside me and that I also felt very sad that we had to finish in December, he curled up and sobbed for the rest of the session. When leaving, he said "I think I have a deep well of sadness inside me".

It has been a very touching experience to move with Mr M from his manic defenses to the beginning of real depression.

REFERENCES

Fairbairn, W.R.D. (1944). Psychoanalytic Studies of the Personality. Routledge and Kegan Paul. London 1952.

Balint, M. (1968). The Basic Fault. Therapeutic Aspects of Regression. Tavistock Publications. London 1979.

Freud, A. (1936). The Ego and the Mechanisms of Defense. Hogarth Press and the Institute of Psycho-Analysis. London 1968.

Rosenfeld, H. (1978). Notes on the Psychopathology and Psychoanalytic Treatment of some Borderline Patients. International Journal of Psycho-Analysis 59, 215.

Rosenfeld, H. (1964). Psychotic States. A Psycho-Analytic Approach. Maresfield Reprints. London 1965.

Kernbeg, O. (1975). Borderline Conditions and Pathological Narcissism. Jason Aronson Inc. New York.

BOOK REVIEWS

The Father: Contemporary Jungian Perspectives

Edited and with an Introduction by Andrew Samuels. Free Association Books. 1985. Pp. 266. Hardback £22.50. Paperback £8.95.

It is a welcome sign of the times that the subject of the father is assuming a fresh prominence in the literature of psychotherapy. In my own practice I am being made aware constantly of the widespread effect of paternal deprivation in patients of both sexes. Andrew Samuels has rendered a valuable service in compiling this volume of papers upon the father, most of which have been published over the last three decades in the Journal of Analytical Psychology. He, as editor, has also provided an introductory paper expounding basic Jungian psychology and elaborating upon the various facets of the father's relationships within the family, i.e. father and mother, father and daughter, father and son. He also explains the Jungian concept of the archetypal father as the innate psychological structure which influences the way the child experiences the personal or actual father. Here Samuels demonstrates his excellent abilities as an expositor of Jungian theory, and provides a compelling introduction to a very varied set of papers. He prefaces each paper with a brief comment of his own and here I would have preferred to do without his guidance and have the papers speak for themselves, as he occasionally does less than justice to the authors' intentions.

After reading Samuels' introduction I turned immediately to the last paper, which was written by C.G. Jung in 1909 and republished in a revised form in 1949. Entitled 'The significance of the father in the destiny of the individual', it is the only paper Jung wrote on the subject and it has added interest because of the unusual amount of clinical material that Jung included in it. He shows how the child's experience of the personal father is reinforced, often in terrifying ways, by the power of the archetypal image of the negative father within the child, and how fateful for the whole of life the "father imago" can be.

Four papers have a predominantly clinical emphasis. David Kay writes on 'Paternal psychopathology and the emerging ego' and describes how a male patient's sense of personal and masculine identity was affected for ill by his bisexual father's smothering of him in infancy with a love over-invested with his (i.e. the father's) personal needs. I liked David Kay's honesty in quoting colleagues' criticisms of his handling of the case, and would have gladly argued with him particularly about his idealising counter-transference and his interpretation of a dream. Eva Seligman's paper on 'The half-alive ones' was for me one of the most satisfying contributions. It is a beautifully written

and presented account of four cases illustrating how an emotionally absent parent, frequently the father, can create a lifelong feeling of "half-aliveness" in the child, resulting in a need, through analysis, to reinstate the "absent" parent within the patient.

W. Ralph Layland offers the one paper written from a Freudian standpoint, 'In search of a loving father'. It complements Kay's paper by showing, in the case of two male patients, how compelling this search is and how the father must be available to receive the baby's needs, wishes, fantasies and feelings while not imposing a similar demand upon the baby to do the same for him. Like Kay, Layland stresses the importance both positively and negatively of the "pre-oedipal" father.

Amy Allenby's paper on 'The father-archetype in feminine psychology' dates from 1955 and describes the effect of what I would call a "devouring father" upon his daughter.

The remaining papers are not so directly clinical in emphasis but full of illuminating ideas. Andrew Samuels' paper (difficult and confusingly written) on 'The image of the parents in bed' reminded me of how much primal scene fantasies are connected with the unconscious fantasies surrounding one's own conception. He emphasises the complexity of the process by which the father-infant relationship evolves out of the infant's experience of the undifferentiated unity of the parents in bed.

