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Editorial

The *BAP Journal* is currently involved in critical discussions taking place between the psychotherapy journals at meetings both in the UK and in New York with the Council of Editors of Psychoanalytic Journals (CEPJ). The focus is on issues of confidentiality in publishing clinical material. This has far-reaching implications for our work as psychotherapists since so much of our training and continuing professional development relies on the freedom to be able to share and publish clinical material. We plan to continue working closely with other psychotherapy journals and organizations to try to establish a unified and publicly accepted approach to good publishing practice which will recognize and protect both the interests of our patients and our need to share clinical material in a respectful and professional way.

In this issue of the *BAP Journal* we have devoted a special section to Adolescence as a way of recognizing the BAP's new training programme in Psychoanalytic Psychotherapy with Adolescents. It includes clinical papers by Margot Waddell, Peter Wilson and Ruth Berkowitz. In addition, the Arts Review is devoted to a discussion by BAP member John Woods about his play *The End of Abuse*, which grew out of his work with adolescents. Our Clinical Commentaries discuss material from an individual session with an adolescent boy, and the Book Review Section includes books about psychotherapy with adolescents. Taking note of the question posed in Ruth Berkowitz's paper 'What happened to adolescence?', we hope that the *BAP Journal* will be seen as an ongoing forum for clinical exploration of adolescence, giving appropriate attention to this key developmental stage as integral to our thinking about all patients.

In addition to this special Adolescence Section we include a paper by the Portuguese child and adult psychoanalyst, Maria do Carmo Sousa Lima, on the development of symbolization in a five-year-old patient. This paper was given as part of a BAP public event called *Symbolic Thinking and the Aesthetic Experience in Psychoanalytic Work with Children*. We are pleased to be able to include the response to Dr Sousa Lima's paper by Margaret Rustin, Head of Child Psychotherapy at the Tavistock Clinic.

We also have a paper on the difficult technical issues which occur when both patient and therapist develop a serious physical illness, by an Israeli psychotherapist, Dvora Florsheim.

Finally, we are delighted to include the *BAP Journal* Second Annual Lecture given this year by Adam Phillips. In it he explores the complex notion of equality historically and theoretically in relation to the similarly complex notion of democracy. He provocatively offers a reading of psychoanalysis in which equality is a governing value and suggests how a psychoanalytic experience based on equality can affect social and political relationships.

The Editors

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The skin of the name

MARIA DO CARMO SOUSA LIMA

ABSTRACT

The author describes the analysis of a five-year-old girl who was referred with a diagnosis of 'psychotic, with traces of autism'. However, once in treatment, she showed a growing capacity for symbol formation and thought. Her parents described a 'catastrophic weaning', temper tantrums and nightmares in which she would scream without waking up. They were concerned about her apparent language deficit. The author describes the genesis of the psychic skin of her internal space, and the emergence of her capacity to construct a separate identity. Once inhabited, her internal space became a world endowed with time *and* history, *a rapidly expanding symbolic universe. With the experience of thought comes the aesthetic experience, as demonstrated in the clinical material.*

Key words symbolic thinking, psychic skin, internal space, adhesive identification, aesthetic experience

I first saw Joana, who was then five years old, in September of 1989. She had been given a diagnosis of 'psychotic with traces of autism'. However, soon in her analysis it became clear that she suffered instead from a deep difficulty in symbolization, which, once she was in contact with the therapist, started to develop exceptionally well.

Her parents had 'never heard of such things' and contacted me in a great state of anxiety. Their only concern until then seems to have been a supposed backwardness in language for which she had been having speech therapy for two years without any results. They find it extremely difficulty to speak about Joana. Her mother only mentions that as a baby Joana was 'always crying with hunger' and that when she was ten days old she had 'vomited blood'. They rushed in a panic to the hospital and calmed down when they are assured that

Dr Sousa Lima is a child and adult psychoanalyst with the Portuguese Psychoanalytic Society. 'The skin of the name', and the 'Response' which follows it, were given at the BAP Conference, *Symbolic Thinking and the Aesthetic Experience in Psychoanalytic Work with Children*, 10 February 2001.

it was just blood from abrasions on her mother's nipples. Even as she speaks to me, the mother appears mesmerized with this, as having still unthinkable a breast that doesn't feel . . . Joana was immediately bottle-fed. Her father also says that he finds it strange that Joana should have nightmares practically every night during which, tearless, she cries desperately without waking. She has sudden temper tantrums due to her inability to 'wait or share'.

It is mostly the more maternal and sensitive father who takes care of Joana and the other daughter, who is seven years older. Her parents come from a low socio-cultural background and both began to work when they were still children. The mother is a hairdresser and the father is a bank clerk.

In the first session Joana appears a pretty, transparent child with an elongated, 'soft' body; she doesn't smile or look at anything in particular. She wanders about on tiptoe lightly and quickly. She babbles in a small falsetto voice with occasional echolalia. She lets me take her into my consulting room. She doesn't seem to look at the toys, but after wandering about in the room, she sits down on the floor and begins to sort the toys out in categories: animals, people, cars, pots and pans, etc. She wanders off again and ends up sitting down, unbidden, at the table where she starts to draw (Figure 1).

She draws everything except a small house and uses a felt pen to colour what she calls the 'thing' (*o 'coiso'*), an enigmatic image which is to accompany us for a long time. I am surprised when she draws a small house! 'Oh, Joana's little house! I wonder if I may go in?' With two fingers, I trace some steps on the table to the drawing and pretend to knock on the door. At that moment, Joana looks at me for the first time, then at the small house and then at me again. 'Hello, Joana. I'm Maria do Carmo, and three times a week, always at the same time, I'll be here, waiting for you . . .' This episode during the first session gave me the hope and confidence I have never lost.

During the next sessions, Joana practically only draws 'things' which make me think of almost-formed babies, elemental foetuses drifting in a kind of

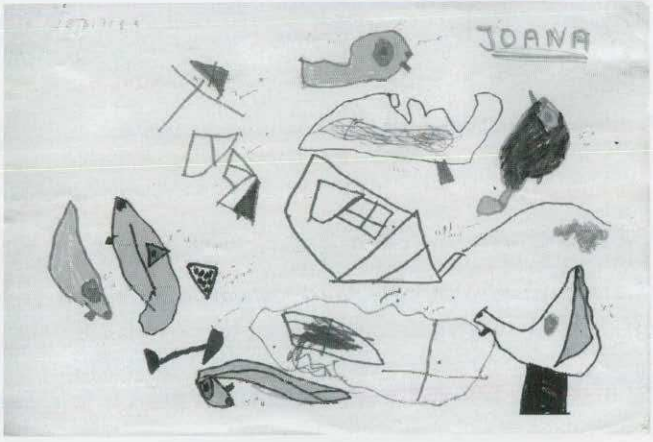

Figure 1: Pink, brown, green outlines; yellow, blue interiors

uncontained womb in an endless space. From the very first drawing she asks me to write her name and points to the top corner of the sheet. As soon as I write 'Joana' she begins to make slightly anxious movements with her hands in the direction of her name, which I then understand as a need to contain her name. She smiles and with obvious delight she traces with her finger the line that I have just drawn around her name (Figure 2). 'Oh! A little blanket to keep Joana together, so you won't break up into "things" and become lost to Maria do Carmo . . . the skin of Joana's name . . . how good it is to have a skin' – and I lightly touch the back of her hand with my forefinger. I get the impression that she looks at her own hand as if she is seeing it for the first time – as if she sees her own sense of touch rather than feeling it.

Thus an inner space full of 'things' seems to emerge. But it is still a huge 'thing' full of 'things' now marked with a cross (Figure 3), a conjunction revealing some capacity for relationship, or then it is a 'thing' that *encloses* similar 'things', the same *within* the same (Figure 4). At times the 'thing' tries to separate itself but remains like Siamese twins in the process of becoming twins (Figure 5), or the 'thing' has a tick-tock, a sound link between the heart and the placenta.

A new element appears which Joana calls 'little water' (*aguinha*). 'Little water crying in the eye of the thing.' But when I say, 'Ah, poor Joana, how your fears hurt you, feeling all alone and so lost . . . when you're sad, you cry . . . ', she looks at me astonished, curious, but does not seem to understand the feeling of loneliness I was linking to the image. As if the submerged feelings still cannot float to the surface of the eyes in live tears.

During a subsequent session Joana appears agitated and unstable. She keeps drawing 'things', repeating 'the thing . . . the thing'. I talk to her in short and simple sentences, but she doesn't seem to hear me. Suddenly, she seems to question me, looking at me anxiously and appealingly: 'THING?!!!' I pick up a cloth and make a 'thing' by wrapping it around my hand and painting a

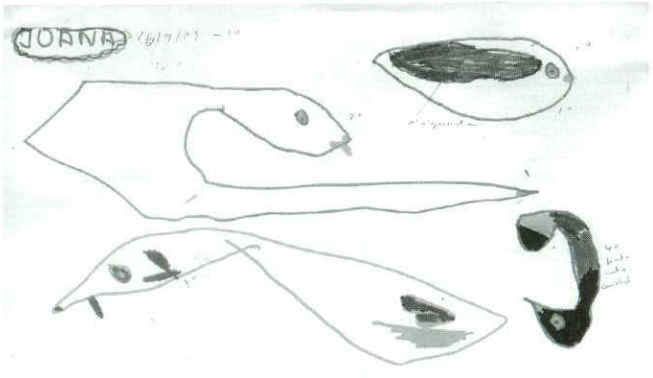

Figure 2: Yellow outline

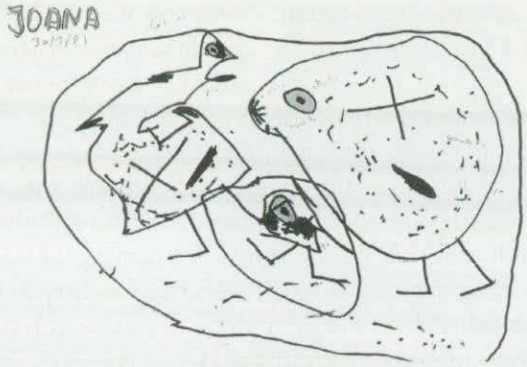

Figure 3: Red outline and yellow eyes

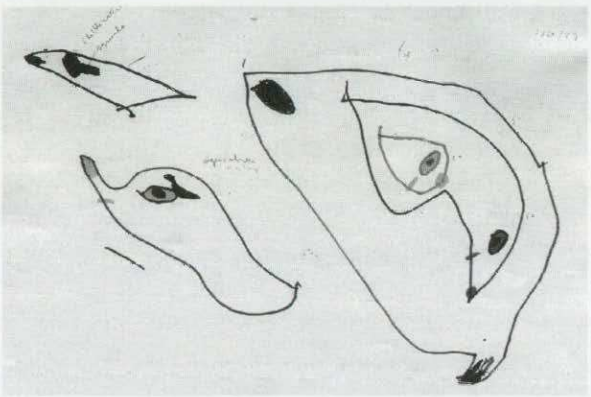

Figure 4: Pink outline

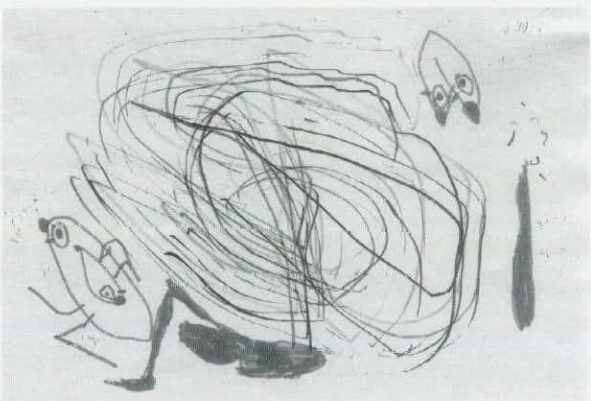

Figure 5: Pink, yellow, blue lines; yellow figures

nose, mouth, eyes and ears. Joana seems amazed, walks around the 'thing', takes a good look and laughs with relief. She takes the 'thing' in her hands and pretends that it wants to eat me up like some large noisy cannibal. 'Ah! Now we can see Joana's fear that the "thing" will eat her up and make her disappear and so become a "thing" . . . just like a baby that can't get out of the mother.' She makes another drawing (Figure 6): 'Oh! Joana wants to get out of the "thing". It's all ears and eyes and big feet . . . it seems very scared.'

When reaching out to respond to what I felt was a plea for help, I found myself giving form to the 'thing'. I was probably giving representation to her fear and thus separating her from a terrifying breast. Her relief shows that the projection was received by the internal mother and the desire to cannibalize a breast without boundaries is now less in danger of returning as a 'nameless dread'. But the 'psychic skin', the boundary space of our relationship, is still very fragile and starts to deteriorate (Figure 7), break up (Figure 8), and dissolve (Figure 9) with the talked-about approach of the Christmas holidays. Joana seems to fade, her transparent face clouds over again like the shadow of the sphinx and the babbling reappears.

During the months following the short Christmas holidays, a 'mouse-part' of Joana seems to dance (Figure 10), to speak (Figure 11), to show me her inner family (Figure 12), her rage and fears (Figure 13), but also her joys. It is also an intense phase of cutting 'things' out of paper that she colours, with great pleasure, in silence, next to me. She stops wanting to take and bring toys, but there are scenes when she screams, without tears, when I don't let her open the cupboard with the boxes of other children's toys. I try to interpret her avid curiosity and tell her she can't go and see, touch and take, but that we can imagine what's inside, such as the babies that she fantasizes concretely inside me on the other side of the wall of my skin. Increasingly, Joana seems to grow out of her demanding attitudes, at first through something

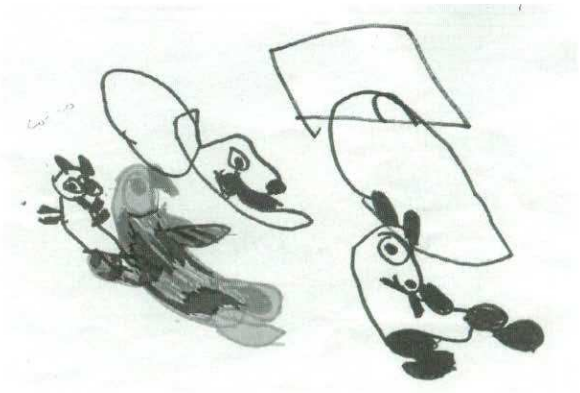

Figure 6: Red outlines, yellow/pink/green figure

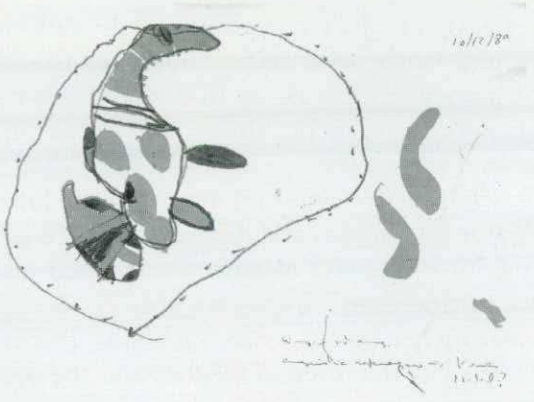

Figure 7: Pale yellow and green

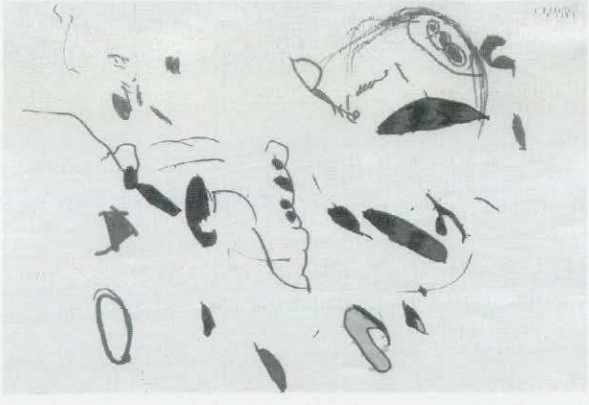

Figure 8: Green, yellow, brown and pink

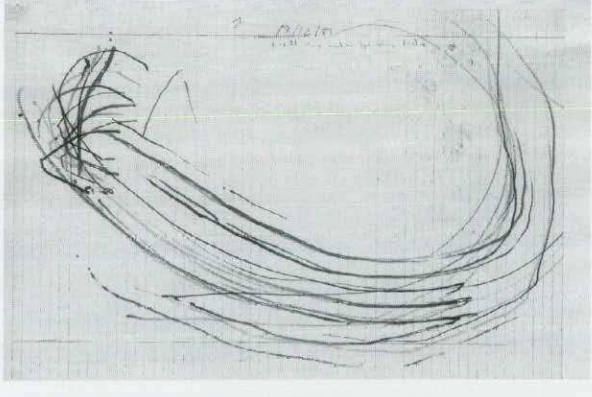

Figure 9: Yellow, red, brown, green lines

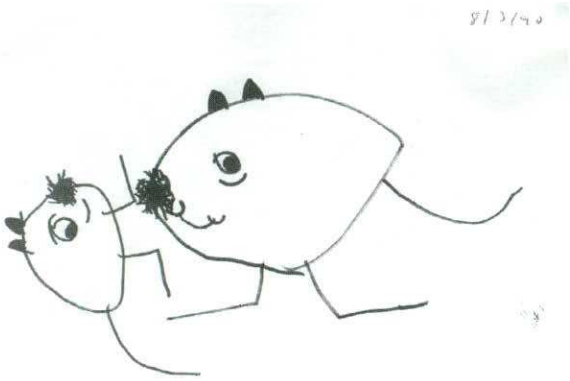

Figure 10: Pink outline/red outline

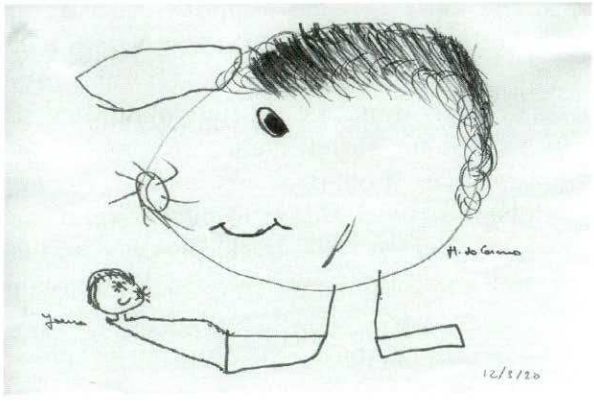

Figure 11: Red outline, multi-coloured hair

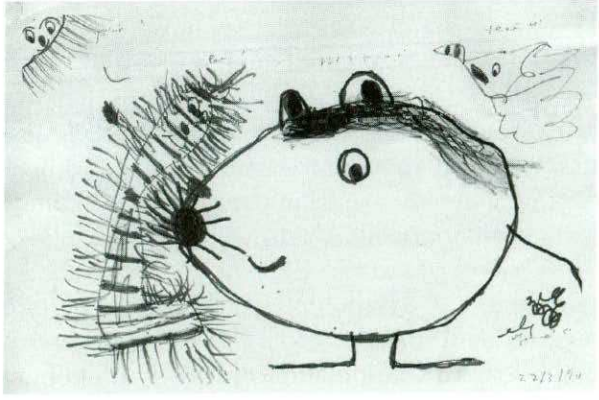

Figure 12: Pink figure and pink/yellow/brown mouse

Figure 13: Purple outline and letters

musical she seems to find in my voice. I have the impression she quietens down like a baby at the soft tones of a mother's voice, and only much later does she begin to be curious about what I draw trying to help her invent the contents. Her temper tantrums are now short, she starts to become suddenly quiet as if switching abruptly from one register to another, sitting down next to me and watching and listening attentively.

Now what I most remember from these first months is a sort of atmosphere. Joana seems more linked to the attention in my eyes and to the music of my voice than to the interpretations – the lively presence and care of a working mind that receives the chaos of feelings, an available thinking-object, as in a dream life.

In June, I talk to her about the approaching first summer holidays. Her drawings still reveal confusional anxieties, fragmentation (Figure 14), annihilation in a kind of inner abyss that sucks her in (Figure 15), an amazing inadequacy of the boundary of the exterior with the interior, a porousness between the self and the external world (Figure 16). At the same time she seems to be able to re-create me in an imagined absence by writing me letters in which hearts, colourful breasts flying in space, already announce the constancy of our relationship, the colourfulness and labile quality of our affections towards each other.