John Beebe's paper on 'The father's anima' interested me as a theologian by its use of biblical analogies, but I found his use of the story of Joseph highly speculative, and I was not happy about the attempt to "psycho-analyse" biblical characters. The Jungian use of mythology to "amplify" patients' material is better demonstrated by Bani Shorter's paper on 'The concealed body language of anorexia nervosa' with its recourse to the myth of Athene and her relationship to her father Zeus to illustrate the anorexic's tendency to become what she refers to as a "man-woman".

Barbara Greenfield writes on 'The archetypal masculine: its manifestation in myth and its significance for women' and describes the various manifestations of the masculine in women's experience, notably the boy, the trickster, the father and the wise old man, corresponding to different levels of ego-development. She looks to the day when "women are able to associate themselves with men who are peers rather than protectors and seducers" (p. 209).

Hans Dieckmann writes from a German standpoint on 'Some aspects of the development of authority' and postulates authority as having an "instinctive" quality.

The book is supplied with an excellent glossary of Jungian terms,

but it is marred by a bad printing error in the mis-spelling of "psycopathology" (sic!) at the top of each page of David Kay's paper. I did not check all references for accuracy but found one mistake on p.116 where Jung's CW 5, para. 507 should read "para. 505".

GORDON HARRIS

Winnicott Studies: The Journal of the Squiggle Foundation

Number 1, Spring 1985. Pp. 81. Price £5.00. Obtainable from The Squiggle Foundation, 19 Chalcot Road, London, NW1 8LL or from H. Karnac (Books) Ltd.

In her introduction to *Developments in Psycho-Analysis* (1953) Joan Riviere told this story about herself and Freud: "In 1924, when I was struggling with obscurities in *The Ego and the Id* for the translation, and pestered him to give me a clearer expression of his meaning, he answered me, exasperated, "The book will be obsolete in thirty years!" Of course this has not happened; but it seems to me that the feeling implicit in Freud's retort — the feeling, that is, of being a part of something destined for evolution through use by others — was particularly characteristic of Winnicott as well, and it is fascinating to see the variety of uses made of his ideas in the six essays contained in this first volume of *Winnicott Studies.*

The essays are based on lectures given under the aegis of The Squiggle Foundation, and are written by Masud Khan, Martin James, Frances Tustin, Renata Gaddini, John Fielding and Alexander Newman. Here indeed is an *embarras de richesses* from which it is very difficult to make a choice in order to illustrate how Winnicott is used; but a couple of examples must suffice, and I choose them because of the contrast in the ground they cover.

The contribution made by John Fielding, who is by profession a teacher, accustomed, as he tells us, to teaching adolescents, looks at *Hamlet* in the light of Winnicott's ideas about adolescence, and especially about the search for an identity. In this context he is able to make sense of Winnicott's obscure words (in *Playing and Reality*) about Hamlet's speech 'To be or not to be'. What is attractive about this essay is that John Fielding achieves his aim without the stultifying effect produced by some psychoanalytic interpretations of literature: as he himself points out (using Winnicott's ideas about cultural experience) the important thing about a work of art is that it *has meaning,* the breadth and depth of content in the meaning of a work like *Hamlet* being

incalculable. *"Hamlet"*, he writes, "... is not a cryptogram to be interpreted by the application of method, psychoanalytic, Marxist or post-structural ... it exists in the recreative response of individual minds." So he makes suggestions, "draws beginnings" more than conclusions, and leaves his reader with imagination free.

The other essay I have chosen to mention is by Frances Tustin and is called 'The Emergence of a Sense of Self'. Frances Tustin came to read Winnicott when her own ideas about early emotional and cognitive development were already taking shape through her work with autisitic children. In her lecture she takes us through the various stages of this early growth in relation to the psychotherapy of a severely autistic boy, occasionally bringing in Winnicott's ideas to illustrate her own. Here it is illuminating to see how complementary the two sets of descriptive hypotheses (the Tustin and the Winnicott) actually are: how each, for instance, makes use of the idea of intolerable breaks in the continuity of being through reaction to overwhelming sensation; and of the notion of 'I am' as an achievement dependent on a holding environment; and of an understanding of the pain and the relief inherent in emergence from "Bishop Berkley's fairy world" into a world of permanent objects where 'Thou art' becomes possible. Like Winnicott, Frances Tustin has found the technical language that exists to describe object relationships inadequate for the description of very early states and processes, and like him she has developed for this purpose metaphors used spontaneously by her patients as well as ones arising from her own insight. This especially makes her lecture a pleasure to read.

In fact, I have found pleasure and profit in all of the six contributions. I believe that a second volume of *Winnicott Studies* will soon be on its way to the printers, and I am looking forward to it immensely.

MADELEINE DAVIS

The Psychology of Self and Other

By Elizabeth R. Moberly. London: Tavistock Publications. 1985. Pp. viii + 117. £9.95.

On 20th February, 1984, John Bowlby visited the Oxford Psycho-Analytical Forum, and I had the great privilege of taking tea with Dr. Bowlby prior to his lecture on attachment theory (Bowlby, 1984). He regaled us with many witty stories about his early years as a candidate at the Institute of Psycho-Analysis; in particular, Bowlby devoted much of our tea to his reminiscences of Melanie Klein. Mrs. Klein has supervised some of Bowlby's earliest case material: Bowlby was treating a little girl

in the 1930s, and the girl's mother used to bring her to Bowlby's office for the sessions. During the course of the analysis, the mother experienced a "psychotic" breakdown and went into hospital; and with mother in an incapacitated state, no one was available to escort the little girl to Bowlby's office for therapy sessions. Dismayed, Bowlby explained the situation to Mrs. Klein and asked her for some advice on how to proceed. Mrs. Klein insisted that Bowlby continue his treatment of the young girl at all costs. But he tried to explain that due to a *realistic* problem of transportation, this was not possible. Nevertheless, Mrs. Klein told him to continue. Bowlby smirked while recounting this story: evidently, Mrs. Klein was so immersed in the *phantasy* material of this case that she proved useless at comprehending a crucial component of external *reality.* (Phantasy is of course a part of *reality,* but it is not *all* of reality).

Fortunately, in the last half century, Freud's followers have begun to shift the focus of their attention to the external world, and we are now inundated with psycho-analytical studies of incest and child abuse, as well as follow-up studies of survivors of the concentration camps (to name but a few of the areas of research). Elizabeth R. Moberly's new and *very important* book, *The Psychology of Self and Other,* belongs to this burgeoning tradition of psychodynamic investigation. In brief, it is a vigorous and concisely argued proposal for a rejuvenation of psycho-analysis.

Moberly, a psychologist practising in Cambridge, and the author of a provocative study on gender formation (1983), criticises much of the waffly metapsychological dross that mars psycho-analytical theory. For instance, she justifiably repudiates the silly dictum that neurosis results from that proverbial clash between *ego* and *id;* and she strenuously objects to that lingering stalwart of psycho-analytical technique: the rule of abstinence. Influenced by Freud's work on Schreber, and by Bowlby's research with children, Moberly insists on the validity of attachment theory, and she argues that all "psychopathology" results *not* from internal conflict but from unfulfilled attachment-needs, caused by early abandonment and neglect. And, as mental turmoil results from actual *developmental deprivation,* the therapist must provide for the early unmet needs of the client. Moberly notes that, "An unfulfilled attachment-need must be fulfilled, not merely interpreted (sincewhen has diagnosis by itself been tantamount to cure?)" (pp. 26-27). She claims that, "A need does not disappear merely by pointing out the fact of its existence." (p. 27), and she contends that in order to achieve therapeutic results with our clients, we must disinter the unfairly maligned concept of the *corrective emotional experience.*

Unlike many psychodynamic therapists, Moberly has never been seduced by the outrageous pomposity of the biopsychiatrists, and she courageously argues that her approach of fulfilling thwarted developmental needs will be particularly useful for the treatment of "borderline states" and "psychoses". The author provides us with a seering and much-needed critique of the medicalistic and judgmental work of Otto Kernberg, who seems to have become the authority *renommé* on the most regressed forms of behaviour. In his classic text, *Borderline Conditions and Pathological Narcissism* (1975), Kernberg pontificates that his "patients" suffer from "excessive pathological dependency needs" (p. 187). Moberly objects most emphatically to this assertion: such dependency *needs* are *not pathological* in the least — they are realistic needs that must be gratified. The excessive cry for dependency is a cry for help that is all too frequently ignored by analysts. Moberly laments the lingering "Therapeutic pessimism" (p. 85) regarding schizophrenia and borderline states, and she criticises the dogmatists who contend that "psychotics" cannot be reached by analysis. (In my experience, it is not theoretical dogma that prevents practitioners from working with psychoses, but rather, fears and emotional limitations on the part of so many therapists).