The last drawing before the holidays leaves me speechless (Figure 17). I have the moving impression that I am witnessing the birth of the world, the epic effort of separation, the change from the chaos of undifferentiation to the anxious concern about relationship. I can still hear Dr Melzer saying, when in the summer of 1991 I bring Joana to him for the first time: 'Oh! It's passing through and coming out! . . . That's alpha!' It's really a process in operation – it's *some'thing'* beautiful and terrible, good and bad, primitive and sophisticated, male and female, something in metamorphosis from animal to human, the first theory of evolution. I don't know why but what continues most to impress

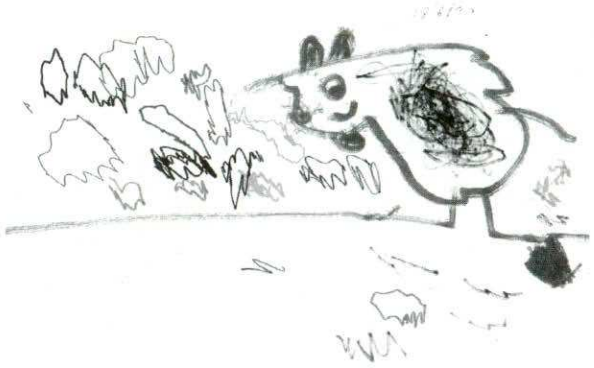

Figure 14: Turquoise outline

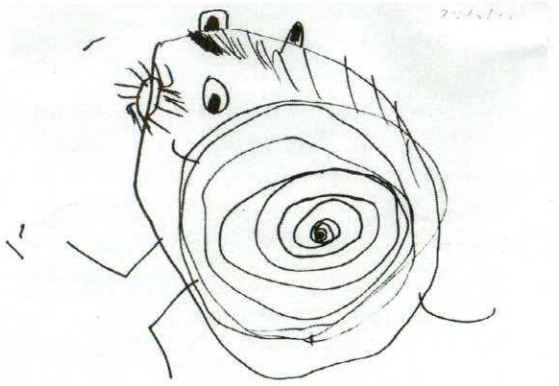

Figure 15: Black lines

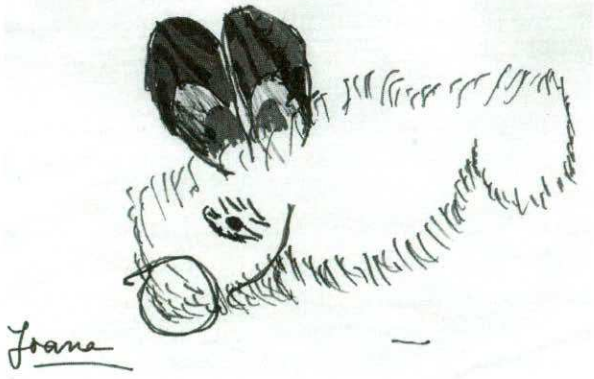

Figure 16: Purple/pink

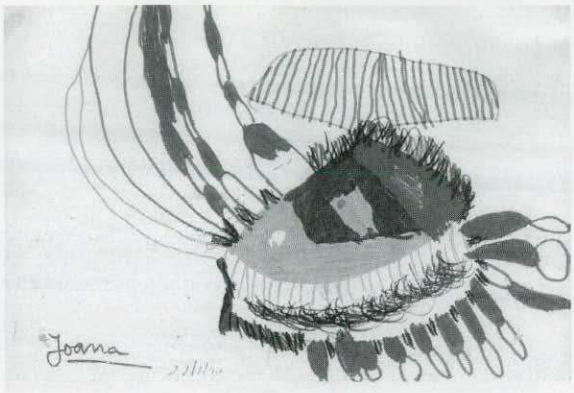

Figure 17: Bright orange, purple, yellow, blue, green

me in this drawing is the movement, sometimes felt as persecutory. A beautiful persecutor!

At the end of the summer holidays, her mother phones me in anguish (a few days before the first scheduled session) because one of Joana's teeth had fallen out that day and Joana was in a panic and would not stop screaming and running about in a terrible state: 'She seems crazy and I too feel crazy without knowing what to do.' I ask to talk with Joana and arrange that we should be together the next morning.

The next day she runs up to me, happy. She has grown and lost her transparent, fairylike quality. She seems more solid, agile and lively. As soon as she comes in she goes straight to her box and starts to draw (Figure 18): 'These are the teeth,' she says as she draws a mouth with jagged teeth while she covers her own mouth with her hand. She comes up close to me and says, 'Show me!' She touches my teeth and then shows the space of her missing tooth, checking to see if mine are loose as two of hers are. 'You need to check and see if I am the same, if I am complete . . . You got a fright because you thought you had lost a little piece of yourself for ever, and maybe it had fallen into me during the holidays.' She starts to draw 'Joana' and laughs while she draws what she calls 'little breasts'. Then with intense concentration she turns the sheet over and looks through to the drawing on the other side. She then does the drawing again tracing it from the other side of the sheet! Astonished, I watch her and hear myself say: 'A baby stuck to its mother's breast: breast and baby are one?!' Joana tries to 'open' the thin sheet of paper as if seeking an 'inside' in the absence of space (still adhesive). Then she folds the sheet and tries to look 'inside'. 'It seems that you are making an effort to understand how a baby can separate itself from its mother's nipple, how a little tooth can fall out of your mouth without you becoming crazy, lost, without disappearing . . . how you and I can separate, go on holidays and not forget each other.'

Joana smiles tenderly, comes up to me, and cups her hands around my face. Like a young baby creating a mother inside and outside at the same time? Or

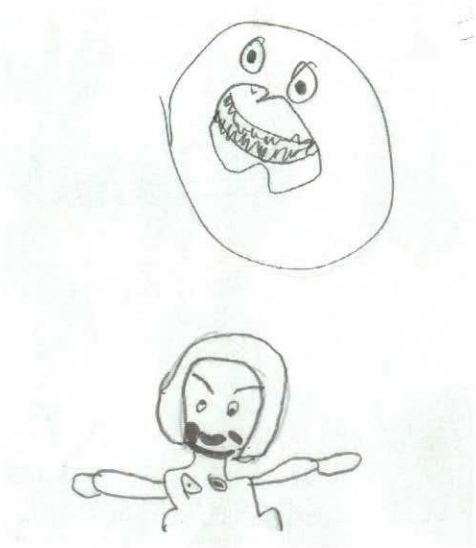

Figure 18: Green outline and yellow and pink outline

perhaps like a baby that treats the breast, my head-breast, as if it was the baby's baby . . . What a little mother she became! When she leaves she calmly tells her mother: 'Don't talk to me anymore about my tooth. Don't tell anyone about my tooth.'

The teeth are not there at birth. They grow inside and then emerge apparently from nowhere. They represent internalized objects. When Joana's tooth fell, I fell from her and she would never see me again. In the face of this catastrophic danger, Joana returned to two-dimensional state in an adhesive identification to the mother as a mere surface. During the session, she checks in my mouth to see if I and all my children are still there, that she herself had not fallen from me forever. There was not only the anxiety that the object can fall out of the inner space of the inner world, but also that even the inner world can collapse, leaving the child two-dimensional, with no home, no centre inside, no emotional life, only a wandering, drifting imitation.

In the first session after the 1990 Christmas holidays, as soon as she comes in she tells me: 'I'm going to make a swimming pool' (Figure 19) and begins to draw while talking all the time: 'This place is for the big children . . . I can't go there yet . . . when I know how to dive . . . dive with my eyes shut . . . Now I'm going to do the night . . . the sun . . . the stars now . . . you'll see . . . one, two . . . I've done fourteen . . . Now it's night in here . . . and it's day out there.' I watch, silent and fascinated by her cosmic creation. 'I haven't finished yet.' She then cuts a piece of paper and she glues it on the back of the sheet where the swimming pool is. She lays the drawing down in front of me and looks at it, happy and smiling, and waiting to hear me. In a very low tone, almost afraid, I tell her: 'You can now dive into yourself with your eyes closed

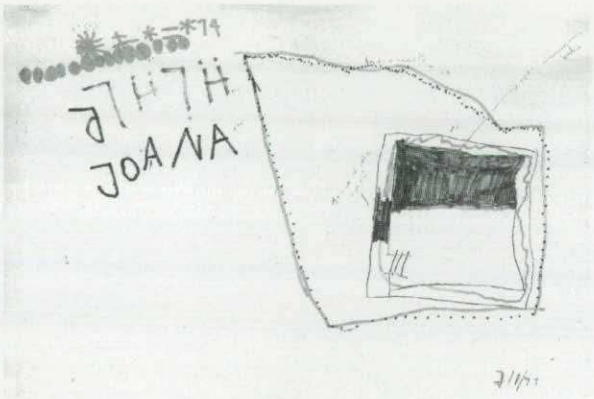

Figure 19: Yellow outline, blue interior

and dream . . . imagine, without being frightened that you will be trapped inside the darkness of nightmares . . . 'Joana now knows that a swimming pool is not a bottomless hole, but a "bluey" (her first adjective that had already appeared in previous material) . . . and you can swim there deeper and deeper . . . one day you'll be fourteen just like Filipa . . . you'll be a big person like me.' 'I'm now going to do my name,' she says. But she starts to draw some illegible letters, pretending to be 'crazy' while she looks slyly at me sideways. She shrieks with laughter, something new to me.

An inside with depth implies a time, a future and, who knows, the capacity to laugh.

At the end of January Joana starts to draw lines across the paper (Figure 20) in such a way that I ask her: 'Joana seems very upset. Can you tell Maria do Carmo about it?' She replies: 'You see, it's thunder. This (the lines) is the rain of the thunder . . . and this is a little girl running away (she begins to draw the girl) . . . and here the thunderbolt pricks the little girl's tummy . . . . here the little girl dies.' She then cuts out the bit with the two little girls and places it on the side of the drawing, and looks at me waiting. 'Joana sometimes dies of fright in that nightmare. You get so small with the sudden thunder that you nearly disappear. But now you can think, separate yourself from the thunder, and talk about this to Maria do Carmo without being crushed, without dying.'

In the next session Joana spots an ant on the floor and 'crushes' it with her foot. I ask her: 'Like a thunderbolt?' She looks at me, amazed; looks for a long time at the crushed ant, touches it and only now seems to 'see' it. She finds another ant and watches with curiosity as it hurries about. She is showing me her worst nightmare: 'To be lost'. This probably related to a special birth experience. Inside Mummy, the baby is floating and the baby and placenta are like two. When they are first born, one disappears – and the baby seems to have lost its best friend, the placenta. But the catastrophe of loneliness and chaos is compounded when the baby doesn't find another object to hold and embrace it in a containing emotional way.

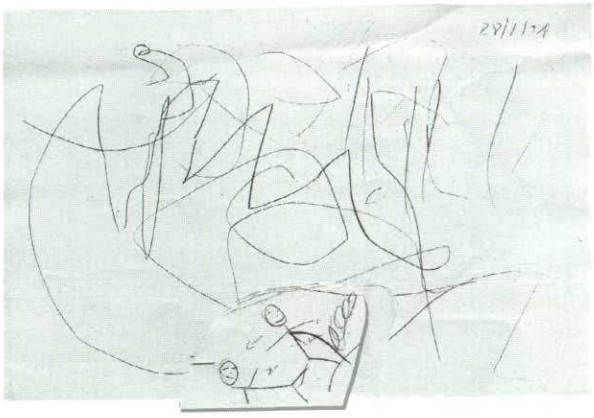

Figure 20: Black lines

As Cesariny, a Portuguese poet, wrote: 'The law of gravity of your eyes, mother . . . ' It is the eyes of the mother that rescue the baby from feeling sucked down by the force of gravity and crushed by the chaos of sensations (light, noise, cold, etc.). Returning from the 1991 summer holidays, Joana shows great enthusiasm about learning the alphabet. She draws the letters of the alphabet and then traces them with her finger as if she is drawing them again. Soon she begins to read and write with a kind of passion. With a growing capacity for intimacy, a rich sexual material appears which allows for deeper differentiations.

In a session in 1992, she comes in saying that she wants to pooh, and then takes a long time in the toilet. When she comes out, she takes the water colours and says: 'Now a drawing' (Figure 21). While she paints, with growing excitement, she laughs so much that at times she has to stop painting.

'Now you are going to see what "silly things" (*disparatinhos*) are . . . I'm going to do a lot of "silly things".'

'Yes, the "silly things" that Joana thinks in the toilet . . . the "silly things" that Joana imagines that Maria do Carmo does with her husband, and her father does with her mother.'

She bursts out laughing, hardly able to speak. 'Yes, yes, everything you do are "silly things" . . . . all day long you do "silly things".'

'Yes, the "silly things" that Joana is already able to imagine, the "silliness" of Daddy's silly penis into Mummy's silly vagina.'

'Yes, yes . . . ,' and she seems to calm down, breathes deeply, and sits down on the couch relaxed.

'Maria do Carmo, this is a house with people inside. Guess what they are doing?'

'Oh, yes. My house . . . Joana has already told me that they are doing "silly things".'

'Yes, yes, lots of "silly things".'

When her father comes to fetch her, he tells me with a certain astonishment that now at dinner she is terrible, that she just laughs and does 'silly things'.

Figure 21: Very bright pink/orange/yellow

In another session, she says: 'Today I do not want to play . . . today I have a magic wand. I touch you and you turn into a crocodile.' Laughter.

'And maybe Joana thinks that she's a princess.'

'Witch!' and she laughs out loud.

'And what does Joana think that a crocodile does with a princess?'

'Psch, psch, psch.'

'Ah! "Silly things"?'

'Yes, that's right, many silly things . . . ' Even more laughter.

'And can Joana tell Maria do Carmo about the silly things that she imagines doing with me?'

'Psch, psch, psch . . . ' Laughter.

'Now Joana is thinking a lot about "silly things" . . . when Joana does things like the giraffe, when it washes its ears with its tongue . . . so she begins to imagine things, if she had a magic wand, if she could do like the grown-ups, like Maria do Carmo with the magic wand of her husband, like the father with her mother in bed at night, when Joana hears "psch, psch . . . " and begins to wonder what it is like when the father's penis is inside the mother's vagina.'

'Yes, the grown-ups when in their "silliness", doing "psch, psch, psch".' But she now begins to calm down, breathes deeply and catches her breath because she's laughed so much that she nearly suffocated.

She comes and sits down next to me and says: 'Let's both of us do a drawing. You start. Ah! This is the sun, so I'm going to draw the moon and the stars . . . and then I'm going to write the names of everything that we are going to draw . . . wait, you are going to see that I can already write . . . my teacher Adelaide has already given me a new exercise book and she says that I can already write new things, things that I have not yet read.'

'Yes, you don't have to copy, you take new things from your head, you cannot yet do what the grown-ups do, but you can now imagine and give names to things that you have created, and can understand the mysteriousness of the

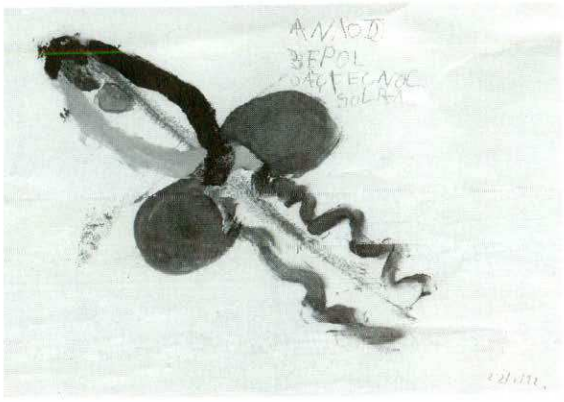

Figure 22: Pink, blue, green, black, yellow

"silliness" . . . how parents are able to make beautiful babies, and give names to new-born babies.'

'Yes, when I grow up I want to be a doctor.'

And now we are approaching the summer holidays again. In a session at the end of July she starts to prepare her things to paint, saying that she is going to draw a 'beautiful drawing to leave here during the holidays' (Figure 22). She looks at the drawing for a long time, and afterwards at me as she waits for me to speak about it. I'm riveted by the drawing. In my mind it's mixed up with another mysterious drawing of about two years ago. 'Can Joana speak to me about her drawing? . . . Can you tell me what it is?' She begins to laugh in an almost manic way, but which I feel she is able to control. She then writes her name from back to front, as she has done on other occasions. 'Hey, guess! . . . come on! . . . It is something I imagined, it is a picture, a painting' (and she looks at her 'artistic creation' with pride). Slowly I begin to separate myself from my fascination and I tell her: 'It seems that Joana is showing me the work of Joana, here with Maria do Carmo, so that you can give form to the mysterious things that you think and dream about, what is a baby, a breast, a penis . . . Joana seems to have put all these kinds of things into this painting.' She gets up and comes behind me to observe the drawing from above my shoulder, perhaps through my eyes. 'This is for Maria do Carmo.'

I keep a special memory of that session as an experience of the reciprocity of the aesthetic appreciation. A beautiful girl gives a beautiful picture to a beautiful Mummy. Joana conceived a mysterious object, something we cannot see, but only dream or imagine. What is inside me, she is allowed to think but not to go there and look. But she still feels the need to check the 'real thing'. At the end of the session she comes and looks at the picture from over my shoulder and writes her name backwards, something balanced between private and secret.

But a week later it was the last session before the summer holidays when she's about to go to Spain: 'Today I'm going to draw the holidays of Maria do

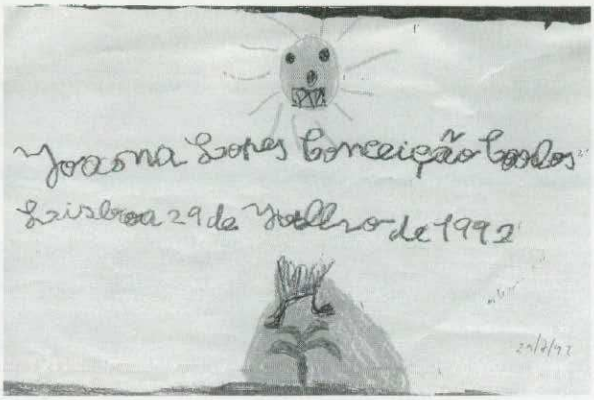

Figure 23: Yellow sun, pink writing

Carmo.' With the wax crayons she draws the sky, sea, sun, an island with a palm-tree. But, after a while, she begins to laugh loudly in a provocative and anxious way, and adds the red of a volcano to the island and the black to the sun. (Figure 23)

'Oh! Yes . . . Joana still doesn't know well enough, in her head, that when Maria do Carmo goes on holiday with her husband-sun, it is something good, or if the volcano Maria do Carmo does "psch, psch, psch" to a bad, dangerous sun-penis. If they are going to make a "dirty thing", an ugly baby, or a beautiful baby . . . Joana still needs Maria do Carmo to speak more about this.'

'No, no, look more, I'm going to write my name and the date.' She writes with great speed and now looks satisfied and calm.

I continue: 'Now, just before the holidays, Joana got confused again and uneasy about the "silliness" and the "dirty things" . . . maybe afraid of being far from Maria do Carmo, of being in Spain and feeling sad and ugly, instead of feeling like the Joana who is growing up and learning, like you felt when you wrote with such speed your name and the date, right here growing between the "sun-father" and the "mother-island".'

I felt she was still worried that her intrusive identifications could destroy the beauty of the object. Worried about what could happen inside her if she becomes ugly and dirty . . . a 'shit baby' from a confused and violent part-object intercourse.

I will end with the first session after these summer holidays in 1992. She seems to have grown a great deal, suggesting premature puberty. She wears around her neck several necklaces with plastic dummies of various sizes and colours. She tells me 'This is the latest fashion in Spain, it was my mother who bought them for me,' while she shows me the dummies. She looks around and then goes to see her things, and takes a deep breath. Although she seemed happy when we met, as soon as she came into the consulting room, I felt that she was unsatisfied, unstable. Finally, she picks up a pencil and draws a quick drawing while laughing loudly (Figure 24). 'Hey! This here is "father"

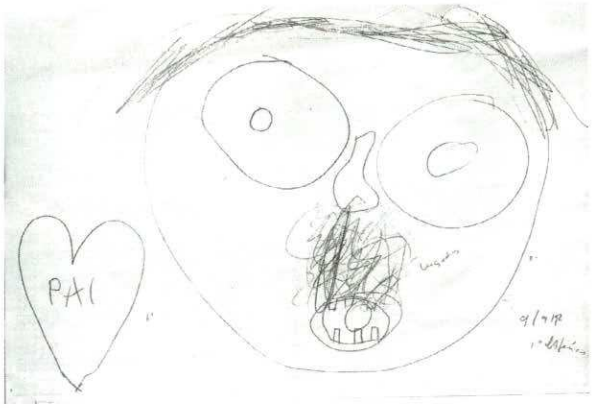

Figure 24: Black lines

and these are Maria do Carmo's holidays,' and she laughs in an anxious way.

'Joana imagines that during the holidays, Maria do Carmo was with her husband confusing everything! Breasts, penis, anus, vagina, mouth. When Maria do Carmo goes away these things still remain all mixed up in Joana's head.'

'Yes, yes, the moustache,' and now she scribbles heedlessly in the middle of the picture, laughing always.

I continue: 'Yes, the moustache . . . a great confusion of not being able to think when in her loneliness Joana starts to imagine that Maria do Carmo has her husband all to herself all of the time, and Joana gets excited with what all these moustaches are doing.'

She looks at me in silence and I feel she is sad. Then she tells me in a low voice: 'I went to Spain . . . the puppy died . . . In Spain a little girl had a puppy . . . the puppy died . . . the father died too . . . and the mother ran away.'

I feel touched and I go on speaking to her in a low voice: 'The little girl was very sad, little Joana was very sad . . . it is difficult to be little and also so lonely . . . it is still so difficult to be without Maria do Carmo.'

She then starts to tell me in a progressively clear way that 'the little dog was pregnant and she was going to have puppies, but the puppies were all born dead . . . but the vet said that the little dog is going to have more puppies . . . that she is thinking of a name that she is going to give to the puppy . . . that the father is going to buy a basket to put in the kitchen for the puppy to sleep in.'

At the end of the session, she asks: 'Are you going to see another child?'

She was already at the door of the elevator when she suddenly returns: 'I still have to pooh.' She went to the toilet to pooh her depression in safety, the pooh she had held all through the session without being sure if I was an understanding toilet-Mummy.

She starts by showing me that something in Spain had begun with vulgarization, something had corrupted her and she reports an internal event, a bad

dream that she couldn't wake up from: a good baby died, and she feels very sad because she realizes that she could kill my babies. Happily, her internal father, the vet says: 'No . . . no, you killed them inside, not outside . . . and what is inside can be repaired.' Besides this, she can see that I look all right and she can recover some hopefulness during the session. And I had understood that she is not yet ready to share the breast with a new analytical baby. That would be too much.

Joana remained another year in analysis (the fourth). She gave me the privilege of thinking with her about her special way of having, right from the beginning, an eye for beauty and an eye for the destruction of beauty. I keep thinking about the precious fragility of beauty.

Acknowledgement

Dr Meltzer kindly supervised this case after the summer of 1991. I am deeply grateful to him.

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Colour copies of the drawings are available by contacting The Editors, *BAP Journal*.

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Response to Maria do Carmo Sousa Lima's paper

MARGARET RUSTIN

What a task it is to match the delicacy of Maria do Carmo's reflections on her work with this very interesting child. I thought perhaps it would be helpful to begin by noting the double reference in the conference title – *Symbolic Thinking and the Aesthetic Experience in Psychoanalytic Work with Children*. For when we are talking about aesthetic experience in work with children we are of course speaking about the aesthetic experience of both child and therapist. These two may come together, as in the final session before the holiday where it was particularly clear-cut. Joana seems to me to be a little girl with an exceptional eye for beauty.

We sometimes see in the process of psychotherapy with a child the child's discovery of a capacity to see something as potentially beautiful. I found myself thinking about Sue Reid's paper about Georgie – a much more primitive child, much less capable of any kind of complex expression than Joana (Reid 1990). Georgie was a little boy who suddenly saw something as beautiful in the context of the ongoing therapy. Reid argues convincingly that this was a crucial developmental moment. The potential for the growth of creative capacity in a child is related to the therapist's continuous experiences of discovering the beauty of the psychoanalytic method. It is in fact an extraordinary privilege to engage with the aesthetic experience of another person as we can do during therapy. We could say that there are two potential creativities relating to each other. This is a very vivid tradition within child psychotherapy. Certain distinctive metaphors have become powerful markers in the child psychotherapy literature, for instance, the way in which Frances Tustin wrote about the 'black hole' which her little patient, John, described to her. I find myself thinking about my first experience of working with a severely psychotic child who had an imaginary set of creatures which were called 'collapsties'. These were pre-human beings, which I think relate a bit to Joana's 'things'.

Symbolic thinking becomes a possibility once there is a container which is big enough to contain the emotional experience which requires containment.

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Let us now turn to Joana's initial picture. I want to formulate a hypothesis about the parents' state of mind which I think is important to understanding what is happening. Maria presented us with a picture of parents who seemed to be rather innocent of experience. They had 'never heard of such things', and seemed tremendously immature. There was no sense that there could be an imaginative understanding of a child's nightmare and, indeed, one could envisage very clearly why Joana might never be able to wake up from her nightmares. There is nobody to wake up to if there isn't a parent there who knows what it might be like to be a child in a nightmare. It is even more terrifying to wake up if there is nothing there, than it is to stay asleep caught in the bad dream. The initial description of Joana's difficulties in terms of delayed language development, so that she cannot speak about things, seems to echo strongly a picture of parents who are unable to speak, to find a language for their child or for knowing anything about her emotional life.

Also powerful was the description of the mother's terrible panic about her initial contact with her baby in the outside world. Something catastrophic took place. A 'bloody', damaging catastrophe of coming to meet each other on the outside, from which there was then a shocked retreat and a traumatic and premature weaning. Joana then is left in a place with no one to wake up to, no one to touch, no one to feel seen by, a non-responsive world. The tantrums described were probably an experience of a collapse of an extremely fragile identity in which there was very little holding her together. I think we can suggest that very little would be needed for her to become completely fragmented.

When she first came to see her analyst we are given a picture of her as limp and apparently unable to use her eyes. Initially she could neither see what she was given to play with, nor Maria do Carmo. We need to imagine a child who is unable to use her eyes to relate – and this is what, of course, changes so dramatically in the process of the analysis. She is also not a child who has any proper relationship to the ground beneath her feet. She is walking on tiptoe, like many other psychotic children. There is no 'mother-ground' available to help her to feel grounded. It is not safe to put your whole foot on the ground if there is nothing solid there – better to make a very tentative contact so you don't just fall into a hole. We also see her not well rooted in her own body, with her falsetto voice, no depth, no connection between the inner space of her body, her vocal cords and her capacity to project something outside, and only a private language. Yet we do get a sense that there is some desire for communication in this child. She has not become completely silent. Even echolalia is a way of using language – a tremendously limited adhesive, echoing use, but there is something of language there. So we have a picture of non-relationship in this little girl but in quite an immediate way – and this is what is so astonishing about the first session, how much comes alive very quickly. There is a sense that she has an interest in a relationship if it could be made safe enough.

What she reveals from the beginning is that she already has an available language, the language of drawing. Nobody seems to have noticed that this little girl, despite her difficulties in using verbal language, has another language through which it might be possible to understand her. How absolutely fascinating to discover that a child, who after all is still quite young, is producing quite complicated drawings and yet her parents have not seen the significance of her capacity to use this medium. They said nothing about her interest in drawing and the relationship to colour and shape out of which this form of expression grows. I think this underlines the degree of their difficulty in understanding her.

Very early on, Joana introduces something called the 'thing'. One gets a sense that she is able to be in touch with this through her intense capacity to look inside, to look at her private visions, and in that way to communicate something about this 'thing'. The 'thing' seems to me to be a something which is not yet human. It's not a baby, it's certainly not a mummy, but it is a 'thing' which might become human, as indeed it does, when the lively, 'mouse' part of Joana appears in her sessions.

I would like to pick out some particular elements that struck me in her drawings. It seemed a very hopeful and important fact that, in the middle of all the 'things', she is able to draw a house, a place to be. It is clearly a container, and in one of the final pictures we see it become three-dimensional with all the 'silliness' related to Joana's conception of parental sexuality going on inside it. But to begin with it is not three-dimensional, and also it is not, just as Joana isn't, set on the ground. It is lost in space, but it does exist. Once the house is drawn and Maria do Carmo is able to relate to the house, Joana can imagine that there could be a link with this person and she looks at Maria do Carmo for the first time. She looks at an analyst who has had eyes to look at her and has seen something and in this moment Joana feels recognized and can then, in turn, begin to see Maria. One way of conceptualizing this mysterious 'thing' is to think of it as something like an unrecognized baby, one that hasn't been given a human sense of itself in any way. I found myself remembering the situation that one sometimes sees in an infant observation when it takes a long time for parents to find a name for their baby, where the baby hasn't yet fully become a person in their minds. Such a baby has greater difficulties in beginning to feel any kind of personhood within.

There is something deeply touching in Maria do Carmo's intuitive understanding of the importance of bodily containment and the connection she made, represented in the title of the paper, that having a name is a verbal way of having a skin, and feeling an identity. The creating of a boundary around the name written on the paper and the touching of the child's hand, which refers to there being an external skin/boundary, brings things together in a way which seems to be very meaningful for Joana. Previously unintegrated senses of sight and touch now come together for her.

Another prominent feature of many of the drawings is that there are eyes everywhere; many of her 'things' have something eye-like within them. It is clear that for this little girl looking is an aesthetic experience, both the potential for looking with appreciation, admiration, love and for seeing the world as a beautiful place, but, as we can also see, forms of looking which convey hatred, which destroy and make ugly. Making beautiful and making ugly are what eyes can do.

In the sequence of drawings from the early months of therapy we can see sadness, loneliness, and also some autistic-type 'hard' solutions. One wonders, when one hears about this little girl's material, how to understand the place of these autistic elements. In the first drawing with shapes which are then coloured in yellow and seem very hard, there is perhaps something which one could see as a kind of autistic cut-off – the yellow she uses is a very non-human somewhat metallic colour. Also evident are psychotic anxieties to do with melting and fragmentation. A very interesting use of colour occurred when red and a very strong dark pink began to appear. I think her anger was becoming accessible and we see crosses on the paper. A very cross little girl was coming into view in therapy. There is also tremendous chaos and uncontainment, and the potential for being a creature who falls out of whatever fragile containment there is, and gets lost on the edge of something. Nonetheless, a bit of order is continuously being created out of the chaos. There is a dynamic process between order and chaos from the very beginning.

In the 'Birth of the World' drawing, which Maria do Carmo spoke about with such feeling, lots of ideas spring to mind. There were two that I want to contribute. One relates to what was quoted as Dr Meltzer's response to this drawing, where he has the idea that this is the birth of alpha, that alpha is coming out. I was struck by the chain-like things which go right to the edge of the picture and clearly continue beyond the picture. It seemed to me that here we see a primitive representation of links, and something it does is link one thing with the next thing, which is perhaps one aspect of the idea about alpha function. The other thing that I was struck by in this drawing was that the central form of the drawing is reminiscent of a crab. I thought about this as a pre-summer holiday drawing and probably a child who goes to the beach (we are in Portugal, after all, where shellfish are a big thing) and I thought how interesting that this little girl maybe needs a very hard shell at this point to survive the holiday that is coming. One could see the arms and legs coming from underneath the crab's shell as the links. This crab can walk, and there is a sense of being able to get back, to return. How interesting that when Joana does return, although there is all the panic about the tooth, she is walking so much more strongly. She is not any longer the little girl on tiptoes. She has something much more solid within her and within her relationship to the external world.

The drama of the lost tooth: what a marvellous coincidence to lose a tooth just at the point of return from the first summer holiday from analysis! It is quite extraordinary how sometimes things match in an almost magical way,

because clearly she has hung on over the holiday, as is represented by her general strengthening, and almost at the last minute this potential catastrophe strikes, this falling to pieces which is represented by the tooth that falls out. In fact, she is already home again, mother can ring Maria do Carmo, all is not lost. I was interested by a slightly different aspect of the tooth material to do with her awareness of and interest in her teeth at this point. I think this is not only to do with the terror of losing parts of the self and the more psychotic anxieties that have been worked on in the first year of treatment, but also the greater capacity to be aware of her aggressiveness, which is located, in the infantile mind, predominantly in the teeth, nails, etc. The discovery of having teeth and having edge, a capacity to bite, to hurt, to be cruel but also to chew, to engage with life – aggression can be used for good and bad purposes, and that is what seems so important about her interest in Maria do Carmo's teeth. A difficulty that this kind of child has is in distinguishing the need to engage with life with one's aggression, i.e. aggression in the service of grasping life, as opposed to destructive aggression. I was reminded of another psychotic patient of mine who used to have the most terrifying tantrums when she would experience a total sense of turning liquid. The discovery that she had bones seemed to have a similar strengthening function for her to Joana's discovery of teeth. This was a moment at which Joana could recover from the trauma of her mother's projection into her of an image of a baby who would bite and damage the breast, a catastrophic confusion of blood and milk.

I was interested and moved by Joana's final beautiful drawing. I understand this as a drawing of Maria do Carmo's intercourse with her, of her imagining of all forms of intercourse, the two shapes that weave in and out of each other and create life, babies, and so on. Down the centre of these two things which interweave there is a backbone, like my patient's relationship to her bones that enabled her to realize that if she was in a rage she wouldn't melt because there was a skeleton holding her together. I would like to hear more about the skeletal structure/paternal function in Joana's world which I sense is an extremely important feature of her experience of analysis. Her picture of the heavenly bodies seems to me to be a representation of a restored internal family in which sun, moon and stars, parents and children, now all have their appointed place. Her night terrors have been replaced by a capacity for dreaming. We can now understand that her delayed language was probably linked to a contamination of words, in which they become saturated with sexuality and unavailable for ordinary communication.

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Knowing and being known: the intersubjective field when matters of life and death affect both psychotherapist and patient

DVORA MILLER-FLORSHEIM

ABSTRACT

The paper uses the experience of the author's life-threatening illness of breast cancer to discuss the intersubjective meaning that such an event stimulated in both the therapist and in the patient who had herself recovered from the same illness. Inevitably, physical illness interrupts the secure indwelling within one's body and can be experienced by both therapist and patient as a breach of an 'omnipotence contract'. Instead of seeing the illness as an intrusion into psychoanalytic work, the author prefers to see it as an integral and inescapable part of it. Accordingly, in such an intersubjective field, the therapist has to struggle not only with self-disclosure, which is the main issue in most of the literature, but with how to maintain a professional relationship in a way that protects the patient from abuse and preserves the analytic space. The case study describes a deeply emotionally deprived and abused patient who, like the author, had experienced many deaths and losses in her life as well as her own life-threatening illness. The author discusses the path which has to be negotiated between the subjective and objective realities to the point where the patient can feel known in a new way and can know the therapist as a separate, emotionally alive and containing figure.

Key words therapist's illness, intersubjectivity, conjunction and disjunction, inescapable self-disclosure

Introduction

According to the English poet and clergyman John Donne (1573–1631), no more than a comma separates life from death. The meaning of life and death, each alone and both together, resounds throughout the work of writers, poets,

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and philosophers. As psychotherapists, we accompany our patients through the process of examining their lives, the times of beauty and of pain, of missed opportunities and satisfactions, of crisis and recovery. But what about our own?

Heinrich Racker (1968) wrote what may be described as the 'anthem' of contemporary relational psychoanalysis. According to Racker, 'the first distortion of truth in "the myth of the analytic situation" is that analysis is an interaction between a sick person and a healthy one. The truth is that it is an interaction between two personalities . . . Each personality has its internal and external dependencies, anxieties and pathological defenses; each one is also a child with his internal parents; and each of these whole personalities, that of the analysand and that of the analyst, responds to every event of the analytic situation.'

In this paper I would like to use the experience of my own life-threatening illness as an opportunity to consider some of the intersubjective meanings that such an event can stimulate in both patient and therapist. I shall try to explore, as openly and authentically as possible, how our personal selves touch upon our professional selves. What happens when both therapist and patient must suddenly confront their vulnerability, the harshness of fate, and fears of destruction? This is a journey through a psychotherapeutic interaction where both patient and therapist are physically ill, where issues of life and death are at the centre of the interaction (or subjective field), where self-disclosure becomes inescapable, and where the conjunctions and disjunctions between my patient and myself are rife.

The journey began four years ago, when I was operated on for breast cancer. As typically happens, the immediate reaction to the news that one has cancer is shock and unpreparedness. At the same time, the medical arrangements are made very quickly. That is the easy part. In my case, they included an operation (a radical mastectomy is no longer required) and a six-month course of chemotherapy administered every three weeks. I received the treatment at the beginning of the week, so that by Tuesday I was already back at work in the office, incredibly weak, but unwilling to give in. Except for a dramatic change of hairstyle (it was now very short, but I never lost all my hair), and another unexpected two weeks in isolation in the hospital, I tried to maintain my regular routine. On the surface, it seemed there would be no need to say anything to my patients about the cancer that had intruded on their therapy. That was the overtly discernible side of the illness.

It was not only the beginning of a long journey into physical suffering, but also of an emotional and mental journey as well. It took me a long time and a lot of introspective work to realize that I was not going to die of cancer right away – I was going to have to live with it. I learned that cancer is not something you can ever stop worrying about. Both invisible and invasive, with an

outcome at best unpredictable and at worst fatal, cancer can certainly plunge the person of the therapist into a state of uncertainty, anxiety, and even terror. I remembered what Freud said: most likely our fear still implies the old belief that the dead man becomes the enemy of the survivor. Nor could I ignore the professional literature that deals with the psychological factors in the origin and development of cancer, for example, the loss of hope that one can ever live one's life in a meaningful, zestful way (LeShan 1994), or, as the poet W.H. Auden defined cancer, 'foiled creative fire'. The contemporary emphasis is on each woman's individual decision as to how to prevent breast cancer. The modern versions of gaining control, which replace the amulets of old with 'positive thinking', 'green tea', and the like, have given many women the sense that if they do fall prey to the disease it is somehow their fault. The blatant accusatory tone of many of the books purporting to promote healing is not only of no help, but is actually a trap. As a psychologist who deals constantly with the connection between the mind and the body, this sort of message can be more of a burden than an aid. The latest research suggesting that the disease is caused by a gene does not make it any easier for me either, especially as the daughter of a stricken mother, and as the mother of a daughter myself.

Confronting life and death is nothing new for me. Cancer is virtually a deterministic presence in my family. I held both my parents' hands as they walked down that road of torment, and parted in similar fashion from a beloved aunt and two cousins. Perhaps I was thrown by birth into the very heart of the struggle between annihilation and continuity, the daughter of a mother who survived the Holocaust and a father whose first wife died in childbirth.

But there has also been another side to the illness: an energizing and enrichment, a greater attunement to my patients as well as to myself, a sense of myself as courageous and emotionally strong, of experiencing the crisis as an opportunity, perhaps even a turning point. It goes without saying that contending with cancer is an ongoing and complex effort that can in no way be spoken of in the past tense. I imagine that my decision to disclose my illness to some of my patients, to my colleagues and friends and here in this paper is an integral part of that struggle and my working through it, a decision that stems from who I know myself to be as a person and as a practising clinician. For me, then, this paper represents what we hope our patients will find from their analyses with us – some positive legacy born out of pain and something to offer others from the struggle.

As I searched for references in the literature, I found two major types of sources on which I could draw. The first category includes the relational and intersubjective approaches, which discuss the use of the therapist's subjectivity for the benefit of the patient. The second category includes articles relating to illness or crises in the personal life of the therapist.

Intersubjectivity

Classic psychoanalysis and analytical psychotherapy distinguish between the patient, who is invited to say 'anything that comes to his mind' (Freud 1919; LaPlanche 1973: 169), totally uncensored, and the therapist, who is cautioned to maintain anonymity, neutrality, and abstinence. The therapist is meant to be no more than a 'blank screen'. The basic assumption here is that knowledge is the great enemy of fantasy. The relational approach and intersubjective approach (which grew out of self-psychology), on the other hand, define the nature of the therapeutic session in a different manner. In Racker's terms, it is a meeting between two three-dimensional personalities, two people with a role to play, with all that implies.

Aron develops the notion that psychoanalysis is, in many respects, a mutual process based on a mutual relationship, but one that must simultaneously and inevitably remain asymmetrical. This means that 'while analyst and patient share a great deal, and while influence and regulation move in both directions, that influence is not necessarily equal, nor do patient and analyst have equivalent or corresponding roles or responsibilities' (Aron 1996: xi). Accordingly, counter-transference is broadened into the concept of 'subjectivity.' Renik (1993) contends that an analyst's efforts to minimize his or her personal involvement and subjectivity are doomed to failure. Instead, he recommends that we be more forthcoming about our reactions, so that our patients will be able to deal with our subjectivity more openly. For Stolorow and his colleagues, the term intersubjectivity is applied whenever two subjectivities constitute the field, even if one does not recognize the other as a separate subjectivity.

The objectives of therapy are also defined differently by the new approaches. Stress is now laid on creating an intersubjective space which will allow for renewed growth and discovery of the real self (Aron 1996; Stolorow et al. 1987). The major thrust of the therapy shifts from examining unconscious contents to investigating the being and experiencing that exists beyond potential space, to use Winnicott's terms. The subjectivity of the analyst is not an impediment to therapy; on the contrary, it is an integral part of the dialogue.

The continual interplay between the psychological worlds of the patient and analyst produce two basic situations: intersubjective conjunction and intersubjective disjunction (Stolorow 1995). The first consists of instances in which the principles organizing the patient's experiences give rise to expressions that are assimilated into closely similar central configurations in the psychological life of the analyst. Disjunction, on the other hand, occurs when the analyst assimilates the material expressed by the patient into configurations that significantly alter its meaning for the patient.

These approaches naturally deal extensively with questions of the therapist's direct and deliberate self-disclosure, undoubtedly one of the most controversial

issues in contemporary psychoanalysis. On the whole, such self-disclosure was frowned upon and was not regarded as a legitimate technique. It was generally mentioned only in the context of failures in countertransference, where it was commonly regarded as a manifestation of exhibitionism, an unconscious attempt to satisfy infantile desires rooted in the primal scene, an unnecessary burden on the patient, or a defence mechanism protecting the analyst from the patient's emotions. One of the most common objections to self-disclosure (voiced even by relational therapists) is that it may impair the transitional space of analysis by concretizing what should remain symbolic. In response to this criticism, Aron states his primary contention: analytic anonymity is a myth; self-disclosure is an unavoidable and omnipresent element of treatment – it occurs of its own accord (Ferenczi 1988; Greenberg 1995). Instead of the vain effort to maintain a therapeutic posture of anonymity and objectivity, analysts should adopt a 'transparency' that allows them, under certain conditions, to deliberately reveal their motives, attitudes, and feelings to the patient. Such voluntary self-disclosure may be perceived as an expression of giving and intimacy, but even more importantly, it enables patients to 'use' the therapist's subjectivity in order to facilitate understanding of their own subjectivity. The degree and nature of the analyst's deliberate self-revelation are left open, to be resolved in the context of each unique psychoanalytic situation. Inevitable self-disclosure is not only the product of the therapeutic dialogue. It is, above all, an inherent developmental situation. Just as children observe and study their parents' personalities, our patients study ours. Children attempt to make contact with their parents, and patients with their therapists, by reaching into the other's inner world. The question is how the patient's parents actually responded to the child's observations and perception of them (Aron 1996: 83).

Kleinian imagery describes the infant's unconscious fantasy of re-entering the mother's body (Klein 1932). We might thus ask whether these violent, destructive fantasies are due merely to innate greed and envy, or whether they may also result from the frustration of being denied access to the core of the parent. Could these fantasies be an accurate reflection of the child's perceptions of the parent's fear of being intimately penetrated, fully known? At the same time, while waiting to be found, the child needs to remain hidden, unfound and untouched by others (Winnicott 1963). The patient and the analyst each want to be known and to hide, and each wants to know the other and to avoid knowledge of the other.

Jessica Benjamin introduces an additional developmental aspect, viewing intersubjectivity not as a given, but as a developmental or therapeutic goal, stating: 'In all our theories of development, the mother has been portrayed as the object of the infant's drives and the fulfiller of the baby's needs. We have been slow to recognize or acknowledge the mother as a subject in her own right' (Benjamin 1988: 24). The child must come to recognize the mother as a separate other with her own inner world and her own experiences, and as being her own centre of initiative, an agent of her own desire.' According to

Benjamin, the child's expanding capacity to do this represents an important, and previously unrecognized, developmental achievement.