Moberly constructs her argument with fortitude and conviction, and because of her phallic style, she is likely to offend many readers, especially the Kleinians, for as Moberly reiterates, "It is not infantile fantasy, but a genuine and unmet developmental need, that is at issue." (p. 40). Further, she challenges us at all steps, concluding with the brash, but justified, remark that the very future of psycho-analysis rests with the acceptance or rejection of her proposal.

I have always advocated the notion of the *corrective emotional experience,* and my work with schizophrenia has led me to believe that our clients cannot improve until they are nurtured to some extent by a loving and protective parent-figure. Yet in spite of my strong sympathies with Moberly's thesis, I must express my reservations about her book. Shockingly, the damning feature of this book is the utter absence of *any* clinical material. Moberly dispenses with egos, fantasy, and the rule of abstinence, and she supports Bowlby's work on attachment, but she never discusses a single case. Further, Moberly leaves her readers confused because she tells us that we must gratify our client's needs, but she never tell us *how* to do this, nor *to what extent* we should do this. (Her silence on this matter conjures Freud's sagacious admonition to Sándor Ferenczi, "why stop at a kiss?" (Freud, 1931, in Jones, 1957, p. 175)). Moberly has given us a highly theoretical text (though one *presumes* that her theories are grounded in the clinic). Theory is fine, but unless

clinicians can understand how to enact these theories, then it is useless. Gratification can be beneficial in treatment, but it can pose great dangers as well unless the therapist gratifies in a responsible way.

Our clients come from frightening and often traumatising family milieux, and as such, intimate relationships often petrify them. A warm-hearted female colleague once told me how her male client started to tremble after she had hugged him, quite spontaneously, during a session. When the therapist enquired why he had responded in such a manner, the client replied: "You remind me of my mother, squeezing the life out of me". Thus, sometimes it is more advisable for the therapist to remain in the chair.

Moberly might have improved her monograph by reviewing the work of previous therapists who have subscribed to models of nurturant psychotherapy, notably Franz Alexander and Donald Winnicott (and of course, Sigmund Freud). Winnicott's commentary on the "holding environment" (e.g. 1960, p. 590) would have lent much credence to Moberly's remarks. I hope that the author publishes another book which will gratify the therapist-reader's needs for clinical material and technical recommendations. This book, *The Psychology of Self and Other,* though brilliant and vital, does abstain too much. But I must leave the last words to Moberly: "Corrective emotional experience — the fulfilment of legitimate developmental needs — is presented as an essential part of the therapeutic task. This study is offered as a challenge to psychoanalysis to accept the implications of its own data, and thereby to make advances in the treatment of the more serious forms of psychopathology." (p. viii).

REFERENCES

Bowlby, John. (1984). Defensive Processes in the Light of Attachment Theory. Lecture at the Oxford Psycho-Analytical Forum, University of Oxford, Oxford. 20th February.

Freud, Sigmund. (1931). Letter to Sándor Ferenczi. 13th December, pp. 174-176 in Ernest Jones (1957). *Sigmund Freud: Life and Work: Volume Three: The Last Phase: 1919-1939.* London: Hogarth Press.

Kernberg, Otto F. (1975). *Borderline Conditions of Pathological Narcissism.* New York: Jason Aronson.

Moberly, Elizabeth R. (1983). *Psychogenesis: The Early Development of Gender Identity.* London: Routledge & Kegan Paul.

Winnicott, Donald W. (1960). The Theory of the Parent-Infant Relationship. *International Journal of Psycho-Analysis, 41,* 585-595.

BRETT KAHR

Phantasy in Everyday Life
A Psychoanalytic Approach to Understanding Ourselves

By Julia Segal. Penguin Books. 1985. Pp. 234. £2.95.

Mrs. Segal's book is offered as a comprehensive account of the role of phantasy in everyday life for the general reader. She explores the relationship between phantasy and perception; phantasy and feeling and then how phantasies can distort or block our perceptions, feelings and behaviour in the context of the family and of work. She then gives evidence for her viewpoint based on psycho-analytic practice and infant observation.

The book is written from a committed Kleinian perspective. As she says, she attempts to engage the reader in the insights that she finds useful in structuring her experience of her perceptions of herself and others. This understanding is offered in a non-dogmatic way relatively unburdened by complex theoretical conceptualisations.