Aron (1996) believes that each analyst–patient pair needs to work out a unique way of handling this precarious balance. From this perspective, both patient and analyst function as subject and object, as co-participants working on the very edge of intimacy.

The illness of the therapist

If I may allow myself a personal remark at this stage, when reading material on these issues, I feel I am conversing with close friends who are insightfully opening up their lives, both personal and analytic, in unusually profound ways. Recently, Sue Shapiro has urged therapists to write their 'background stories' more often, making it 'easier for us therapists to explore our own subjectivity' (Shapiro 1993: 378).

Freud described how an ill person withdraws his libidinal cathexis from the outer world and reinvests it in his own body. Only when he recovers is he again free to invest in other objects. Despite severe pain and discomfort during his later years, Freud continued to be active and to produce some of his major works (Jones 1957; Schur 1972: 383). The story of his illness, however, is closely related to the question of disclosure and non-disclosure. One of the most moving anecdotes about his life concerns this aspect of his personality. In a letter to his wife, Ernest Jones describes the anxious atmosphere surrounding Freud's illness. The most important piece of news, he wrote, was that Freud did, in fact, have cancer and that it was developing slowly and might go on for years. However, he was unaware of this fact, and it had to be kept secret. When Freud realized that his doctor friends were keeping the truth about his condition from him, he became infuriated and felt they were patronizing him. Peter Gay (1988) states that for Freud, telling the truth, no matter how hard to swallow, was the most merciful approach. Although he stressed the importance of honesty in the doctor–patient encounter, from what we can understand he did not for the most part deal with the impact of the sixteen-year-long struggle with what he called his 'dear old cancer' on his patients. In his correspondence, for example, he thanks a colleague for not mentioning his obvious recent surgery. At a certain stage in the illness he referred the patient known as the 'Wolf-Man' to Ruth Mack Brunswick for further analysis. Although Mack Brunswick describes the impact of Freud's cancer on the Wolf-Man's symptoms and transference, the illness was in no way worked through in the course of the analysis.

A related anecdote concerns Winnicott, about whom Margaret Little reports:

> One day his secretary told me that he was not well and would be a little late for my session. He came, looking grey and very ill, saying he had laryngitis. I said: 'You have not

> got laryngitis, you have got a coronary. Go home.' He insisted that it was laryngitis, but he couldn't carry on. He rang me that evening and said: 'You were right. It is a coronary.' This meant quite a long break, which was very painful, but at last *I was allowed to know the truth.* I could be right and I could trust my own perceptions. It was a landmark, and he knew it. (Little 1958; emphasis mine – DF)

This story reveals not only how critical knowledge of the truth was for Margaret Little, but also Winnicott's attempt at 'healthy denial' and refusal to consider his own mortality. It was, in fact, Winnicott who formulated the rule 'It is the analyst's job in therapy to survive', stating: 'In doing psychoanalysis, I aim at: keeping alive, keeping well, keeping awake . . . Having begun an analysis, I expect to continue with it, to survive it and end it' (Winnicott 1965: 166).

As I see it, no other issue embodies the professional and scientific commitment to therapy and the most profound meaning of the therapeutic relationship as fully as the disease or death of the therapist. Although personal crises and acute chronic diseases are no longer a secret, little attention has been given these issues in the literature. Schwartz and Silver's *The Therapist's Illness* (1990) and Gerson's *The Therapist as a Human Being* (1996) appear to be the first books to discuss at length not only the technical but also the existential aspects involved. On the whole, the question of analysts' self-disclosure of the facts of their physical health has been the central question in much of the literature, where concern for transference changes in the face of decreased anonymity is expressed. The nature and degree of this concern varies in accordance with the analyst's theoretical orientation, although increased self-revelation seems to be the norm in times of physical change.

From a review of the scant literature available, it appears to me that each therapist contends with the problem on the basis of his or her particular life experience. In Mitchell's words:

> Just as there is no one generic analyst, there is also no generic way to deal with crises and traumas in the analyst's life. If one gives up belief in the magic cloak of invisibility provided by classical theory of technique, there are enormous numbers of complex choices to be made: What to listen for? What to speak about? How much to tell? There are certainly wrong decisions, when patients are hurt and treatments damaged, but there is no right decision in the sense of a singular correct choice . . . And although we cannot learn how to do it from someone else, we can learn a great deal from each another. (Mitchell 1996: 295–96.)

One person from whom I have learned is Amy Morrison (1997) who bravely reports on the position she adopted in her work during her 11-year struggle with breast cancer. She writes about the process of deciding what and when to tell her patients about her illness, and how to handle the questions of accepting new patients, termination, and referral. Morrison continued to work to the very end as her health deteriorated. Her husband, Andrew Morrison,

wrote a touching paper on his own crisis after her death and its implications for his clinical work.

Pizer (1998), another therapist who suffered from breast cancer, states that what distinguishes between inescapable and deliberate self-disclosure are the elements of time and choice. In the first type, the analyst's subjective choice of what and how much to say is dictated by obtrusive circumstances, rather than by the intrinsic clinical process.

Beyond the question of self-disclosure, little attention has been directed to the consequences of a therapist's life crisis on the course of treatment. The therapeutic problem lies in the need to adequately explore the full gamut of the patient's responses, affects, and associations to the illness, and to do this in the face of complicated countertransference temptations.

Durban et al. (1993) focus on the extent of damage to the capacity to contain, addressing the impact of chronic illness on the therapeutic setting, contract, and language, as well as on certain less overt features of chronicity. These authors claim that working through the paranoid, sadomasochistic and exhibitionistic elements has the potential to enlarge our inner space and enable further containment, both of our own self and of the other. The interminable struggle of the 'wounded therapist' requires that he confront the fact that the only certainty in life is that it is unexpected and uncontrollable, and that he abandon his view of himself as an ideal self (Durban et al. 1993: 710). Having said that, the illustrative examples they offer are all presented in the third person. I would agree with Colson, who notes the generally sparse information available regarding the details and subjective experience of analysts' illnesses, denying us the opportunity to examine 'how the hopes, disappointments, and sufferings that are at the heart of being seriously ill and the fearing for one's life affect the analytic work' (Colson 1995: 460). In the case study presented below, I hope to make a small contribution to advancing our understanding of these issues.

Clinical case study

Therapy with Sara began some two and a half years before I fell ill, and has continued for several years since then. Sara is seriously overweight, and has protruding, somewhat frightened eyes. Whenever the door opens, I see a large woman with the shy expression of a little girl. Her body language seems to say: I cannot contain my body and my body cannot contain me. I wish I were invisible, but I'm so conspicuous. She designs her own clothes, which display marks of charm, taste, and attention to detail, and she is an extremely intelligent woman with a sharp mind and a very witty, albeit cynical, sense of humour.

Upon entering therapy, Sara complained of a number of general symptoms: depression, difficulty in functioning, a sense of hopelessness, compulsive

overeating, marital problems, and an extremely low self-image permeated with shame and guilt. We decided on twice-weekly face-to-face sessions. The suggestion that she lie down on the couch seemed highly traumatic, an 'indecent proposal' that would not be quickly forgotten. To this day, Sara is unwilling to make this change.

She had no difficulty reporting her history from the time of her marriage. At the age of 18, she came to Israel in order to get away from home. Shortly thereafter, she learned that her mother had died suddenly at approximately the age at which I myself became ill. She did not go home for the funeral. Not long after that, she met her husband. The wedding, not attended by either set of parents, took place in the home of distant relatives and she felt it was a shabby, makeshift affair.

Seventeen years ago, when her children were still quite young, she was diagnosed with breast cancer and underwent a mastectomy (without any other treatments.) Four years later, she underwent a preventive hysterectomy. At this point she became totally overwhelmed by her rage at her neglectful, absent husband, her depression, and her sense of loss. She grew fatter and fatter, transforming her damaged body into a testament to her suffering.

At approximately the same time, Sara's sister, until then a single woman who for years had functioned as their father's 'companion', got married. Soon after the wedding, she too was diagnosed with progressive breast cancer. Her condition deteriorated rapidly until her agonizing death. Sara went through several extremely difficult years of mourning. On the one hand, she was relieved at being released from her sister's 'stranglehold' of concern, which had also been critical and belittling. On the other hand, however, she had unconscious guilt feelings at having survived the disease and built a 'happy' family, unlike her sister.

In contrast to the detailed reporting of the present, Sara's memories of her childhood were vague and fragmented. On the intersubjective stage of the therapy, the leading characters in her life began to take shape. Sara's well-to-do parents had a spacious home. Nevertheless, she slept in her parents' room until the age of eight. She recalled frightening sounds in the night, the terror of her father by day, the capricious enforcement of trivial rules, and occasional affection as a reward for good behaviour. Although she could not recall when it began, she remembered being called into the bathroom to watch her father and touch his genitals. Perhaps it is not surprising that only later, in therapy, did she remember in panic her mother's depression, death, and absence. She described her mother as someone who was always exhausted, a despondent woman who existed in a state of inertia. She perceived herself as the cause of her mother's debility and hopelessness. She felt guilty not only for her forbidden desires, but also for her very existence.

As was to be expected, Sara developed all the post-traumatic and personality symptoms of anyone who undergoes childhood experiences such as these.

In this paper, however, I would like to focus on the aspects relating to life and death in the intersubjective field.

Whatever terms we use to describe it, either Andre Green's 'dead mother' syndrome (Green 1986: 142–73) or Grotstein's 'black holes' (Grotstein 1990), what was highly apparent in Sara was the lack of an inner sense of belonging to a mother. As described by Adams (2000), there was a sense of her 'being on the outside, of always living on the edge of an abyss, of feeling empty inside, of feeling she did not matter, and perhaps most of all, of feeling she wanted to die'.

In Sara's case, it was undoubtedly not only the figure of the dead mother that created 'emotional holes' and a sense of the abyss. She had been 'robbed' twice. She was the victim of what Bollas (1987) calls 'extractive introjection' on the part of both her mother and her father. This term is used to describe a situation in which a parent steals part of the child for his or her own needs, so that the child is condemned to live the object and history of the parent. Moreover, since the stolen parts are replaced by emptiness and despair, there is inevitably a death wish, a desire to kill the body that serves as some sort of silent monument to suffering, humiliation, pleasure, and shame.

Throughout my contacts with Sara, I could almost always sense the presence of what Green (1993) calls 'the empire of the dead mother' who grasps, sucks and empties out, as well as that of the father permeating every corner of her objective and subjective life. Sara threw her whole weight in my direction, the castration of her femininity, her damaged body, and death. She entrusted me with her passivity in respect to her fate (in one childhood memory, she is sitting alone on a chair, covered in flies; she does not chase them away and they keep biting at her). She entrusted me with her loneliness and her sense of rejection in her marriage, and after the divorce, with her anxieties of being abandoned by her children.

Sara also entrusted me with her need for total presence, without any 'holes', silences, or spaces between therapy sessions, and most definitely without any time off for holidays. She could not tolerate the void that yawned when she was not an integral part of me, when she did not have full control and ownership of me – as her father had had of her. But she also entrusted me with her aesthetic side. For a long time she found it difficult to fight her tangible need to fill my office with pretty things (mostly butterflies and flowers). So too, the organized parts of her, the good life, and the travels she made in her fantasies were placed solely in my hands. We functioned as a mutual self-system, a sort of parasitic relationship in which I was the one who had the answers and was full, and she was the one who was empty. (In her dream, we were sitting in her home. My daughter and I were wrapping presents, while she and her daughter were toiling to clean up a mess of cat dung. She felt envy and shame.)

At this phase of the therapy, I felt that Sara needed me totally as an object, in the role of mirror or, as Winnicott (1971) phrases it, as the face of a mother

in which nothing is reflected but the infant itself. Ever since I told her she had never been tucked in, had never been covered, she fell asleep imagining me doing it. I had to identify, listen to her needs, bear and process her sense of death and provide emotions, life, love, and responsiveness. In this phase I was contained by Bion's words: 'When the patient strove to rid himself of fears of death within him, he splits off the fears from himself and puts them in me, and the idea is that if they can stay there peacefully long enough, they will be modified by my soul and can then be again safely internalized in him' (1967).

Grinberg (1991) takes this one step further:

> The receptive attitude of the analyst reveals itself by his consent to be invaded by the projections of . . . the analysand's psychotic anxieties, and by his ability to feel, think, and share the emotions contained in such projections as if they were a part on his own self, whatever their nature (murderous hate, fear of death, catastrophic terror, etc.). (Grinberg 1991: 21)

Similarly, Bollas contends that the fact that the analyst's

> internal life is the object of the analysand's intersubjective claim is known . . . to analyst and patient alike. Disturbed patients, or analysands in very distressed states of mind, know they are disturbing the analyst . . . To answer the question 'How does the patient at a preoedipal level employ us?' we must turn to countertransference and ask of ourselves, 'How do we feel used?'. (Bollas 1987: 200–3)

From the very start of therapy, Sara's plight moved me deeply. Her wounded bleeding body, her illness, her magnetic, yet obviously vulnerable, personality, her helplessness and the sense that we were dealing with matters of life and death – all these made her a very precious, although highly demanding, patient. I felt I had to make an effort to maintain the boundaries of therapy, along with a need to respond at times like a real object. I was aware of the danger of falling into the narcissistic trap of playing the all-knowing saviour, as well as Sara's total avoidance of any expression of negative transference. The presence of chronic traumatic experiences in her past, the huge damage they caused, and the various dramas and attacks on her body and her children in the present required that I attend to both the external and the internal reality. This was a particularly difficult task in view of the fact that her internal life and capacity to fantasize and symbolize were severely impaired (Bollas 1989: 171–80).

After about two years of working with Sara and at a time when I was worried by what was happening in my own breast and body, I presented her at a training seminar and heard Nina Farhi say: 'In a parasitic relationship such as this, some patients can make us ill.' I thought of the tragic-ironic element of both Sara and her sister absorbing their mother's ruined breast. With considerable unease I remembered when Sara had just started therapy and spoke like a prophet of doom about all those healthy people and how some day it would be their turn to spend time on the oncology ward.

When I returned from the hospital, one of the most urgent questions I had to face was that of self-disclosure. What should I say? How much should I say? To whom? How? In general, I felt I would work better if I could acquaint my patients with what was going on. The circumstances of my life had already intruded on their therapy and were likely to do so again. Nevertheless, I expected there to be differences in what felt right with each of the individual patients. There was no doubt that it would feel different with Sara.

I believed I had to speak with Sara about my illness. I did not see any other option. First, she would know in any case, as she had known so much about me thanks to her penetrating perceptiveness. More than that, however, in this specific case, sitting opposite Sara, a 'wounded woman' who had herself had breast cancer, I could not imagine keeping my condition a secret. The first association that came to mind was humiliation, kicking her out of the house, forcing her into her childhood hiding place in the attic, giving her the sense that my illness was somehow less shameful than hers. As I was also aware of the dynamics and price of keeping a secret, I believed that in this case the secret in the room would cast a heavy shadow over our therapeutic relationship. So I told Sara that I had breast cancer and informed her of the expected course of treatments. She paled, but also became furious that I had not told her the facts *before* the operation. She tried to recommend her doctor, fought the desire to cook for my children, but most of all was terrified. She was afraid to think I had fallen ill because I had not taken good enough care of myself, that the conditions of my life were frustrating, that there was a psychological side to my disease. At the same time, she envied me as she was sure I was surrounded by people who cared for me, and would not have to face it alone as she had. But, beyond mere information, what was most significant from this time on was her need, indeed her demand, that I share everything with her (even when I cancelled a meeting for nothing more serious than the flu) and not leave her alone to cope with the destructive fantasies which immediately took shape in her mind.

Although two women with damaged menacing breasts were seated in the room, there was no space there for a feminine dialogue, perhaps because of the near-fatal attack on Sara's femininity in her childhood, or perhaps because of the problematical intergenerational transference between Sara and her mother, Sara and her daughter, and Sara and me. Or maybe the space had not yet been created. One of the things that Sara had brought to the office was a clay statuette of a broad-hipped woman on a swing, her dress flying up. There were cracks in the clay, and the statuette soon started to fall apart. Sara asked the sculptress to make another one and brought it to the office, but it suffered the same fate.

Shortly afterward, Sara began to suffer from horrific afflictions that primarily attacked her face and the scar tissue of her amputated breast. Now her monstrousness could no longer be ignored, she said. There is no doubt that the 'crack in the container' nearly grew into a fracture.

In the course of time, my illness, in both her existence and mine, was transformed from foreground into background, from the drama itself to the stage on which it was performed. Sara found it hard to accept that the stage was not so fragile, and that she was not the one who was destroying it.

She began to grow stronger and to work through her anxieties concerning the imminent separation from her children who were leaving home. When she learned of her husband's extramarital affairs, she immediately suggested that they divorce, and he agreed. It took a great deal of therapeutic work to distinguish between the manner in which Sara hastened to rid herself of all the people leaving her and her ability to separate from them. In the space created, she began to care for her neglected, damaged body. She lost weight and started to see a light at the end of the tunnel. However, in the quiet that now loomed, the repressed voices from the cellars of her past were making themselves heard. We both realized that we could not expect some magic transformation without crossing the road of horrors. It was painstaking work to put together the tiny, elusive pieces of the complex puzzle.

At this stage, known in the theory of trauma therapy as remembering and mourning (Herman 1992), the idea of joining a group of survivors of sexual abuse was again raised. Sara waited six months for the group to get organized. The group leaders, about whose parenting abilities Sara had serious doubts, kept putting off the starting date. As I was making plans to attend a weekend conference in Paris, I was astonished to learn that the first session of the group had now been scheduled for precisely the same date. Overcome by the guilt of a mother abandoning Sara to her abusers, I mumbled out the news that I would be away then. I felt confused and so lost that I began to think that perhaps I should forego my trip, and had to contend with the rage of a mother whose child should be grown by now but continues to cling to her. In this state, I remembered Bollas' words:

> In moments such as these, who is the patient? In my view, much of the work of analysis will have to take place within the analyst . . . since it is the analyst who, through his situational illness, is the patient in greatest need. To be sure, in treating myself I am also attending to the patient, for my own disturbance in some way reflects the patient's transference. (Bollas 1987: 205)

I now learned more about mother–daughter separation and the all too familiar guilt I felt for having a different and less traumatic life than my mother or Sara. At the same time, there was anger and envy of my mother who only had to start contending with cancer when she was 15 years older than I am, and of Sara whose illness was not only 17 years in the past but discovered at a less progressive stage than mine. And let us not forget the desire to hurry up and live my life.

Sara knew immediately that I was going to Paris, the symbol of aesthetic beauty, just like her psychologist friend. She became infuriated, not about the trip *per se*, but that I had kept it a secret from her for so long. Another feeling

was hovering in the air of the room, what Bollas calls the 'unthought known', that her very 'day of judgment' had also been the date of my operation. What she said in the group was: 'They – our parents – screwed up our lives and now my therapist has gone to Paris.' Then she described the physical pain she had suffered, the ripping feeling she had at moments of parting. 'We're not one body any more. It's awful, because all the neglect, all the illness, all the death will be in my body. It's awful because then the envy will also be unbearable.' She recalled how her mother, terrified of separation, did not send her to kindergarten for years. When she finally went, she held onto her mother's skirt at the kindergarten door, reluctant to leave her. Her mother tore herself from her by force and left. In Sara's perception, she evaporated again. Sara then related a dream: in a parking lot, she sees a car in a state of total loss after an accident. She wonders how the people inside got out alive and unhurt. I felt a sense of relief that this time Sara was transforming the destruction of her inner world into a dream. I grasped at this hint in the dream to believe that perhaps the experience of some good-enough mothering with me had numbed the destruction.

Conclusion

The story of death knocking on the door appears in numerous societies in every conceivable form. People think, write, and pray about death, they flirt with it, and try to comprehend and analyse it, and then one day, when they least expect it, there it is. Ramon Gomez de la Serna (1992) wrote that death is the place where there are no breasts. A woman's breasts, beyond the concept of the 'good and bad' breast in psychoanalytic theory, embody the existential tension between Eros and Thanatos: they give life and symbolize the transition from girl to woman and motherhood, and they also take life.

In this paper, I have attempted to open a window on the pain, the power, and perhaps the potential beauty in my encounter with Sara from the perspective of our similarities and differences, what Stolorow would call intersubjective conjunction and intersubjective disjunction. In view of the presence of death in her life and mine, I have sought to consider what happens when, in the course of the therapeutic encounter, it suddenly emerges that both therapist and patient share a common world. The Jewish philosopher Martin Buber (1967) calls this realm 'interhuman' and refers to the process as an 'inclusion'.

Although Sara recovered from cancer, she in no way recovered from the hold that death had over her life. The fact that I was diagnosed with cancer two and a half years into her therapy, at a stage when she needed me to be indestructible, vital, and enduring, brutally invaded the intersubjective field and presented me with cardinal professional and human dilemmas. These issues went far beyond the questions of self-disclosure that preoccupy most of contemporary theoretical literature.

As I have said, in this instance self-disclosure seemed inescapable, and in retrospect it appears to have allowed me greater freedom as a therapist. What I have to ask myself, however, is whether these circumstances also allowed the patient greater freedom to examine her internal processes? Was I able to provide Sara with a different and curative experience of a non-grandiose parent with certain vulnerabilities, as well as that of a strong, emotionally alive parent? Did I succeed in steering, as Hoffman (1994) says, between a more detached, reflective and interpretive stance, and more personal engagement with the patient? Were we able to progress along the developmental axis from subjective concerns (my feelings, needs, urges) and objective reality (the disease, my absences) toward greater separateness and autonomy? Did my trip to Paris and our working through it afterwards help Sara to start to see me not only as a breast, a mirror, a screen for projection, but also as a separate and lively object she could 'use' (in the Winnicott sense) as a subject?

I have to ask myself whether the intimacy generated by my disclosure, together with an unambiguous maintenance of my therapeutic role, invited Sara to 'use' my subjectivity, thereby making it easier for her to discover her own 'I-ness' and reclaim some of the 'knowing' and 'life' which she had entrusted to me. Perhaps in this way she no longer needed to be the accused and have me be the defender of life. Were we able to make the transformation from knowledge that Sara could not contain, to knowledge of separateness and growth? Did we manage the transition from despair to hope, from thanatos to libido?

Will I be able to survive my own life, to maintain my separateness, to continue to function in the therapeutic space when the verdict has yet to be handed down, when I have merely been given a stay of execution? From the perspective of time, I sense that recognizing my separate existence makes it possible for me not only to live, but to die as well, and that is a considerable relief.

As Stolorow and Atwood (1992) state:

> When the analyst is able to become reflectively aware of the principles organizing his experience of the therapeutic relationship, then the correspondence or disparity between the subjective worlds of patient and analyst can be used to promote emphatic understanding and insight. We have found that such analysis can transform a therapeutic stalemate into a royal road to a new analytic understanding for both patient and analyst.

As I was writing this paper, I received a gift from Sara. This time it was she who had been on a trip to a city no less beautiful than Paris, and when she returned she brought with her photographs of the sights that she asked me to glance at, and two pictures of herself over which she lingered. With a smile, she said: 'I'm so pleased with myself. I look so soft and serene in these pictures.' And as for me . . . rather than hide my feelings, I shared my excitement with her.

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Equalities

ADAM PHILLIPS

> . . . stability does not depend on the immutability of individual particles but solely on the dynamics of their interaction.
>
> Evelyn Fox Keller, *The Century of the Gene*

In 1945, just after the end of the war, Lacan came to London as a French psychiatrist to find out about the effect of the war on British psychiatry. His report on his visit, 'British Psychiatry and the War', was published early in 1947 (Lacan 2000). What evidently most impressed Lacan was his meeting with Bion and Rickman and their accounts of their work in small groups with soldiers. There are, as one might expect, given the historical moment and the personalities involved, many fascinating things in Lacan's impressions and celebrations of this early influential psychoanalytic work with groups. But there is a thread running through Lacan's paper, a preoccupation that punctuates whatever else he is saying, and that is clearly linked to his thoughts about the 'mirror stage'.

What Lacan keeps returning to – perhaps unsurprisingly after the devastations of the war against fascism – is the idea, the modern political ideal, of equality. In the 'mirror stage' paper, Lacan shows how we are never equal to our (unified) image of ourselves; that what the child sees in the mirror is, as it were, his complementary rival. If Freud had proposed in his structural theory of the mind that there was not and could never be internal equality between his various 'agencies', Lacan had added to this unending uncivil war, an image of the child diminished, tyrannized and enraged by his wished-for self-representation. Whether or not Freud or Lacan (at this time) thought of themselves as democrats or believed in equality as one of the rights of man, there is nothing in their psychoanalytic accounts of what people are really like that is conducive to the kind of social hope invested in ideas of equality. Indeed, one might think from a psychoanalytic point of view that equality, like many of

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the other so-called 'rights of man', was ripe for ironization. Something, perhaps, along the lines of Joan Riviere's infamous, and possibly apocryphal, remark that socialism was the religion of younger siblings.

And yet in Lacan's paper, even in its tone of idealistic pessimism generated by the experience of the war, it is as though he cannot give up on the notion of equality. Despite Freud's work on group psychology and the daunting, invasive forms of identifications, despite the fact that 'the dark powers of the super-ego make alliances with the most cowardly abandonments of conscience' (Lacan 2000: 28), Lacan is interested in what might be called alternatives to leadership. If his early work on the family was about the consequences of the modern destitution of the 'paternal ego', it is to re-descriptions of the notion of leadership, what we might call sociologically the problem not only of authority but of the fantasy of the authoritative, that he is drawn to through his encounter with the British:

> In Bion's work, the analyst as group leader will undertake to organise the situation so as to force the group to become aware of the difficulties of its existence as a group, and then render it more and more transparent to itself, to the point where each of its members may be able to judge adequately the progress of the whole. (Lacan 2000:17)

Lacan sees this as a version of 'forcing' people to become equals. Clearly the aim is to arrive at the point at which the position of leader disappears. It is a description of what one might want to be creating as an ideal in a certain kind of democracy. But, of course, it has to be noted firstly that it requires a group leader using the psychoanalytic method to get the members of the group to this point. Secondly there is the question of who decides what it is to 'judge adequately the progress of the group'. Where do the criteria for adequate judgement come from, and what has the group consented to when it acknowledges any judgement as adequate? When 'the crystallisation of an autocritique materialising in the group' (Lacan) occurs, it is as though the psychoanalytic method of enquiry has given the members of the group a shared genre of useful judgement. But what is this 'autocritique' like? It could, for example, be the group having agreed the rules of the game. But agreeing to the rules of the game does not stop some people being better at it than others. Indeed, it creates the conditions under which people can distinguish themselves. It is only when rules have been consented to that prestige and inequalities begin to emerge. To consent to a set of rules is to set up a potential hierarchy. By putting a basic structure of equality in place, by providing a baseline of sameness, differences can appear.

The question lurking here, a question that seems tailor-made for psychoanalysis, is: why is hierarchy the reflex response to difference? In his description of the Bion group, Lacan intimates that the psychoanalytic method can make possible the enjoyment and the productive use of difference. If everyone gets to the point of being able to 'judge adequately the progress of the group,

they must have a shared sense of what constitutes progress, of what it is better for the group to be doing. And yet, of course, we know that too much consensus, like too little, is the enemy of democracy.

It is when Lacan refers in his paper to a comment made by Rickman that he begins to formulate his question. Rickman, he says, 'makes the following remark which to some will seem striking, that if one can say that the neurotic is ego-centric and loathes any effort of co-operation, it is perhaps because he is rarely placed in an environment where every member would be on the same footing as himself when it comes to relating to one's counterpart' (Lacan 2000: 19). One's immediate response to this is, where could there be such an environment? This surely is an environment of absolute equality. And yet to behave as if one is on the same footing with others is a virtual definition of equality, if not of democracy. What would psychoanalytic treatment be like if the analyst considered himself to be on the same footing as the so-called patient? It is the need for superiority, the need to be the exception, the need to exempt oneself from something that Rickman is using the word neurotic to describe. Lacan refers to the *noli me tangere* that one finds more than frequently at the root of the medical vocation no less than that in the man of God and the man of Law. Indeed, these are the three professions which assure a man that he will find himself in a position in which superiority over his interlocutor is guaranteed in advance' (Lacan 2000: 23).

Of course, Lacan's omission of the analyst, of psychoanalysis as the fourth profession, is essential here. In psychoanalysis there is no touching and it is, as it were, the redemptive wishes that are to be analysed. And yet here we have, in a paper which is nothing if not celebratory of what Lacan calls the 'revolution' created by psychoanalysis, the juxtaposition of two images. We have Rickman's neurotic, and ego-centric loathing of cooperation because he places himself, 'in an environment where every member would be on the same footing', and we have the doctors, lawyers and men of God, 'professions which assure a man that he will find himself in a position in which superiority over his interlocutor is guaranteed in advance'. The neurotics, like these great and legitimate professionals, need to exclude themselves from something, need to reject something in advance. They must, in one way or another, be untouchable. It is, to exaggerate, as if their lives depended upon their not having equals. It is as if they are phobic about some notion of equality. What could it be about equality, what does equality entail or involve us in that could make it so aversive? To be treated by one's interlocutor as superior or different places him or her in a threatening position as though to lose one's superiority or prestige could be catastrophic. The analyst, Lacan later famously says, is the one who is supposed to know, the person in whom the patient delegates his superiority. Among the targets of Lacan's later critique of the psychoanalytic establishment are those psychoanalytic institutions and theorists who put themselves in a position in which superiority over their interlocutors is guaranteed in advance. In other words, for Lacan psychoanalysis is about the way the

individual suffers, and loves to suffer, his terror of equality. Psychoanalysis addresses how an individual excludes himself, exempts and distances himself from certain kinds of association. It is as though the modern, 'civilized' form of what anthropologists called 'participation mystique' is a horror of participation.

There is something about equality and the absence of guaranteed superiority about which psychoanalysis has something to say. It is not merely one's own superiority. It may be the need to believe that there are some people whose superiority is guaranteed in advance. It could be a deity, a race or a nation-state. It could even be a psychoanalytic training institute. But without this superiority existing somewhere in a person's orbit they, we, are destitute. Clearly, it is not incompatible to be committed to democracy and to dread equality or, in the name of democracy, to foster forms of prestige.

There are two questions here: what would equality feel like such that people might organize their lives to avoid it? And, does psychoanalysis, as Lacan intimates in this early paper, have anything akin to a cure for the wish for a superiority guaranteed in advance? To put it another way, does psychoanalysis have anything to do with democracy?

'When we envisage democratic politics from . . . an anti-essentialist perspective', writes Chantal Mouffe, 'we can begin to understand that for democracy to exist no social agent should be able to claim any mastery of the foundation of society' (Mouffe 2000: 21). No one in a democracy, in Mouffe's account, has a superiority guaranteed in advance if acting democratically. Would it not be a definition of Lacan's notion of superiority of the medical profession, the judiciary and the church that each of these professions claim some kind of mastery of the foundations of their own society? The kind of equalities implied by democracy need to find new definitions of mastery. Democracy, as Mouffe describes it, involves re-describing the whole notion of leadership and the value of conflict.

Defining antagonism as the struggle between enemies and agonism as the struggle between adversaries, Mouffe proposes what she calls 'agonistic pluralism':

> The aim of democratic politics is to transform antagonism into agonism . . . One of the keys to the thesis of agonistic pluralism is that, far from jeopardising democracy, agonistic confrontation is in fact its very condition of existence. Modern democracy's specificity lies in the recognition and legitimation of conflict and the refusal to suppress it by imposing an authoritarian order . . . a democratic society acknowledges the pluralism of values. (Mouffe 2000: 103)

From a psychoanalytic point of view, Mouffe's version of democratic politics is an interesting provocation. We are more likely, for example, to feel superior to our enemies than to our adversaries. Indeed, the whole idea of an enemy makes the idea of superiority possible, if not plausible. (It may not be enemies we are in pursuit of, but states of inner superiority.) If we use Mouffe's

picture as a model of the mind, if we map her model of democracy back on to what some psychoanalysts call the internal world, we will at first find a great deal of reassurance. Isn't it, after all, one of the aims of at least some versions of psychoanalysis to transform enemies into adversaries, to free a person to be at odds with himself (and others) rather than in lethal combat? If agonistic confrontation is the very condition of democracy's existence, can we not say that by the same token conflict is the individual's life-support system? And yet, of course, psychoanalytic schools can be defined by the points of view they espouse. What, for example, would be an internal pluralism of values? Mouffe's definition of the authoritarian is that which suppresses conflict, as though it is the very existence of conflict that certain versions of authority cannot bear. And this might be a clue to what is intolerable about equality. What the person whose superiority is guaranteed in advance cannot bear is the existence of conflict. Equality, then, is the legitimation, if not the celebration of conflict. Is it then possible, from a psychoanalytic point of view, to free a person to be internally adversarial, more of a democrat?

It could be said that people come for psychoanalysis, people suffer, because they have suppressed a conflict by imposing an authoritarian order. They feel coerced and they are coercive (the coerciveness is called transference). People describe themselves as living under various forms of domination and oppression and the analysis uncovers an unconscious authoritarian order called the super-ego. It is illuminating to think of the super-ego not as the cause of conflict but as the saboteur of conflict.

If we take up Lacan's privileging of psychoanalysis as being part of a project to free the individual, then we have to think carefully about psychoanalysis in the light of Mouffe's sentence: 'Modern democracy's specificity lies in the recognition and legitimation of conflict and the refusal to suppress it by imposing an authoritarian order.' The authoritarian order pre-empts conflict which is a primary value. To value conflict, to prefer the openness of conflict to the closure of intimidation, necessitates some notion of equality. Conflict that is not between equals ceases to be conflict very quickly. It becomes a simulacrum of conflict called sadomasochism. We may wonder what the preconditions are, both psychically and politically, for keeping conflict alive and viable. What would a democratic psychoanalysis be like, and what, if anything, does psychoanalysis have to offer to the making of democrats. It would be good, for example, if the outcome of a successful analysis would be that a person would be able to hear and listen to what other people have to say and that through the experience of analysis a person might rediscover an appetite for talking and listening, which is an appetite for democracy. Would a democratic analysis end up as, or begin as, a conversation between equals? The advantage of the one who is supposed to know is that he can tell us the truth about ourselves which will dispel the rival truths, so that instead of having to conciliate rival claims on ourselves we can attain a superiority of knowledge.

From Bion's small potentially leaderless groups to Lacan's professionals whose superiority to their interlocutors is guaranteed in advance, to Mouffe's democracy that depends on conflict, on agonistic pluralism: in each case something about equality is being contested. It is as though we are not sure whether equality as an ideal is our most pernicious mystification or one of our best inventions. What could be described as being equal between the analyst and patient, what are they equal to, and what might they be equal for?

* * *

a common ear for our deep gossip...

Alan Ginsberg, 'City Midnight Junk Strains'

Psychoanalysis as a treatment, like democracy as a political process, allows people to speak and be heard. And it is with a sense of urgency, of something being at stake, that people seek psychoanalysis or enter the political arena. The democratic process may not be simply the best way of making decisions or of conciliating rival claims, but being in a democratic forum, being in contact with the different voices, either in oneself or in others, may itself be a kind of satisfaction.

There is on the one hand the need to make decisions, to have a capacity for choice, and on the other a willingness to sustain disagreement. If choice and conflict are inextricable, the conflict only exists as such because the conflict is in some sense between equals. Equality here does not mean sameness. It means differently appealing but equally compelling good things. Desiring one's mother and desiring one's father; wanting to be independent but needing to feel attached; wanting to be excited and wanting to be kind. All have much to be said for them. They can either be usefully sustained as conflicts, or the conflict can be suppressed by authoritative imposition. I can become unassailably either heterosexual or homosexual; I can be invulnerably arrogant or abjectly needy; I can become more or less sadomasochistic; I can become altruistically ascetic or brutally promiscuous. I am not suggesting that these are conscious decisions, but they are, in overly schematic form, the conscious and unconscious self-fashionings that we come across in this culture in ourselves and others.

The aim of psychoanalysis, one could say, might be the precondition for democracy: that a person be able to bear conflict and be able to see and enjoy the value of differing voices; that a person might want to confer some version of equal status on the conflictual voices that compose and discompose him. And from this point of view aggression would not be seen simply as some kind of innate, quasi-biological essence. It would be seen as, or also seen as, the voice called up in the self to put a stop to conflict. Aggression would be seen to be creating a certain kind of conflict as a way of suppressing vital conflict.

The analyst, like the democrat, would be vigilant about attempts to suppress both the possibility and the sustaining of conflict within the individual and the culture. The analyst would position herself as a democrat wherever the patient place her through the transference. In my version of analytic neutrality, neutrality would never be the right word because to think of oneself as neutral in a democracy doesn't make sense. It would only make sense that the analyst would be finding ways of sustaining that conflict which is a form of collaboration. The analyst and the analytic setting would be like a rendezvous for the conflicts involved in the suppression of conflict.

In other words, the analyst would be wanting to be the opposite of Winnicott's definition of a dictator:

> One of the roots of the need to be a dictator can be a compulsion to deal with this fear of woman by encompassing her and acting for her. The dictator's curious habit of demanding not only absolute obedience and absolute dependence but also 'love' can be derived from this source. (Winnicott 1987: 165)

The dictator is, as it were, the ultimate version of the figure Lacan refers to whose superiority to his interlocutors is guaranteed in advance. Psychoanalysis, one could say, has always been involved in one way or another in the war against dictatorship, in the difficulty, if not the impossibility, of equality between people (and within people). If for Winnicott the meaning of the word democracy takes him straight back to the meaning of the word mother-infant, it also takes us back to the meaning of the word psychoanalysis. After all, from a psychoanalytic point of view it would not be surprising to find (whether or not individual psychoanalysts think of themselves as democrats) that the battle between dictators and equals has always been fought out in every area of psychoanalysis. Psychoanalysis has, perhaps, been exemplary as a profession in the way that it has kept the whole question of superiority – of the nature of prestige and dictatorship – on the agenda. Issues to do with equality are never far away when psychoanalysis is discussed, celebrated or disparaged.

* * *

> High hopes were once formed of democracy; but democracy means simply the bludgeoning of the people by the people for the people. It has been found out. I must say that it was high time, for all authority is quite degrading. It degrades those who exercise it, and it degrades those over whom it is exercised.
>
> Oscar Wilde, *The Soul of Man Under Socialism*

If one wanted to reflect on psychoanalysis and democracy it might seem sensible at first to give some definition of democracy. But the difficulties of doing this are instructive in themselves. And it is worth remembering that democracy, like psychoanalysis, is a quite recent phenomenon. The political theorist, Larry Seidentop, writes:

> Democracy was a word unknown to most of the non-Western world. Even in the West, until two centuries ago, the word carried decidedly unfavourable connotations. The role of the idea of democracy was not unlike the role of the id in Freud's theory of the psyche – both suggested a dark, inscrutable and fathomless threat from below. The upper classes of European society and the established churches looked upon democracy as something almost demonic. (Seidentop 2000: 47)

It is interesting that he should have recourse here to Freud's id by way of analogy. The threat posed by democracy was its assertion that certain kinds of liberty were not reserved for the privileged. It is curious to think of the ego and the super-ego being somehow akin to the aristocracy and the church. And yet when Freud showed us how the ego was no longer master in its own house he was intimating something similar. As though the id was the new, alternative, previously repressed voices which either are sexual and aggressive or are described as sexual and aggressive. Something else was demanding its right to be represented and heard, and put like this, the psychoanalyst is both herald and sponsor of the new democratic world.

It is very clear, and entirely appropriate, that the nature of democracy has been greatly contested. In Seidentop's view democracy evolved from Christianity with:

> the assumption that we have access to the nature of things as individuals. That assumption is, in turn, the final justification for a democratic society, for a society organised to respect the equal underlying moral status of all its members, by guaranteeing each 'equal liberty'. That assumption reveals how the notion of 'Christian liberty' came to underpin a radically new 'democratic' model of human association. (Seidentop 2000: 194)

It is the valuing of the individual, despite his social status, that both Christianity and democracy promote. It is as though people are deemed to be something that is of equal value, and of a value greater than any worldly assessment can encompass. It is paradoxical that what exempts people is the ground for their inclusion. And it is, inevitably, the forms of equal liberty and the nature of this supposed 'underlying moral status' that are ultimately contentious. What, I think, is less debatable is that there was 'a radically new democratic model of human association'. More people associate with people from different classes and countries and histories now. Some of them may assume that despite their manifest differences they have some other things – perhaps more important or 'deeper' things – in common. And the keyword, as it is for psychoanalysis, is association, as the way to something new. Indeed, the only time the word 'free' ever gets used with any regularity in psychoanalysis is with reference to free association, in which words are encouraged to consort with each other to unpredictable effect. Psychoanalysis, like democracy, works through the encouragement and validation of new forms of association and the conflicts they inevitably reveal. To have an appetite for association – either political or psychic – is to have an appetite for, if not to actually seek out, fresh forms of conflict. Democracy, one could say, extends

the repertoire of possible conflict. It fosters an unpredictability of feeling and desire. It makes people say, or people find themselves saying, all sorts of things to each other.

When Chantal Mouffe says that, 'for democracy to exist, no social agent should be able to claim any mastery of the foundation of society', I take her claim to mean that there can be no superordinate expert, nobody tuned into the real or true nature of things (as a dictator would claim to be) because there is deemed to be no absolute foundation of society. Indeed, it would be a monarch or a dictator or an aristocracy or a church who would represent themselves as essentially the representatives and the masters of the foundations of a society. Democracy in Mouffe's version does not provide foundations in the sense of ones that can be mastered. It is again similar to psychoanalysis, whose paradoxical foundation is the unconscious, which by definition is not subject to mastery (even if what it is subject to is always in question). The new, both similar and different kinds of association promoted by psychoanalysis and democracy are not, though, or not only ends in themselves. What, after all, is all this new association in the service of? How does it bring us the lives we want, and what is it about these particular lives that we seem to prefer? We may not want to be so overtly dominated by absolutist tyranny, but what do we want these new kinds of conflicts to do for us?

If it is perhaps more obvious what these forms of free association are freedom from, it is less clear what they are freedom for. Free association, in a psychoanalytic context, is designed to reveal the strange orderings of unconscious desire. Freud writes, 'When conscious purposive ideas are abandoned, concealed purposive ideas assume control of the current of ideas' (S.E. V: 531). Freedom from censorship is freedom for the disclosure of unconscious desire. And desire, one could say, is always desire for exchange. Freud's 'conscious purposive ideas' could be translated as the accepted entitlements of those with status, and 'concealed purposive ideas' could be read as the voices of the subordinated. Freedom from acknowledged forms of regulation is freedom for economic and erotic exchange. What proliferates is proliferation itself. The reaches of appetite can be explored, and in providing a setting for such freedom – and in defining the space as being for this and nothing else – what is quickly revealed are the obstacles to free association, the difficulties, the hesitations, the pauses, the knots and shames and ruses that occur, and occur to someone when they are encouraged to speak.