The main thesis of the book is how phantasies, which are by definition unconscious, form the background to our thoughts and feelings. "They determine our perceptions and in a sense are our perceptions" (p. 22). Phantasies are also seen as metaphors for our emotional experience. They can be consciously felt, or denied, experienced in a psycho-somatic form or perceived as the attributes of others. Here the distinguishing feature would appear to be not that of consciousness but of the capacity to acknowledge our own thoughts and feelings. However, though the concept of phantasy is initially defined as unconscious phantasy, it soon becomes extended in the examples to describe any form of misperception of reality based on inappropriate beliefs. One feels that the general reader will gain awareness of the power of the unconscious in everyday life but that he might have benfited from a more thorough discussion of transference, displacement, reaction-formation, identification with the aggressor etc.

The book could be useful to the professional in promoting discussions with counsellors or parents, particularly with reference to the chapters on 'Phantasies and Relationships'. She emphasises the role of the "good container", or the empathic acknowledging other who can help the disturbed individual or child to be in touch with, make sense of and hopefully transform these intolerable phantasies and feelings in such a way so that they can be modified and integrated. Denial of our experiences of loss, pain, rage and despair can lead to us blocking those of others and thus deprive them of the space to work them through. Similarly relating to denied bits of ourselves in others incurs a risk that

we either exacerbate or attack that behaviour in the other or, by identification with their rage and frustration, become incapable of providing appropriate boundaries.

Discussion could also be focused on the valuable features of the externalisation of psychic conflict in as much as the ensuing process of projection and introjection can lead to the modification of inappropriate phantasies if the object of the projections can acknowledge them without being induced to behave in a retaliatory way.

The account of the inner world is written solely from a Kleinian perspective. She writes that she does not attempt "to criticise other people's work nor to look very much at criticisms of the Kleinian approach" (p. 20). Thus the book is valuable solely as a Kleinian account. No mention is made of the extensions and modifications of Melanie Klein's ideas that have occurred in the past 20-30 years. Even in the appendix on "Books and papers on related topics from standpoints similar or opposed to that presented in this book" (p. 231) the names of W.R.D. Fairbairn, M. Mahler, J. Bowlby, A. Miller and H. Kohut are not mentioned, while D. Winnicott and M. Balint are only mentioned once.

Thus, particularly the general reader might not be aware that in some versions of psycho-analytic theory reality is given more of a role in understanding the aetiology of phantasies, and reconstruction more of a place in understanding transference, than appears in her account.

ELEANORE ARMSTRONG-PERLMAN

Wilhelm Reich – The Evolution of His Work

By David Boadella. Arkana Paperbacks. 1985. Pp. 400. £5.95.

The author has set himself a marathon task in this book, attempting to show how Reich's work evolved and developed, and also trying to put it into both an historical and emotional perspective. He tries to present Reich's work objectively, which in view of the emotional responses his work evoked, is useful, but difficult to achieve. He feels that Reich's work has often been misunderstood and reviled, and attempts to put the record straight.

From the psycho-analytic standpoint, Reich's early work in Vienna — he started in private psycho-analytic practice in 1919 — centered on developing Freud's early libido theory towards his own orgasm theory, whereby neurosis, in his view, was directly linked with 'orgastic potency', meaning an ability to have a full sexual and emotional

relationship with a partner. The idea met with a mixed response from analysts working in Vienna at the time. Reich himself felt that his theory, developed between 1921 and 1924, formed the basis for all his subsequent ideas, including that of character analysis, for which he is most widely known in psycho-analysis. In his book *Character Analysis,* not published in English until 1945, he put forward his views on 'character armour' — that defensive and rigid attitudes and behaviour need to be dissolved to allow a patient to be in touch with his feelings, ideas that are central to psychotherapy today.

From his original interest in, and practice of psycho-analysis, Reich's enquiries led on to viewing man within his environment. This introduced sociological and political issues, such as the possible prevention of neurosis, sexual reform, and fear of authoritarian repression as he saw it around him in the 1930's, all of which the author narrates meticulously. Reich's interest in the self regulatory upbringing of children and his friendship with A.S. Neill, the English educationalist, his involvement with Marxism, and his attempts to help young people who were in conflict with the rigid sexual mores, all led him into conflict, and to a final break with the psycho-analytic movement in 1934. This makes most interesting reading.