When Ferenczi said the patient is not cured by free association, he is cured when he can free associate, he was acknowledging the very real difficulty everyone finds in sustaining and making known an internal democracy. People literally shut themselves up in their speaking out, speech is riddled with no-go areas, internal and external exchange, as fantasy and as practicality, is fraught with resistance. Psychoanalysis reveals just how ambivalent we are, to put it mildly, about freer forms of association. And this must surely be where the analyst comes in. If the so-called patient is deemed to be suffering

from one form or another of association-anxiety, presumably the analyst has something up his sleeve, so to speak, for precisely this predicament. Encourage the patient to free association, Freud says. Call this the 'fundamental rule' of analysis and what will come to light, in detail, are the patient's misgivings about doing this. Let someone talk and they will start showing you that they cannot, and how they cannot. They are always, in Mouffe's words, from a quite different context, 'suppressing [conflict] by imposing an authoritarian order, and in all probability delegating to the analyst this thankless task of ordering them about'. In this sense psychoanalysis reveals – whether or not the analysand recognizes himself as a democrat and someone who professes democratic rights and obligations – the anti-democratic voices and urgings and their complex history. And as anyone knows who has had a psychoanalytic experience, there is often a great and shocking immediacy to these unconscious authoritarian impositions of order. One cannot help wondering just what conflict is experienced that it calls up such violent hatred. The protest against, the hatred for (not to mention the desire and longing for) the figure whose superiority to his interlocutors is guaranteed in advance must be as nothing to the agonies and terrors of conflict. As though the alternative to there being a subject supposed to know, rather than a subject who can only live his dividedness by not trying to abolish it, is felt to be catastrophic. So what can the analyst do, where can she put herself, so to speak, to make conflict the desirable and desired state of being? How does one acquire a taste for democracy, a desire for democratic values?

John Dunn begins the Preface to his book of essays, *Democracy, The Unfinished Journey: 508BC to AD1993*, with the words:

> This is a book about the history and significance of an old but vigorous idea: that in human political communities it ought to be ordinary people (the adult citizens) and not extra-ordinary people who rule. This is not a very plausible description of how things are in the world in which we live. But it has become the reigning conception today across that world of how they ought to be. The idea itself is devastatingly obvious, but also tantalisingly strange and implausible. (Dunn 1999: v)

The idea of something at once devastatingly obvious and also tantalizingly strange and implausible is as good a definition as any of what used to be called making the unconscious conscious. That which has been rendered unconscious tends to have an elusive strangeness, even uncanniness about it, and is both hard to believe and hard not to. And yet here, of course, John Dunn is talking about an idea of political community and organization called democracy, which Dunn's faintly amusing subtitle, *The Unfinished Journey: 508BC to AD1993*, points to as having been something of a long-term struggle, that is to say, something with potent adversaries and enemies. The whole notion of extending effective political power to more and more people, the idea of people having a right to choose their own government and, in some sense, rule

themselves by themselves – by their own consent – without the need for people (or deities) of extraordinary and superior status, this, as an ideal and a political struggle, turns the world upside down. And it does this in part by making new kinds of association between people both possible and necessary. The whole idea of an extraordinary or superior person, or group of people, has to be re-described. The old tautologies – the King is superior because he is the king – no longer hold. Hierarchy becomes a matter of consensus rather than divine or any other kind of right. Agreement and disagreement have a whole new status: they become the new effective currency of political life. And psychoanalysis, of course, has something to say, or something to add, about the causes and reasons or agreement and disagreement, about the function of the agreeable and the disagreeable in people's lives. From a psychoanalytic point of view this has to do with the inequalities – for want of a better word – that human development involves and entails. The gist of this might perhaps be captured in the absurd question: what would it be for a child to become the equal of its parents? What might there be in this obvious but also tantalizingly strange and implausible question that might be cause for resistance? To identify with democratic values and institutions requires, among other things, that children no longer need, for their psychic survival, to think of their parents (and so of anyone else, including particularly themselves) as extraordinary or superior creatures. In psychoanalytic language, the enemy of democracy is not so much admiration as idealization. And this means, in Mouffe's terms, that it is essential to the viability of democratic values that they are not themselves idealized. Stories about equality, stories about self-government, stories about consent are there to be continuously reconsidered, not fixed (or reified) by idealizing them. The whole notion of mastery is both the cause and the consequence of idealization.

If we speak in the psychoanalytic way of mothers and fathers and children, the democratic idea and ideal of people's right to choose and participate in their own government comes out as, however consciously or unconsciously conceived, people's right to choose their own parents and siblings. I cannot choose my parents, my family and its histories, but I may be able to choose the form of government I live by. It is obvious why democracy can seem unnatural and transgressive. We do not speak enough, in other words, of democracy as a forbidden pleasure. And if we were to do this we would get a clearer sense of the profound ambivalence in psychoanalysis about democratic values, an ambivalence reflective of this same ambivalence in the wider culture, of which psychoanalysis is always a part.

When I was training to be a child psychotherapist about 20 years ago, we were asked by the committee running our course for suggestions for what we would like to be taught. When some of these suggestions were turned down and some of us got rather cross we were told by a member of the training committee that 'children cannot bring themselves up'. As it happens I was a child then, but

some of my contemporaries were in their 30s and 40s and had children themselves. So, unsurprisingly they were rather affronted and bemused by this. It is integral to the point I want to make that, in retrospect, I think of this as an emblematic story about the ambivalence, in both parties, about democracy, about the anxieties of equality. To be told either rather abstractly or rather dogmatically that sanity depends upon acknowledging and respecting the difference between the sexes and the difference between the generations does not always clarify this issue. Because the issue is: what kind of equality is viable in the light of difference?

It is peculiarly difficult to produce descriptions in psychoanalytic language, from a psychoanalytic point of view, of equality. Or rather, of what kinds of equality might be emotionally viable for people rather than just more spurious ideals or too-wishful propaganda. All versions of psychoanalysis are informed by the relative helplessness and dependence of the human infant, the centrality of the Oedipus complex, and the excessive power and logics of unconscious thought and desire. All this provides, at best, a sense, to use Dunn's phrase, of an unfinished journey in psychoanalytic theory and practice towards any feasible ideas of equality, or indeed of freedom. It would be extravagant to say that psychoanalysis is essentially a story about why equality is impossible for human beings. But in the most cursory reading of Freud, or Klein or Lacan equality in any form does not spring to mind as a key word. If psychoanalysts are mindful of the ways in which people are not equal to being themselves, not equal to the task of living, are unable or unwilling or overly enthusiastic about treating others as equals, if psychoanalysts tend to produce accounts of what people are really like that stress desire, dependence, greed, rivalry and abjection, the question of equality, in one way or another, has arisen around issues of treatment and training. All analysts agree, though they have different ways of saying this, that people are split subjects, but people are not assumed to be, as it were, equally split. All analysts agree that everyone has an unconscious, though people are not assumed to be equally unconscious. But when it comes to training and treatment these issues become particularly pertinent.

Though training and treatment are inextricable, I want to concentrate, by way of conclusion, on the question of the connection, if any, between equality and psychoanalytic treatment – a connection that would have to be privileged if there was to be a democratic psychoanalysis, or rather a psychoanalysis that declared itself democratic in intent. By that I mean a treatment that saw itself as being about the difficulties every person has in identifying with democratic values. Psychoanalysis, of course, was not conceived as a political training camp, but that it has pretended not to be one, that it has, at its worst, created the illusion that it is possible to exempt oneself from group life, from politics, has I think been more damaging and misleading that need be. All social practices transmit preferred values, so, to localize the larger question, I want to ask in what sense it may be useful and true that there is any equality between analyst and patient?

I do not mean by this some kind of equality being the aim or the consequence of a good psychoanalytic experience. I mean: what kind of equality could be considered as a precondition for a democratic psychoanalysis? What would it mean for the analyst to assume at the outset any kind of equality between herself and the patient? Treating someone as an equal, as psychoanalysis shows so well, is not as simple or easy or uncostly as it might seem. But then, not treating people as equals is also its own kind of prophecy, its own kind of project.

Throughout the history of psychoanalysis there have been statements by psychoanalysts like Ferenczi, Winnicott and Laing, among others, to the effect that the analyst and the patient are above all two human beings. Sometimes saying this does not quite say enough, or rather it begs the question that needs to stop begging and being begged. Winnicott writes:

> A sign of health in the mind is the ability of one individual to enter imaginatively and accurately into the thoughts and feelings and hopes and fears of another person; also to allow the other person to do the same to us . . . When we are face to face with a man, woman or child in our specialty, we are reduced to two human beings of equal status. (Winnicott 1970:13)

The idea that when we are face to face we are two human beings of equal status leaves open the question of when we are not face to face, when one person is on the couch, facing away. The phrase 'two human beings of equal status' requires us to describe what this equality could consist of, just where it might reside. It is interesting that Winnicott's sense of equal status overrides here the differences between generations and between the sexes: 'When we are face to face with a man, woman or child we are reduced to two human beings of equal status.' But why is 'reduced' the word here, because it is akin to one of Freud's antithetical words meaning at once diminished and restored? Winnicott implies that the quality resides in each person's ability to 'enter imaginatively and accurately into the thoughts and feelings and hopes and fears' of another person, and, as integral to this, to have the freedom to 'allow' the other person to do this to oneself. This reciprocal entering into, this mutual intercourse between people that he sponsors here is, at least in a psychoanalytic context, a radical new form of association. It implies that the analyst allows himself to be, for want of a better word, known by the so-called patient.

It would be the mark of Lacan's professional whose superiority to his interlocutors is guaranteed in advance that he would have to set certain kinds of limits to intimacy. Like Rickman's definition of the neurotic who is egocentric and loathes collaboration, this person has always decided, however unconsciously, beforehand on the nature of the exchange that will take place. The entering into of each other will be severely regulated. What Winnicott does not tell us – and it seems rather important in the context, though also perhaps forbidden to broach – is how this mutual imaginative intercourse is

compatible with psychoanalytic practice, with the gathering of the transference?

In the more democratic forms of analysis it would be assumed that the analyst and the analysand need to find ways of knowing each other, or experiencing each other, such that the idea of the superiority of either of them disappears. It ceases to be relevant to the matters at hand because superiority, as Lacan's respectable professional and Rickman's neurotic make clear, is a function of distance. In a more democratic psychoanalysis the aim is to transform superiority into useful or bearable, or even pleasurable, difference. But perhaps this need not be merely the aim of psychoanalysis so much as the precondition of its possibility. The analyst, that is to say, starts from a position – a listening position – in which there is no such thing as superiority. And that, of course, is as much to do with his manner – who he happens to be and happens to want to be – as to do with his technique. Indeed, the whole notion of technique, at its most extreme, is complicit with fantasies of superiority.

If we think of psychoanalysis as a listening cure, as an agreement that two people will bear together the consequences of their listening (to themselves and to each other), we could then start wondering about something I want to call free listening, in counterpoint to the notion of free speech. And we could think of psychoanalysis as an enquiry into the equality of listening, into the senses in which we can be equal to what we hear.

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What happened to adolescence? How might a training in psychoanalytic psychotherapy with adolescents contribute to working with adults?

RUTH BERKOWITZ

ABSTRACT

In this paper the author describes the experience of doing a training in psychotherapy with adolescents. The question is raised about the relative absence of attention given, in a training in adult psychotherapy, to adolescence as a developmental phase, either as a topic in itself or in the understanding of adult patients. The paper is divided into aspects of the training experience which, on the one hand, raise issues which are not confined to work with adolescents but highlighted by it, and on the other are more directly related to the adolescent process. The training experience with adolescent patients is seen as a valuable and enriching one for working with adult patients.

Key words adolescence, psychoanalytic psychotherapy training, developmental breakdown, the body as object, acting out, 'interviewing'

In the training to be an adult psychoanalytic psychotherapist, we learned and spoke often about infants and children. In theoretical and in clinical seminars, the primitive, the early, the infant, the child were all firmly embedded in theory, thinking and clinical work. But where was the adolescent? It was for this reason that I began a training in adolescent psychoanalytic psychotherapy and it is this experience and its contribution to my work with adult patients that I would like to describe.

This long period of development, adolescence, involving considerable physical, emotional and social change, although not entirely absent from the training was given relatively little time and thought. Perhaps there was an implicit view that adolescence is a recapitulation of earlier experiences and so learning about infancy and childhood took care of adolescence. However,

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Perret-Catipovic and Ladame (1998) point out that adolescence has generally been, and to some extent still is, relegated to the background. They suggest several reasons for this, including the idea that the emphasis on infantile sexuality may have pushed puberty aside.

Then there is also the question of the suitability or appropriateness of psychoanalytic work with adolescents. Anna Freud considered that classical psychoanalysis was contraindicated because of the upsurge of drive energy at puberty and a weakening of the ego, leaving the adolescent with little frustration tolerance and the desire for immediate satisfaction. She assigned a specific place to adolescent psychopathology. Winnicott, in contrast, wrote that there was only one cure for adolescence: 'the passage of time and the gradual maturational processes' (1961: 79). Perret-Catipovic and Ladame (1998) consider that Winnicott did some considerable harm by making rather throwaway statements, such as 'we meet the challenge rather than set out to cure what is essentially healthy', rather than advocating psychotherapy, although the adolescent patients he described were severely depressed and even suicidal (Winnicott 1961: 87).

There have, therefore, been obstacles in the way of offering psychoanalytic psychotherapy to adolescents as well as learning about this phase of life. Perhaps there still are. When I took on my first adolescent training patient, a clinical seminar leader told me it was unhelpful to offer this patient long-term intensive therapy. What was needed was to get *away* from relationships of dependence and, I was told, the patient certainly will not stay. This attitude, it seems, sometimes still prevails.

However, there was in the late 1950s something of a change when Jeanne Lampl de Groot (1960) said it was not only possible but also necessary to analyse adolescents. More recently, the Laufers have offered intensive psychoanalytic treatment to disturbed adolescents. (Laufer 1995, 1997; Laufer and Laufer 1984, 1995). Adolescence, according to them, is a finite period of development whether or not it ends normally. They view the main aim of this phase as the establishment of a fixed and irreversible sexual identity. They define psychopathology in terms of breakdown in development. Central to their view is the importance of the body in adolescence and the body as the object of destructive attacks. They do not take a neutral position in regard to therapy with very disturbed adolescents. They clearly advocate therapy and underline the risks to the adolescent if it is not undertaken. Theirs is not a Winnicottian 'wait and see' attitude.

The training

The training was similar to the adult training in psychoanalytic psychotherapy, with theoretical and clinical seminars, year advisors, two training patients, to be seen under supervision, one for two years and one for a year.

The main differences were that analysis was not a requirement and that we worked at the Brent Adolescent Centre for two years seeing young people who were referred or referred themselves to the Centre. This experience at Brent, where we also went to weekly meetings for case discussions, made it plain to me that adolescence and the experience of working with adolescents is quite different from working with adults.

The experience, whether as an observer or as a therapist, felt rather like being put into a maelstrom or rapids without a clear sense of where or how the journey will end, rather like the adolescent process itself, perhaps. Of course, these were very ill adolescents who abused their bodies violently by starving, cutting, mutilating, taking drugs, promiscuity, some of which can be understood as suicidal impulses. Then there were the more clear-cut suicide bids. Being alone in the room with an adolescent could impose severe strains, the impact of adolescent experience, the shifting transferences, the attacks, the acting out. There is a sense of fluidity, of things in flux, of possibilities and immense dangers. So what could I possibly have learned that would help me in my work with adults?

General aspects

Although not all of these aspects were new to my work, the experience of doing therapy with adolescents heightened their importance. Issues of containment, acting out and the role of supervision with very difficult patients were familiar. However, the importance of non-analytic aspects was more evident, and the role of 'interviewing' was new.

Containment and enactment

The importance of containment was brought home in the first session with my male adolescent patient. He came four times a week and began an unrelenting attack on me and the therapy. Being under attack was not new but this had a different quality. It felt like a naked attack. 'Who do you think you are? I don't want to come. I hate this horrible room. Okay, so what do you want, fire away.' He could be funny and charming, lolling over the arm of the chair, looking at me upside down. He could be quite mad and feel that his brains were spilling out of his head. At times he was frightened that he had lost his mind. And so the fluctuations in the transference and countertransference were rapid. I was at times the child who was subjected to attacks as he had been by father's mad attacks on him. Within moments I was being seduced by his funny turns of phrase, wanting to please him, mindless, as he was, not remembering or able to make sense of anything. The impulse to act rather than think, so characteristic of these adolescent patients, can be massively powerful in the countertransference.

While it is a lesson in 'not doing' under duress, it was also a lesson in understanding my own enactments. My 14-year-old female patient, a 'replacement' child, began the therapy coming to sessions very early. Unfortunately, I do not have a waiting room. While I mention this to all my patients, there was something in the way I did it in this instance which echoed something of her own experience of not being wanted. When I replayed my interpretation, I could feel the rejecting aspect of it. I had felt more strongly than with other patients that I did not want her intruding on my time and space prematurely. I then felt very guilty but was able in supervision to think how I could recognize with my patient how she might have felt rejected. Instead of asking her not to come early, it was suggested by my supervisor that I put out a stool for her to sit on, in the far too small lobby. This decision seemed right to me, although something that in my adult work I would not have considered. It is not that I would always do something similar with my adult patients but that, given thought, it opened up a different way of relating to my patient.

Supervision

The intensity of the experience is well recognized by those who work with adolescents, the risk of being unable to think, of being enveloped by the experience. As a result, even those who work with adolescents consistently and are, therefore, very experienced would ensure that they have the opportunity for consultation and supervision. It is regarded by some as imperative when working with adolescents. Of course, it was vital for me. It was not only the need to have another mind to help me to think about the material, it was also that these patients are worrying in a particular way. They are young, they are impulsive, they are self-harming and it is essential to have the opportunity to talk through the anxieties about the risks these patients pose. This experience has reinforced my view that it is probably important for us all as adult psychoanalytic psychotherapists to have such groups or supervision in the interests of ourselves and our patients. It also provides a forum for developing one's thinking about work with a particular patient group.

Non-analytic elements

Non-analytic aspects and their role and even dangers in analytic therapies have been written about in a variety of ways. Perhaps in our adult trainings, where the emphasis is on learning about the unconscious and transference and countertransference, these elements or interventions can feel like 'sins'. Presenting an adult case in one of the clinical seminars before I had taken on an adolescent patient I reported that I had responded to a male patient, who was terrified by his masturbation, saying, 'What is wrong with that?' I felt in telling the group I was taking a risk, and to some extent I was, because the

other members of the group were questioning, perhaps even critical, of a response which was plainly not neutral. The seminar leader took a different view saying more or less, 'What's wrong with that?' This was my first experience of presenting clinical work to someone who was not only an adult psychotherapist but a child psychotherapist as well. I began then to appreciate a different quality in child psychotherapists. What can I call it? I'm not sure. Imagination perhaps? I am not suggesting that they are so-called wild interventions but that there could be interventions which might not be transference interpretations or extra-transference interpretations but a response which makes contact at a deep level with a patient.

One seminar leader, talking about a patient of his, told us how he had struggled for months with a young boy who would not talk to him. One day the patient mentioned his music and the therapist asked about his music, his interest, his hopes and dreams in a quite straightforward way. This was the beginning of the psychoanalytic treatment. Edgecumbe points out that Anna Freud (like her father, Ferenczi, and Eissler) believed 'that even when the analyst tries to guard against these non-analytic elements, it is the child who selects which therapeutic elements he needs from all the possibilities contained within child analysis' (Edgecumbe 2000: 192).

How are these interventions to be understood? Could they be enactments of a different sort? They may not only be a repetition of what went before, but a countertransferential response allied to the patient's wish to be helped, to move on to what the patient feels is needed at that moment.

Interviewing

This consists of a series of meetings with the therapist or analyst, in which the adolescent patient talks about his problems, with a clear statement that the object of the meetings is trying to understand the adolescent's difficulties and to make a decision about what to offer in terms of help. This could be seen as a prolonged assessment, and patients can be seen in interviewing for some months before a decision about referral is reached. In the course of the interviewing there is an attempt to understand the adolescent's behaviour in terms of his relationship to his own body and own internal and external world. There is rarely interpretation of the transference. My own understanding of this has been that, while it is an ongoing assessment, it is also a process of gradually introducing the adolescent to the idea of understanding himself, to the idea that he is not always aware of the reasons for his behaviour although feeling compelled to act in certain ways. It also raises the question of when transference interpretations could be threatening. Although, of course, the interpretation of the transference is important in the therapy of adolescents, for many it can be very difficult, feeling drawn too soon into an intimacy and closeness with which they may anyway be struggling. In addition, they may

feel that their own interests are sidelined by what appears to them to be the therapist's preoccupation with themselves. This interviewing then is many things but it is also a kind of induction into therapy.

My experience of interviewing and hearing about the interviews done by others has made me think and consider the early stages of an analytic treatment with certain adult patients. Some may be driven away by too early interpretation of the transference. With the widening scope of analysis, many of us see patients who are not at all psychologically minded to start with. This does not always mean they will never be psychologically minded. A young man referred because of severe depression was quite illiterate psychologically. He had no experience of talking about himself or of listening to others talking about themselves. He was the child of refugees who had cut themselves off from their origins. Deprived of the very ordinary opportunity of asking questions about himself and his parents, he had become a child for whom curiosity was hopeless. Instead, he invested practical solutions with all his hope and optimism. Every week he arrived with a list of difficulties which I was to solve. Naturally, he was someone in a great hurry. It seemed something of a disappointment when I could not find solutions. Naming his feelings about himself and others was all we could do in the beginning, feelings about his parents, their responses to him and his to them, bringing in some way the possibility of a spirit of inquiry. He had never been allowed to ask questions about his parents' origins and emotional life. The disappointment about the lack of solutions turned to relief when one day he had a revelation. 'Is this it?' he asked. We had arrived at the place he had been avoiding, the place where he might want to know but would then feel knowledge was barred to him. The transference interpretation I could now make was about his anxiety that I would stifle his curiosity and just give him practical solutions.