From here on, however, the book charts the progress of Reich's work as it further developed into the biophysics field, and in my view, becomes less convincing. Reich's attempts to harness energy for therapeutic goals led to his orgone therapy, linking his original idea of damned-up libidinal energy to bio-energetic concepts with which the author is concerned. Reich also became interested in the treatment of cancer and heart disease, and his concern with what man can do to his environment led him to his experiments in attempting change in climactic conditions. Although expressed simply and unemotionally, the reader is struck by the increasing fantastical quality of what Reich felt to be possible. Many of his observations of the human predicament seem relevant to us today, but the brilliance of his intellectual grasp dimmed as the paranoia of his later years became inextricably bound up with his scientific findings.

While the author succeeds in giving a meticulous account of Reich's work and, therefore, adds enormously to the reader's knowledge of it, and although he shows how Reich saw man, not in splendid isolation, but as an integral part of his environment and society, he does not succeed, in my view, in showing us that Reich's solutions to the 'sickness of society' are viable. Reich's eventual psychological breakdown, no doubt exacerbated by the attacks upon him, seemed tragically predictable. I feel that while I remain committed to his concepts of

character analysis on the one hand, on the other, I am still the interested, but unconvinced, observer. Reich felt that the world of his day was not yet ready for his work. Mr.Boadella feels that today we should be ready "to grasp Reich's essential message about the reality of life-energy and the crucial need to ground our existence in its laws if we are to survive as a species".

HELEN ALFILLÉ

Creativity and Perversion

By Janine Chasseguet-Smirgel. Free Association Books. London. 1985. First American Edition 1984. Pp. 172. £6.95.

In this book Janine Chasseguet-Smirgel presents a unique and compelling argument for a revised theory of perversion. The breadth of her vision, the extent of her scholastic research and the sheer force of her intellectual reasoning are formidable indeed. She combines impressively well substantiated arguments with a turn of phrase that renders sometimes difficult concepts at once colourful and memorable.

Chasseguet-Smirgel understands perversion as an attempt to deny the realities of the Oedipal Complex; to avoid the stage when a little boy must begin to identify with his father and both realize and, ultimately, accept that in truth he cannot fill the role of object of his mother's desire. To the child who in future will become a pervert such a situation is intolerable, for his seductive mother has led him to believe in the primacy of his importance to her. She has relayed a covert, indeed perhaps overt, message that the father's role in her life is secondary, that his genital attributes are to be discounted. This is tantamount to illusion, and it is an illusion that must be maintained albeit at great cost. In order to accomplish this the child must disavow the reality of the differences between the sexes and between generations; he must set up what Chasseguet-Smirgel terms a new universe, one where all the differences, all the separateness recognized in the process of maturing through the Oedipus Complex will be abolished. The accompanying conflicts and psychic pain will then disappear.

To achieve such a state, regression to anality takes place and the establishment of an anal universe in which no boundaries impede the satisfaction of desire and where there is no need to acknowledge that pregenital satisfactions are not equal or even superior to those of the genital stage. As in the digestive tract, all differences disappear. When the author draws upon the writings of Sade, turns to history to examine the behaviour of Caligula, looks at 'The Island of Doctor Moreau' by H.G. Wells and the work of Hans Bellmer, we see this idea of the

'melting pot' universe carried out to its extreme. But it is a structure (or, more accurately, a lack of such) telling in its relevance to the psychodynamics of all perversion. And, as Chasseguet-Smirgel points out, the temptation to push away the strictures of perceived realities is one that is common to us all.

As a part of her argument about perversions, the author reconsiders Freud's view of phallic monism. Where Freud emphasized the little boy's fear of castration, taking the female genitalia as evidence of such possibility, Chasseguet-Smirgel suggests a knowledge, tentative, perhaps even inate, of a vagina. Such an awareness may heighten the little boy's feelings of inadequacy when faced with a father whose larger penis can penetrate and fill this cavity. Her scholarly reappraisal of the cases of Little Hans and The Wolf Man illustrate and substantiate her argument and whether or not one accepts it in its entirety, it warrants serious consideration.

For me, one of the most interesting aspects of Chasseguet-Smirgel's theory is in her description of the process of idealization. In order to preserve the superiority of the anal universe over the paternal universe, the former must be submitted to a process of idealization, a process which leads inevitably to a splitting of the Ego. Idealization, then, strives to repress the unwelcome ideas connected with anality. The Ego Ideal, in place of being projected on to the father is projected on to pregenitality. Again, the examples drawn from literature are cogent and forceful: Oscar Wilde's 'The Picture of Dorian Gray' aptly illustrates the thesis. The aestheticism of many perverts becomes instantly explicable: their love of and need to be associated with beautiful objects and exquisite surroundings in order to mask the dreary inadequacy of their anal world. Like the glittering, gold-covered statue of the Happy Prince which, when its precious-seeming covering was removed, stood revealed as drab and miserable in aspect.

This, her account of idealization, leads me to my only major criticism of Chasseguet-Smirgel's book which is, after all, entitled *Creativity and Perversion.* I have doubts as to its helpfulness in regard to creativity. A pervert's aestheticism may be reflected in his tastes, his possessions, and perhaps his profession. But aestheticism falls short of true creativity, and it seems to me that insufficient sublimation takes place in the case of perversion to result in real creative activity.

And finally to the application of theory to practice. We are given case material at once rich and markedly sensitive, material that illustrates, for example, a need on the part of the pervert patient to 'abort' the 'analytic baby' thus destroying the psychoanalytic situation as a replica of the Oedipal couple. One's intellectual understanding of

the process is much enhanced. I found lacking, however the kind of illumination some other writings on perversion have shed upon one's own patients, an illumination that makes the words seem to leap from the page to meet with and clarify one's own experience.

Certainly the translation of this book into English is an important event for our understanding of the process of perversion. Far from focusing solely on the analytic treatment situation, it sheds light upon a broad spectrum of life including group behaviour, politics, history and religion. It is a book which left me with a appetite for further exploration.

MIDGE STUMPFL

The British School of Psychoanalysis The Independent Tradition

Edited by Gregorio Kohon. Free Association Books. 1985. Pp. 448. Hardback £25.00. Paperback £9.95.

The book comprises of a collection of specialist essays by leading analysts of the Independent group. The extensive introduction by Kohon traces the history of the British movement whilst attempting to define its original contribution to psycho-analytic theory; along the way he also briefly outlines the area of contention between 'Freudians', 'Kleinians' and those of the 'Middle' group. The following essays are then divided into four sections which cover 'early environment', 'transference and counter-transference', 'regression and the psychoanalytic situation' and 'female sexuality'.

The introduction raises several questions without answering them in quite enough detail. In the historical section Kohon whets the appetite with his summary of the development of the analytic movement in Britain. The British intellectual tradition with its gentle empirical bias, would seem to be inimical to Freud's relatively closed system of thought; but psychoanalysis appears to have gained a measure of recognition and respect very early on. The influence of Ernest Jones was clearly a factor, but the precise nature or extent of that influence is left unexplained. Kohon argues that one of the strengths of the British School has been its relatively catholic approach which enabled, for instance, lay analysts to be accepted within the movement despite opposition from influential figures such as Jones himself. However, the relationship between psychoanalysis and the eccentric vagaries of British class and culture is barely sketched and needs more detailed commentary.

In many other respects Kohon attempts too much but then he is dealing with intrinsically intractable material. Kohon's problem is that

he recognises that the major achievements of the independent group are not in the sphere of new analytic theory; he praises the group's diversity of approach to treatment and yet this is the most difficult quality to show in a series of essays. The hardest thing to express in words is the changing relationship between analyst and analysand.

The book's epigraph from Wilfred R. Bions *Evidence* reads as follows: "the individual analyst should forge for himself/the language which he knows how to use/and the value of which he knows." The best contributors — Khan, Winnicott, Rycroft, Mitchell, follow this advice and technical terms are wielded with delicate precision. Elsewhere technical expressions descend to jargon because the writers do not take care. The concepts become victims of what Kohon describes, too politely as "overextension".

The book as a whole struggles to suggest conformity within a group who are, by their nature varied, independent and perhaps more original in practice than in theory. The essayists themselves struggle to convey the nature of their practice, a hard task because the experiences that confront them often appear to be beyond words; perhaps only Freud has ever fully succeeded in the latter because, as a great creative writer, he could fictionalize and dramatise the patient-analyst relationship thereby conveying to the reader something of its emotional 'truth'. With lesser writers, and there are one or two in this collection, the case-work does not always seem to relate to the theory or to illustrate the given argument.