This somewhat educative line of thinking may have had its origins in the work of Anna Freud, herself a teacher. Edgecumbe points out that Anna Freud was at times dismissed as a teacher rather than an analyst. She points out, though, that education was understood by Anna Freud in its widest sense:

> Upbringing which facilitates psychological and emotional development, by offering moral guidance as well as models for understand and coping with life tasks and social interactions; helping the child to subdue and channel instincts in constructive ways, to find socially acceptable ways of expressing or defending against strong feelings, to manage rivalries and jealousies, to develop the strength needed to cope with fears and anxieties. (Edgecumbe 2000: 64)

Anna Freud's view was that education encompasses all the inner developmental processes which can be influenced by the attitudes and demands of important people in the child's life, and is therefore truly psychoanalytic. Perhaps these ideas contributed to the development of interviewing at Brent. Anna Freud's views were specifically expressed in relation to children because she felt that what might be absent in a child was insight and a wish for help. Is

there a possibility that with certain adult patients this kind of approach might be appropriate?

Specific aspects

Some of the more specific areas which I have felt have influenced my work with adult patients have been the following: the role of the body, attacks on the body, the fear of breakdown, the repetition compulsion, developmental therapy, suicide and acting out.

The role of the body

The role of the body, as mentioned earlier, has been at the heart of the work of the Laufers. At the time of puberty there are changes in the body and associated with this is what the Laufers have described as the establishment of a fixed and irreversible sexual identity, which is the aim of the process of development. These changes may be welcomed by some, but to others they can represent a devastating blow to omnipotence, facing them with the inevitable course of life. The more disturbed the adolescent, the more likely it is that he or she will try to escape the inevitability of this developmental process, either by attacks on the body and/or by breaking down in other ways.

A young female patient dropped out of school and stayed at home leading a very solitary life. In the interviewing, she seemed like a rather ordinary, though very unhappy girl. However, in the final session before she was to move from the interviewer to the therapy with me, she told the interviewer that the day before their meeting, she had ridden her bike the wrong way down a one-way street. This was the first intimation of what was to come in terms of this girl's massive attacks on her body. Soon into the therapy, she began to drink, increasingly heavily, and on occasion until she was unconscious. She took drugs, smoked a great deal and rode her bike in a dangerous way.

I began to think about some of my adult patients who had told me of the attacks they had made on their bodies in their adolescence. Their therapy had begun before my training with adolescent patients, but now I was seeing how problems which had surfaced in adolescence were being perpetuated. These particular patients had all come into therapy at points of major transition in their lives and had continued in their adult life to attack their bodies. They had been offered help as adolescents but had turned instead to some addictive and destructive substance which would hopefully satisfy their omnipotence and the regressive longings that are so often part of the adolescent and especially the more pathological adolescent process. In the transference with these adult patients, as with many adolescents, there has been the fear of the intense tie to me, of relying on me and in the early stages a wish to destroy the therapy.

A 45-year-old man, whom I have been seeing intensively for three years, was referred because of his drug taking. He was resistant to coming into therapy for many reasons, but one of the most important for him initially was

that he was afraid I would try to make him stop taking drugs. It became evident from what he said that he had broken down in his adolescence. He left school and then home at the age of 16 and led a somewhat vagabond life, not wanting to be told by anyone what to do. There had been some recognition that he had difficulties, and a well-meaning vicar had offered him the opportunity to talk. Full of shame, he rejected the vicar's approaches. He chose to avoid humiliation and turned to drugs as the object he could control in terms of quantity and availability. He came into therapy with me at the point at which he would have to make a transition, one which to some extent mirrored the transition in adolescence. He was to become a father, and there was, just as in adolescence, something inescapable about the process of bodily development. Once again in the therapeutic situation he was fearful of a potentially shaming and humiliating experience, exposing his need for help. Before doing the adolescent training, I had not been aware of the role his adolescent experience might have played in his subsequent psychopathology. But now I was able to link some of my interpretations to that period of his life. The developmental failure which had occurred all those years before was now resurfacing and with the help of the training I was able to explore his adolescent experience with him. This raises the question as to whether, without the training, I might have thought more in terms of much earlier material. There is also the question of whether it made a difference. I cannot say except that my interpretations which made links to his adolescence made sense to this patient. It was a route to thinking with him about his drug taking as the object he could control but which was at the same time an attack on his changing body which was not under his control.

Most striking of all was a young woman who came into therapy at the age of 27. She was pregnant with her first child and came because of her dread of being a mother. Once again she was faced with the inevitable changes in her body. She had broken down at the age of 15 and had attempted suicide. During the course of the therapy, she made repeated attacks on her body by being promiscuous, falling pregnant by men she hated. This patient like others I have seen took no precautions and seemed surprised that I thought it relevant or important that she use contraception to prevent pregnancy and HIV. She once again, like other similar patients, had several terminations and showed no recognition that it was a baby she was aborting. I took up the attack both in the transference (I was the mother who did not care about her or the baby) and as an abuse of her own body.

Adolescence is not the only time when there are changes in the body that come unbidden. It is during times when patients are pregnant and the menopause that I am again aware of the possibilities of attacks on the body. Of course, there are huge differences between these times of life and adolescence, but becoming a parent, becoming a grandparent, for example, are again times of transition when any sense of omnipotence is threatened. At the time of

adolescence there is the loss of the ties with the parents which Lampl de Groot (1960) describes as a difficult and protracted process which is often accompanied by genuine mourning. Similarly, at the time of menopause there may be the loss of ties, death of parents, children who are leaving home, the loss of fertility, unfulfilled hopes and the associated mourning at these times. It may be that patients who broke down at the time of adolescence are more vulnerable at these times than others who did not.

Fear of breakdown

Working with adolescents one is exposed to the full horror of adolescent breakdown and the subsequent torment of the possibility of its recurrence, as observed by Winnicott (1963). This breakdown may, of course, be a repetition of a breakdown which had been experienced in infancy. Some writers talk about the importance of reliving the adolescent process in the therapy. Anna Freud was sceptical about this, although Lampl-de-Groot (1960) not only considers it possible but important. She suggests that the patient will cling to infantile material because of the fear of feelings of shame, guilt and hurt pride, and the analyst might shy away from the adolescent forms of aggression, acting out. It may be that because we are so much more familiar with interpretations which are linked with early experience, we may understand the behaviour of patients in these terms rather than in terms of adolescence and therefore miss the other connection. I think that this is what I have been trying to convey: that it is the linking of the kind of behaviour which I have described above with adolescence rather than infancy which may have a special importance. Whether or not there is a reliving of the earlier adolescent experience, what is evident is the fear of reliving the experience of breakdown. An understanding of this anxiety, or more accurately terror, is important because the difficulty with engaging in the therapy, the use of alcohol, drugs and sex, is not only an attack on the body but perhaps a misguided attempt at protecting the fragile self from breakdown.

One adolescent patient, strident and rude, funny and childish, mad and frightened for the first six months, broke down after the first Christmas break. He returned saying he had had severe panic attacks during the break. He became very withdrawn and clung to me and the therapy. While his anxiety had something to do with the break, it also linked with writing his first year university examinations. He had broken down at his first attempt at writing A levels and had managed to get through a second attempt. I made the link with the earlier breakdown and then, throughout the therapy, I would link any anxiety around periods of change to his fear of breaking down. It was so clear to me in the therapy with this young man where everything was so fluid, so available, just how right Winnicott was when he spoke about a fear of breakdown that has already happened.

In my work with my adult patients, I am now much more aware of the meaning of the fear of breakdown, the terror is one that is known, one that was traumatic and that was overwhelming and potentially could not be survived. It may also be that at the time of the breakdown in adolescence, the experience of some of our adult patients was not dealt with or understood. This may contribute not only to their fear of breakdown but to their fears of engaging with, or relying on the therapist. My patient who had several terminations was only over time able to recognize how she used sex defensively against the possibility of breaking down. Again and again I interpreted this fear, her anxiety that she would again experience the horrors of the breakdown without anyone who could help her. As she broke down in the therapy at least five times, I was able in time to think about what it meant now, in contrast to her adolescent experiences, to have someone go through it with her and attempt to understand it.

The compulsion to repeat

The compulsion to repeat, which perhaps I have been talking about implicitly in the notion of breakdown, or in the continuing attacks on the body, is something that once again feels more florid in the adolescent process. When an adolescent boy came late, which was his way of thumbing his nose at authority figures, I took up the aggression. There was a quality to his lateness which conveyed that he had no understanding of why he came late. Of course, the compulsion to repeat is at the heart of an analytic therapy but it was a supervisory comment which made the experience more vivid. This comment bypassed the attempt at understanding the lateness and addressed instead the compulsion, put to the patient in terms of 'you feel compelled'. This seemed a relief to the patient and we could then turn to the possibility of understanding the behaviour.

Suicide

It is well known that adolescence is a high risk period for suicide and it was the work at Brent Adolescent Centre that showed that intensive psychoanalytic work with suicidal adolescents can prevent suicide in vulnerable patients. The adolescent boy came into therapy with suicidal ideation and described incidents when he had cut himself, though this then receded. The young girl gave the first hint of suicidal impulses when she rode her bike so dangerously just before beginning therapy with me. Her suicidal wishes and actual suicide bids have been a constant feature of the therapy. Although I had always felt that suicidal wishes need to be taken seriously, very seriously, it was in my work with her that I learned to scan all the material for any evidence of suicidal ideation and to interpret it. Her drinking, her drug taking, her not eating, riding her bike in careless ways, walking down the road drunk, were not only

attacks on her body but also ways potentially of destroying herself. It has all prompted me to think about all my patients and the issues that need to be considered in relation to suicide. There is the importance of uncovering the fantasies that lie behind suicide, for example. Is there a belief that death will be an idyllic place, a place of bliss? There may be the fantasy that the pain that is being experienced, can be killed off. There may be the fantasy that being dead is not being dead at all. What does one say about the attack on all those around, including the therapist, and about one's own reaction to these intentions. I have often wondered about the meaning of the communication, since the therapist cannot stop the patient. Who is it who holds onto life? One might usefully interpret the patient's wish that the therapist would protect him from his own impulses. There is also the exploration of what it means to be dead, that it is not a means to nirvana but the end, avoiding or missing the opportunity to understand. Suicide has to be confronted, otherwise, as I have learned, it can be used as a secret weapon. This applies to our adult patients as well

Developmental therapy

Edgcumbe refers in her book on Anna Freud to 'developmental help', and she describes it in relation to Anna Freud's innovative approach to deficiency disorders:

> The concept of ego restriction . . . in which ego functioning may become stunted. There is an important consequence for technique: inhibitions may be lifted by interpretation of the underlying conflict and the functioning thereby restored; but ego restriction results in there being no functioning to restore; it is a developmental distortion such that developmental help is required to set the functioning going again before the original conflicts can be meaningfully addressed. The nub of developmental help is the distinction between 'making conscious' in the sense of lifting repression, and 'making conscious' in the sense of helping the patient acquire a previously non-existent representation. (Edgecumbe 2000: 19)

Such a 'non-existent representation' was evident in the adolescent boy I saw. Unaware of this line of thinking, I had been struck by his total lack of memory for his early life, for his recent past, for what had happened in the therapy. Anything that had an affective content vanished. I found myself attending to this by talking about my own memories of what he had said and done. 'It is interesting that you should say that.' 'I remember your telling me some time ago.' 'That seems to link with the dream you told me last month.' 'I remember when you first came to therapy how you hated the room.' 'I remember how in the early months . . .' It was as though I were creating a capacity to remember as well as a capacity to have a past. Gradually he began to remember, pleased with himself that he could hold on, at least occasionally, to some experience that had happened either in or out of the therapy. I feel

my adolescent patient taught me this, needed this from me. It is, however, a well-documented therapeutic approach (Hurry 1999) and it is one which I continue to think about in relation to all my patients.

Acting out

Acting out is so much the language of adolescence. As the Laufers (1995) point out, very disturbed adolescents express their thoughts through actions. The young girl acted out, as I said, drinking, taking drugs, stealing, fraud, driving dangerously, missing sessions, My young male patient acted out not only by coming very late and missing sessions but also by wearing dark glasses and earplugs in sessions, never taking off his coat or putting down his bags. Some of this could be interpreted as it happened, some was more difficult to understand. Only later did I understand, for example, that my adolescent boy did not put his bags down because he had to be ready for when he was kicked out.

Conclusion

I feel that my work with my adult patients has been profoundly influenced by my training in working psychoanalytically with adolescents. It was a very difficult experience being exposed to the adolescent process, to someone who is neither adult nor child, and who can go back and forth between the two with alarming rapidity. Sometimes it felt as though the adolescent process was reflected in the training itself. For example, some said this was the 'right' way, others disagreed and said that was 'wrong'. Views seemed to be strongly held: intensive psychoanalytic psychotherapy should *never* be the treatment of choice for this age group or it should *always* be offered when appropriate. Often one was caught between these strongly held views. The process of choosing what seems appropriate for oneself felt at times like an adolescent struggle, finding one's own way. This too was an important contribution to my work with adult patients.

Finally, the supervisors and teachers on this training were nearly all child psychotherapists and it was a revelation and pleasure to have the opportunity to work with them. There was a particular quality of imagination, of meeting a challenge, and, with so many, an enviable capacity to play with meaning.

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Perverse states of mind in adolescence

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ABSTRACT

This paper is located within a developmental structure. It explores the nature and manifestations of perverse states of mind in adolescence in particular. The theoretical framework is post-Kleinian and draws extensively on clinical material. The paper stresses the role of early developmental disturbances and links infantile and adolescent experiences in the attempt to discriminate between pathological states and those associated more generally with adolescence as a specific phase of development. As a whole, the paper is concerned with the psychodynamics of perversity of character and of purpose, rather than with sexual perversity as such, but it does include a detailed example of the latter and situates it in the vicissitudes of early traumatic experiences.

Key words adolescence, perverse states of mind, Bion, pathological narcissistic organizations, early trauma, attacks on truth

The focus of this paper is on those states of mind in which the inner world is being turned upside down, where, effectively, 'fair is foul and foul is fair' – as the weird sisters shrieked in the opening scene of *Macbeth*; where 'evil be thou my good' is the guiding principle and perversity of purpose dominates the personality.

During adolescence, it is easy to mistake the destructive, contrary, wilful, negativistic and sexually exploratory attitudes of this happy/unhappy multitude as constituting perversity. Yet the disturbing behaviour and attitudes so often encountered during the teenage years are often more akin to heightened expressions of unmanageable, and often very confused, libidinal and aggressive forces – ones which can subside as quickly as they can flare up, without leaving any particularly lasting scars.

An initial, brief example may be helpful in establishing some understanding of what is meant when describing certain states of mind as being 'perverse'.

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The clinical picture is of Nigel, an extremely troubled four-year-old boy in intensive therapy (previously discussed in Waddell and Williams 1991). It offers a searing expression of the main characteristics of the perverse states of mind that are explored in the body of this paper: perversions of character and of purpose; the systematic distortion and misuse of psychic and external reality; the slaughter of truth. The thinking belongs in a post-Kleinian frame of reference and draws both on the literature of pathological or destructive narcissistic organizations, and also on Bion's understanding of the centrality of truthfulness for healthy emotional development, and the poisonous impact of an aversion to truth, to the emotions, and ultimately, to life itself.

'I want to eat pooh food and grow up and live dying.' This was Nigel's chilling response to his therapist's attempts to make sense of the child's hopeless confusion. Nigel, totally trapped in a 'perverse state of mind', relished his relationship with what became known between himself and his therapist as 'the muddling Nigel' or simply the 'Muddler'. He would state firmly, 'I am not listening to you, because I like listening to the "muddling Nigel"'– the sower of confusion, in other words, the eliminator of meaning.

From this part of himself came repeated slogans: 'Poohs are delicious, good to eat'; 'Making a mess is wonderful.' Blinking his eyes as he looked through a narrow opening, he would say that he was busy, 'taking pooh-to-graphs'. Nigel's idiosyncratic way of perpetuating ignorance, attacking truth and nourishing himself with pooh-lies, is graphically put across in this 'pooh-to-graph' pun. He reduced his world to a set of faecal images, versions of his own perverse improvements on reality, thus poisoning the personality, in Bion's terms, with lies rather than taking in anything growth-promoting – in the sense of food for thought.

His mother's severe puerperal depression may have contributed to his turning away from a genuinely dependent relationship and towards so dubious a source of protection as the Muddler, and the way the transference developed seemed to confirm this. Whatever the details of possible aetiology, it was certainly the case that Nigel was enslaved to an anti-developmental alliance with a destructive part of the self that he idealized. He loved the 'Muddler' who told him that poohs were infinitely better than milk. He stated that he was 'never, never, *never*' going to use the toilet.

While, on the one hand, he was strikingly immature, still, aged four, wearing nappies, there were, on the other, certain areas of Nigel's mental development that were extraordinarily precocious. But the precocity was marked by the consistently destructive way in which he used his prodigious knowledge – an impressive example of the minus K mode described by Bion, to which I shall return. Nigel had taught himself to read at the age of three, and he had a very extensive vocabulary. But he seldom used words for communication, nor for making symbolic links. He preferred breaking links to making them. He would relish literal and concrete terminology rather than anything more symbolic, and would delight in assembling fragments of words *as if* they made

sense – to the anxiety and consternation of those about him. Verbally, he lived in his own artful universe. Like Humpty Dumpty, in Lewis Carroll's *Through the Looking Glass*, he seemed to be saying, 'Words mean what I choose them to mean, neither more nor less.' 'There is only one ruler,' he would shout, tyrannically brandishing a stick above his head. In Hanna Segal's terms, he preferred symbolic equation to symbolic representation – words were instruments of power and control rather than conveyors of meaning.

The violence which Nigel continuously perpetrated on words and their meaning seemed, in spite of his hatred for symbolic thought, to be associated in his mind with violence done to babies. 'Baby dead, baby dead, killing babies,' he would intone as he literally ripped up the written word in book after book. He was observed tearing the page of a children's story in what his therapist described as a 'deliberate way, with a cruel air and slow, jerking movements'. The therapist recoiled from what he called the intensely sadistic feel of this process: 'As if he was tearing the wings off flies, he shredded the paper into little bits, and, scattering them about the room spoke into a mock microphone, "testing, testing".'

This last extract helps us to observe a central characteristic of Nigel's identifications. So often in his behaviour he caricatured an adult, usually a scientist involved in an experiment, the aim of which was, in essence, that of baby-killing. 'Kill them, burn them, bury them underground,' he would say, as if coldly giving instructions. His father was, in fact, a scientist, and Nigel seemed at times in total identification with his own distorted version of him, conveying a sense of negativistic exaggeration, in order, it seemed, to assert that daddies don't make babies, they kill them. In one session he walked to the therapy room muttering 'minus, minus, minus'. One wondered which victims he was totting up, perhaps those who, in his internal world, *were* minus, minus, minus – that is, 'killed, burned, buried underground'. Destructive envy seemed to be feeding his Oedipal need to destroy any creative intercourse between his parents and certainly the dreaded product of such a union.

These elements of negativism, sadomasochism, confusion and caricature function under the aegis of a destructive part of the self and are devoted to distortion and attacks on the truth. They are essential features of the perverse state of mind. Nigel also manifested another core component of perversity: the fantasy, conscious or unconscious, of the secret killing, rather than parenting, of babies – an oblique form of attack on the inside of the mother's body, so central, as Donald Meltzer (1973) suggests, to perverse character organizations.

Nowhere is this constellation more clearly evident than in the links in *Macbeth* between baby-killing and perversity. In her passionate exhortation to murder, Lady Macbeth speaks as follows:

> I have given suck, and know
> How tender 'tis to love the babe that milks me:

> I would, while it was smiling in my face,
> Have plucked my nipple from his boneless gums,
> And dashed the brains out, had I so sworn as you
> Have done to this. (Macbeth I. vii. 54–59)

Her woman's breasts are used to promote neither love nor nourishment but hatred and murder ('Fair is foul').

The witches' cauldron contains a ghastly recipe – part objects, in Kleinian terms, and emblems of perverse, murderous destructiveness – 'pour in sow's blood that hath eaten/Her nine farrow; grease that's sweaten/From the murderer's gibbet'; 'Finger of birth-strangled babe/Ditch-delivered by a drab'. This is death food indeed. Nigel would have loved it.

As Gail Grayson points out, 'if hell-stew is a parody of eating . . . so the Macbeths' sexuality is a black parody of love. *Murder* is the "swelling act" as, like the witches, they assert "foul is fair", good and bad mixed all together, in bits, like a hell-broth stew' (Grayson 1991: 225). She goes on: '. . . rather than mitigating aggression, loving impulses are used to sexualize it and so increase its power (Fair is Foul)'. Destruction becomes highly eroticized – excitement of a very cruel kind is added to confusion – all components of what Stoller describes as 'an erotic form of hate'. (I am reminded of a ghastly photograph in the English press recently of a gang of adolescent murderers, excitedly embracing and kissing one another in a kind of manic orgy after beating up a young student and throwing him off a bridge. He drowned in the Thames below.)

As I have suggested, my emphasis throughout is on perversity as an aspect of character rather than on the particularities of perverse sexual behaviour as such – although this latter will very likely be an expression of perversity of character as well, as my final example will indicate. The roots will tend to go back to infancy. Freud establishes the link especially clearly between early experience and later disturbed and fractured mental states: 'If we throw a crystal to the floor, it breaks, but not into haphazard pieces. It comes apart along its lines of cleavage into fragments whose boundaries, though they were invisible, were predetermined by the crystal's structure' (Freud 1933: 59).