This is a very interesting volume and one hopes that Kohon may one day devote more time to a comprehensive historical survey of the whole British analytic movement. Certainly much of the strength of the book lies in the suggestiveness of the introduction.

PAT EDWARDS

ERRATUM

NOTES ON CONTRIBUTORS (p.86) should include:

Elizabeth MOBERLY D Phil	Research psychologist in Cambridge. She has recently published: (1983) *Psychogenesis: The early development of gender identity* R & K P; and (1985) *The Psychology of Self and Other* Tavistock Publications.

NOTES ON CONTRIBUTORS

Helen ALFILLÉ BA	Full Member BAP. Psychotherapist in private practice.
Eleanore ARMSTRONG-PERLMAN MA	Psychotherapist in private practice. Teaches psycho-analytic theory — Guild of Psychotherapists, Lincoln Clinic, Arbours, Tavistock Clinic.
Cecilia BATTEN	Graduated as a physician from the University of Buenos Aires. Part-time Psychiatrist in the National Health Service, part-time Psychotherapist in private practice, Cardiff, Associate Member BAP, Founder Member Severnside Institute of Psychotherapy, Bristol, Secretary Welsh Psychotherapy Society, Cardiff.
Patrick CASEMENT MA	A training analyst of the British Psycho-Analytical Society. He studied Anthropology and Theology at Cambridge, worked for ten years as a social worker, and qualified with the BAP before training to become a psychoanalyst. He is now in full-time private practice, and has recently written the book *On Learning from the Patient.*
Madeleine DAVIS	Editor: Winnicott Trust. Student training with the BAP. Co-author Davis M., and Wallbridge D. (1983) *'Boundary and Space. An Introduction to the Work of D. W. Winnicott'*. Penguin; and co-editor, Winnicott C., Shepherd R. and Davis M. (1984) on *'D.W. Winnicott – Deprivation and Delinquency'*, Tavistock.
Pat EDWARDS MSocSc	Student Counsellor and psychotherapist in private practice.
Robert FENTON BA (Melbourne, Australia)	Registered as a psychologist with the Victorian Psychological Council. Professional Member of the Society of Analytical Psychology and Chairman of its Professional Committee. Training therapist and supervisor with the BAP. Author of several papers.

Gordon HARRIS MA	Full Member of the BAP. Senior Psychotherapist in the Therapeutic Community at Fairmile Hospital, Oxfordshire, and minister of the United Reformed Church. Psychotherapist in private practice.
Brett KAHR BA MSc	Psychologist at Yale University in the USA, specialising in research on the psychotherapeutic treatment of schizophrenia. He is former Research Officer at Littlemore Hospital in Oxford, and the former Director of the Oxford Psycho-Analytical Forum. He is the Editor-in-Chief of a forthcoming six-volume series on the history of psychiatry and psycho-analysis; and he is the Host of *Fifty Minutes,* a new American television programme on psycho-analysis.
Sybilla MADIGAN	Formerly group therapist in a Psychiatric Day Centre, London. Now psychotherapist in private practice in Paris.
Midge STUMPFL BA Dip Soc Admin Cert Mental Health	Senior psychotherapist, Brent District Health Authority. Psychotherapist in private practice.

NOTES FOR CONTRIBUTORS

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 and Books for review to Book Reviews Editor, Mrs Judy Cooper, 131 Broadhurst Gardens, London NW6 3BJ.

Manuscripts should be typed in double spacing, on one side of the paper only and be submitted in duplicate. The maximum length of any one contribution is normally 7,000 words. The Editor reserves the right to edit all contributions. Authors must ensure that publication does not involve any infringement of copyright.

CONFIDENTIALITY: authors should take responsibility for ensuring that their contribution does not involve any breach of confidentiality or professional ethics.

REFERENCES

References within articles should indicate the surname of the author followed by the date of publication in brackets, e.g.(Khan, 1972).

For all works cited in the text there should be an entry in the list of References at the end of the paper, arranged in alphabetical order by name of author.

When referring to articles include authors' names and initials, date of publication in brackets, the full title of the article, the title of the journal, the volume number and the first and last pages, e.g.

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.

AN IMPORTANT RESPONSIBILITY OF THE AUTHOR IS THE PREPARATION OF A CORRECT REFERENCE LIST.

In order to be certain that the reference is correct it should be re-checked against an original source.

Acorn Press, 15 Goldhurst Terrace, London NW6

ISSN 0268-6643
ISBN 0 9511034 0 7