The notion of planes of cleavage affords a way of thinking about the underlying operation of forces which often only become apparent later, especially during the teenage years. Such a notion focuses attention on the significance, for character, of a person's infant and childhood experiences. Psychoanalysts focus on the unique interaction in each individual between dispositional factors in the baby and the nature of his/her earliest environment – the mother or caretaker's mind. That interaction is, in turn, supported or undermined by early internal and external events, the effects of which, whether adverse or benign, may subsequently be mitigated, confirmed, altered or diffused. The legacy of these early times often only becomes properly evident as the young person makes his or her way through adolescence, when the stress of that undertaking can reveal cracks and fissures, vulnerabilities and weaknesses which, though long present, have not been manifest hitherto. If early difficulties have been

ill-contained, the physiological and accompanying psychological changes of puberty can detonate what may have been unrecognized fragilities in the personality and require a complex range of defensive measures lest 'things fall apart, the centre cannot hold' (W.B. Yeats, *The Second Coming*). As the known personality gets drawn into the vortex of uncontrollable change, breakdown threatens. The scars of early setbacks become inflamed. As Donald Meltzer put it: 'the impact of interferences such as prematurity, incubation, early separations, failures of breast feeding, physical illness in a mother or baby reveal themselves in character development as unmistakably as the "shakes" in a piece of timber mark early periods of drought' (Meltzer 1988: 25–26).

Consultations with parents of some if the most troubled of the young people who find their way to the Adolescent Department at the Tavistock Clinic confirm the link between early traumatic experience (especially perinatal difficulties) and adolescent pathology. In the very early history of many of our current cases there is a high incidence of, for example, maternal depression, puerperal breakdown, sudden hospitalization, unexpected bereavement, previous infant death, toxaemia, etc. Although exceedingly painful for them, parents often find it helpful to begin to think about these links, not so much to seek causes and explanations but rather to understand a broader picture of the long-standing factors which may be contributing to the mystifying and deeply distressing changes occurring in the child whom they thought they knew – a child whose mental states and attitudes are so often described in terms of 'sheer perversity'. The long-term developmental picture often turns out to be extremely instructive in these cases.

Bion attached enormous importance to the relationship between the baby's constitutional capacity to bear frustration and the degree to which the painful or frightening impact of early adverse events, whether internal or external, is variously modulated or modified by resilient and understanding adults. Lacking what he termed 'containment', that is, the experience of having infantile anxieties mentally held and thought about by a mind capable of 'reverie', the baby or young child will have had to seek refuge in various forms of flight and evasion, erecting ever more extreme defensive blocks to unmanageable emotional states. Such a baby will not have had the benefit of the mother's making sense of the infant's projections and giving this sense some kind of a shape and a form. This maternal capacity Bion called 'alpha-function', a function that the baby gradually acquires for him/herself, one that is a *sine qua non* of the continuing capacity of the baby's own mind to develop through meaningful emotional encounters. Nigel would seem to have lacked such an experience. Indeed, his retreat into 'infant-scientist' mode constantly evoked Bion's description of the consequences of the desire to evade any experience with live objects: 'destroying alpha function leaves the personality unable to have a relationship with any aspect of the self that does not resemble an automaton' (Bion 1962: 13). 'We hear of inanimate objects . . . when we would normally expect to hear of people' (Bion 1962: 9). 'Testing, testing'!

These days, the virtual relationships of the internet chatrooms are often preferable to any actual relationship and, among adolescents in particular, information technology can take precedence over the painful acquisition of the kind of knowledge which is in the service of getting to know the world, the self or others. The sense of omnipotent control is naturally attractive to those who are seeking to avoid struggling with the pains of impotent confusion – those who are no longer children and not yet adults. 'Net' life all too easily substitutes for real life among this uncertain and anguished population.

When infancy or early childhood have been disrupted by traumatic or unsettling experience, the individual's capacity to deal with the onset of pubertal and adolescent disturbance is often reduced. Puerperal breakdown, for example, and its likely sequelae (which would certainly have militated against a capacity for alpha-function) may well have been a factor in the unusually flagrant perversity of little Nigel. Similar factors were present in the backgrounds of the adolescent cases which I shall touch on, ones where we can also variously see chilling evidence of the kinds of contempt, detachment, omnipotence, confusion, negativism and caricature which already played so central a part in Nigel's perverse pathology.

The treatment of adolescents so often involves exactly the process, so evident in Nigel's mode of relating, of (defensively) reducing or eliminating any possibility of shared meaning. Yet there would seem to be an important difference between an arrogant and dismissive attitude based on a fear of intimacy or a recoil from making contact on the one hand, and, on the other, a Nigel-like dedication to negating any possibility of genuine engagement. The therapist may repeatedly have to withstand the destructive impact of a deadly mode of relating on the part of a patient who would seem to be coming to every session as if to kill it off, as if, indeed, perversely dedicated to the goal of getting nowhere and tormenting his therapist in the process. Such a patient may negate, mock or distort any interpretations offered. He/she may be 'misunderstanding the interpretation to demonstrate that an ability of misunderstand is superior to an ability of understand' (Bion 1962: 95).

There is a characteristically addictive quality to such perverse states of mind – especially observable when there is any suggestion that it might be possible to dis- engage from the internal domination of the destructive parts of the personality, sometimes theorized as the workings of an internal gang. Donald Meltzer (1973) and Herbert Rosenfeld were particularly experienced with these character types. Rosenfeld describes the destructive impulses have become diffused so that they actively dominate the entire personality and all the relationships the patient has.

> They express their feelings in an only slightly disguised way by devaluing the analyst's work with their persistent indifference, tricky repetitive behaviour and sometimes open belittlement. In this way they assert their superiority over the analyst representing life and creativity by wasting and destroying his work, understanding and satisfaction. They feel superior in being able to control and withhold those parts of themselves which

> want to depend on the analyst as a helpful person . . . It appears that these patients have dealt with the struggle between their destructive and their libidinal impulses by trying to get rid of their concern and live for their objects by killing their loving, dependent self and identifying themselves almost entirely with the destructive narcissistic part of the self which provides them with a sense of superiority and self-admiration. (Rosenfeld 1971: 173–174)

To this description must be added the more explicitly sadomasochistic aspect of such states, an aspect which lends these kinds of destructive organization their distinctively perverse qualities. The situation is well described by Betty Joseph:

> ... such patients feel in thrall to a part of the self that dominates and imprisons them, and will not let them escape, even though they see life beckoning outside . . . [the patient] is not only dominated by an aggressive part of himself . . . but . . . this part is actively sadistic towards another part of the self which is masochistically caught up in this process and . . . this becomes an addiction. (Joseph 1982: 451)

The adolescent, in particular, so often presents him/herself as both captivated by, and captive to, an aspect of the self which seems perversely bound to a self-punitive (whether actually or in fantasy) part of the self at the expense of another part that can dare to live on the 'outside'.

Such a process is visibly exemplified in the following dreams of two different adolescent patients. Eighteen-year-old John's characteristic mode of defence against the pain of separation, the fear of intimacy, the experience of littleness and especially the threat of change lay in homosexual fantasies and dreams (not practices), often with anal connotations. The nature of the internal conflict was expressed with great clarity in a number of dreams. For example: *I was imprisoned in a dark house. Every time I attempted to escape over the horizon and towards life and freedom I found myself pulled back by a gang with a leader named 'Cave'.* (This was apparently an individual who, as a child, like little Nigel and indeed the Wolf Man, enjoyed pulling the wings and legs off insects.)

The dream indicates both the healthy part of John's personality, one which seeks to liberate him from residence in his particular 'psychic retreat' (Steiner 1994), or 'Cave'-like claustrum (Meltzer 1992), but also a less healthy part, a gang of the more destructive elements in his personality which forever combat the liberating impulse and repeatedly pull him back to re-imprison him.

A similar constellation is evident in the dream of another patient, 17-year-old Jenny, the setting for which was, as she put it, a '1984-type place': *There was a building – a huge, dark cavernous, barn-like structure. It was the headquarters of a 'Big Brother' organization, under whose watchful eye enslaved people laboured in uniform in the fields and orchards nearby. I found myself unexpectedly at a distance from the main group, somewhere down a grassy track, enjoying the beauty of the evening. I suddenly became aware that I could have*

escaped, but terrified that the alarm would be raised, I ran, slipping and sliding back up the muddy track to the headquarters. There I was met by my own big brother who has always had such a terrible hold over me, even now.

Jenny, physically and emotionally in thrall to her bully brother since childhood, would, despite her better self, psychically sign up for further punishment whenever hope of escape was in sight. Likewise, time and again in her treatment, she would masochistically return to aggrieved complaints, accusations and denigrations whenever there was any evidence of some slight progress – a kind of negative therapeutic reaction so often encountered in such patients.

We can see how different aspects of each of these patients' material demonstrate the way in which the links of genuine relatedness between people – whether based in feelings of love or hate, or the desire to get to know and understand (theorized by Bion as links in L, H, and K) were constantly opposed by a pulling away from honest engagement, away from freedom, individuality, intimacy and aesthetic sensibility. In the face of the threat of loss or change, or of any new development in the personality the patient clings all the more desperately to his or her own perverse reality – however distorted, empty or bizarre (Bion 1962: 98). With such patients, words tend to be used to mess up meaning, and, as we shall see in the details of a single session, there is a tendency towards displays of emotionality rather than expressions of genuine feeling.

There is also, not infrequently, an active mental desire for the misrecognition of truth and meaning, even in a passive-seeming patient, and a tendency for real, present anxieties to be taken over by past ones which are no longer relevant. As Betty Joseph said, so accurately in the case of Tom, the patient I am about to describe: 'Today's interpretations become tomorrow's perversions' (unpublished contribution to conference discussion, 1999). When these manoeuvres and manipulations are in force, the possibility of creative exchange between patient and analyst is killed off. There is no live outcome, only deadened repetition: the cruel and tormenting process of strangling or smothering at birth any product of thought and shared work in the sessions. The dominant mode is a destructive, psychically murderous one, which characterizes and almost caricatures Bion's suggestion of a negative grid of anti-linkage, anti-thought, anti-knowledge. The perverse states of mind into which such patients, and especially adolescents, so often fall in their defensive evasion of the tumultuous changes with which they are dealing, epitomize this kind of minus linkage, so disturbingly and graphically observed in Nigel's 'minus, minus, minus' baby-killing exploits.

Elizabeth Spillius puts the theoretical picture of the very early origin of these pathological states particularly clearly:

> Bion is one of the first . . . to tackle the problem of how an organization of this sort arises. His model of what he calls 'minus K' paints a chilling picture of the inner world when reverie and alpha function fail (Bion, 1962b, especially chapter 28). One

> wonders, he says, why such a thing as minus K should exist and says he will explore one factor only, envy. In his model, the hypothetical infant projects his fear of dying into the breast together with envy and hate of the breast. Because of the projected envy the breast is felt enviously to remove the good elements from the fear of dying and force the worthless residue back into the infant. Worse still, the envious breast takes away the infant's will to live. When the object is re-introjected, it becomes an extremely destructive internal object, bent on stripping the infant, or what is left of the infant, of any qualities he still possesses, enviously asserting moral superiority, arousing guilt, but only to show superiority, not to put anything right. The ego becomes partially identified with this envious, stripping internal object to form what other authors variously call the bad self, the destructive self, or the narcissistic self, which attempts in diverse ways to rule the internal world. (Spillius 1988: 196)

A brief and distressing extract from the observational material of Jamie, 16 and a half months old, may give some sense of what happens when 'reverie and alpha-function fail'. Much hangs on whether these earliest dynamics are modified or reconfirmed as time goes on. The following account of a random half-hour in Jamie's day can be understood as contributing to the general emotional groundswell of this little boy's life – a groundswell which might well, in his adolescent years, throw up 'breakers' of quite unmanageable proportions. (These observations took place for one hour a week, in a family home, over a period of two years.) It had long been noted that food was a particularly problematic area in this family and Jamie's older sister, Mary (age three), was already a very picky eater and painfully, even dangerously, thin. On this occasion, unusually, Mary said to her mother 'I'm hungry.'

> Her mother, holding a conversation on her mobile phone, said, 'Well, what do you want to eat?' She then ignored her daughter. Mary did not reply. While her mother continued talking Mary disappeared into the kitchen. She returned shortly afterwards with a handful of biscuits. She came up to where the observer was sitting and surreptitiously slipped a foil-wrapped chocolate biscuit over the arm and into the chair, smiling mischievously. Looking up, her mother said sharply, 'Mary, where did you get those?' Turning to the observer she said that Mary had discovered how to undo the child-locks and that she could now get into the biscuit cupboard. Mary picked up the chocolate biscuit from the observer's chair and offered it to her little brother, Jamie, who had just come into the room himself holding a foil-wrapped biscuit of his own.
>
> The mother said, 'Those are mummy's biscuits.' (The chocolate biscuits were, indeed, reserved for this mother, and her children, on the grounds of health, had to make do with rice crackers.) She called Jamie over and he went towards her. She took the biscuit from him and put it on the table. He strained towards the biscuit and, unable to reach it, rapidly became furious and very upset.
>
> Acting as if she didn't know what he wanted, his mother said, 'What do you want? You can't have the scissors.' Jamie lashed out at his mum, fell dramatically to the floor and burst into inconsolable tears.
>
> His mother, seemingly innocently, said: 'Oh, do you want me to cut it open for you?' She picked the biscuit up, snipped off the wrapper and gave it back to Jamie. He took the biscuit, walked towards the settee, clambered up and sat in the middle of it to eat his biscuit. Because the biscuit was submerged inside the wrapper, he could only pick crumbs out with his fingers. The same was true for Mary. The observer described the acute discomfort of watching how hard Jamie was trying to extract the biscuit

crumbs from the wrapper while anxiously brushing away the ones that fell on his lap. His mother called out sharply, 'Are you making a mess Jamie?' 'No,' he said, 'aw gohn.' He brushed away the crumbs ever more frantically, as if desperately trying to be 'a good boy'. His mum asked peremptorily, 'What are you doing?' There was muted anger in her tone as she went towards him, 'If you've finished put it in the bin – go on Jamie put it in the bin, in the kitchen.' Jamie had hardly managed to start his biscuit. He looked up at her perplexed, bent down and picked up a plastic toy cup. He headed for the kitchen. He was holding the biscuit in one hand and the cup in the other. Swiftly he put the cup in the bin, keeping hold of the biscuit. His mum said, firmly, 'No Jamie.' She took the cup out of the bin, snatched the biscuit from him and threw it in the bin instead. Jamie burst into tears of fury. He was intensely angry and began scrabbling in the bin to retrieve the biscuit. His mother intervened. She picked him up, carried him to the sitting room and began tickling him manically. A confused and rather desperate expression appeared on Jamie's face and he looked ambivalently willing, yet far from happy. As soon as his mother put him down on the floor he threw himself away from her, sobbing with a mixture of frustration and distress, beating the floor with his fists.

This was an exceedingly painful episode in which bullying, teasing behaviour was being enjoined on a young child who had no capacity to understand what such behaviour might mean, nor how to handle it. In this case we already had evidence of ways in which Jamie had developed defensive strategies to deal with his, at times, cruel and confusing mother. Even at 16 months he was strikingly accident prone, constantly falling, cutting himself, and hitting his head, already with many visits to Casualty. He had also, more recently, become quite aggressive towards his sister, hitting and teasing *her* whenever he got the chance. Unless things were to change for Jamie, it would be unsurprising if, later on, he were to enjoin either on himself or others some version of the perverse cruelty that had been foisted on *him* in these early months.

The detailed account of a single session from the analysis of a young man, Tom, may draw together some of the elements of the foregoing picture of adolescent perverse states of mind and their putative links with early trauma and failures of containment. Although, in this case, sexual perversity was central to the symptomatology, the present emphasis is on what would actually happen between patient and analyst in the session, and on the light that such interchanges might throw on the perverse mentality and thought processes which underlay the more obviously recognizable sexually perverse activities.

Tom was locked in a particularly adolescent form of sadomasochistic excitement when he began treatment. He had suffered many traumas in infancy and early childhood. Some of his reminiscences of this unhappy time made it clear, as we shall see, that from very early on sadomasochism and voyeurism were ways of holding himself together in the face of feeling lonely and frightened most of the time – to the point, one might surmise from the analytic material, of suffering almost psychotic anxiety. At school he achieved nothing worthy of his ability and was taunted and bullied continuously. He left at 15 and became a teenage tearaway. But under his protractedly adolescent behaviour lay darker, exhibitionist and voyeuristic impulses and activities

about which he remained largely unconcerned until the failure of his first real love affair. During his late adolescent years he would find himself excitedly compelled to 'streak' in crowded places – thrilled by the risk of imminent discovery; to expose himself to women in parks; to undress in public places, covering himself only a split second before sure detection.

It was concern about sexually perverse thoughts, and his failure to get on with his life that decided Tom on seeking help. He lived, in Henri Rey's words, 'a limited and most abnormal emotional life'. It became increasingly evident that any kind of real intimacy was dangerous and posed a significant impediment both to moving into proper adulthood and to making use of the analysis, as these detailed extracts from the fine grain of parts of two sessions will show.

Tom began a Monday session by saying, 'I really *do* want to talk about *important* things, but I always find myself forever just talking.' There was a pause and he began to describe in a familiar, sincere voice of complaint how, 'the way the dean spoke to me today put me right back with my father, just wanting to get out of the way, not be seen, freeze in the anticipation of disapproval'. Tom continued in this vein and became increasingly tearful. As so often, I felt downcast at how swiftly his initial declaration of regret and intent had been taken over by a listing of old grievances. I felt that while expressing emotional distress, he was, in fact, using emotionality to conceal how cut off he actually was from any real engagement with me in this first session after the weekend break.

I suggested to him what he might be doing when he thought himself back into a state of mind, and a way of speaking, which were not, in fact, about the present 'important things' at all, however 'important' they might be made to sound. Tom nodded in response, as if in agreement, but went on as if I had not spoken, to recount a childhood experience which I had heard many times before. With some force he said, 'Why couldn't she just stand up to him [meaning his mother to his father], just support *me* for once? Why did she have to slip bits of meat from her plate onto mine when he wasn't looking? Why couldn't she just say that I had been given less than everybody else? She just couldn't show me that she remembered how it had been before [i.e. his mother's breakdown during Tom's early childhood]. She just couldn't stand up for *me*.' Sobbing, he said: 'She just *wouldn't* let herself know how awful it was for me.' I talked with him about how he continued to feel that I also didn't take in the extremity of his suffering, and about how difficult it was for him to accept or appreciate the analyst who *was* supporting and helping him. He preferred his picture of himself as a betrayed and ill-treated victim, and of me as someone who could not, even after all this time, allow myself really to know him.

Tom again nodded and calmed down a little, but immediately began reverting, tearfully, to a variation of an early dream/fantasy which he had

always recounted with intense erotic pleasure. He was a small boy (this time without trousers), inadvertently being 'seen' by me in a mirror. By now my own feelings were alerting me to two things – both to the dressing-up of old material for hidden erotic purposes, and also to an element of Tom's own split-off and increasingly evident desire, namely, the desire that this eroticized repetition to *be* seen, or 'seen through' by me. Part of him wanted a halt to be called of a kind which could enable him to stop escaping down these well-trodden paths of perversity and insincerity. It was calling such a halt that would constitute proper help and support. I wondered aloud about whether what he was doing in these emotional repetitions of memories, dreams and fantasies, was trying to 'expose' what was actually happening, that is, his wish to avert my attention from the truth of his use of this 'old rope' for the purposes of arousing pity and excitement. I also suggested to him that his wish to 'expose' himself to me 'without trousers' (his fantasy was that I would be transfixed by the sight of his penis) functioned as a way of diverting my attention from his difficulty in honestly 'showing' himself to me in the consulting room. Yet he also feared that I would not realize that that was the case. We were nearing the end of the session. First he questioned my meaning, then he nodded and quietened.

In this session, the countertransference suggested that what Tom had really been wanting to 'expose' was the lie that he was always ambivalently seeking to sustain in the analysis – the lie which the actual 'exposure', in supposedly being so exciting, was in fact meant to conceal. He wanted to continue his rather passive, deadened relationship with me, and with everyone else, seeking hostility towards his objects to maintain his victim position and not suffer the guilt that was entailed in his hostility that was, on the whole, safely split-off into external-world persecutors, but was also making its covert appearance in the sessions in these continuous offers of red herrings. Tom's mental deviousness was much more subtle and difficult to identify than Nigel's all-too-explicitly murderous attacks on truth, but the effect was quite as deadly. His considerable intelligence was, at this stage of the treatment, rigorously martialled against any contact with genuine feeling, and chronically drained the more imaginative and creative aspects of his personality which only emerged very much later.

He opened the next session quite enthusiastically: 'What you were saying yesterday made me think something that you may have said before, but it felt new to me.' He paused: 'I thought that when I talk to you about sexual fantasies what I am really doing is wanting, from a position of 'hiding', to observe the impact it's having on you.' This was, in fact, very close to what my own thoughts had been the end of the session and *was* indeed by no means a new idea. Under the guise of suggesting that we were getting somewhere in the analysis, it felt as if Tom was again, covertly, going round in circles.

Conclusion

With the patients described here there was, in each case, a feeling on the therapist's part of working at the interface between impasse and development. As we have seen, perverse states of mind, by contrast with isolated acts of perversity, often convey a specificity of history and expression. In adolescence they also convey a kind of urgency – that these states be addressed, understood and modified before they become an unshiftable force in the adult character.

As I have suggested, it is so often in the teenage years, with their developmental recapitulation of infantile states, that perverse impulses and urges, if unmodified in earlier times, may settle into extreme, or chronic caricatures of the negativistic, distorting, depressed or manic states which can so easily pass for normal adolescence. The caricatures, in turn, distort and deform the young person's possibilities of establishing and sustaining the kinds of relationships which would be of service to the growing personality.

The vortex of adolescent experience can be potentially life-confirming or life-denying. This is true almost from moment to moment. But the kinds of perverse states under discussion risk putting in jeopardy the progression, necessary at this stage, from narcissistic structures to more object-related ones. The attacks on emotion and truth which typify such perverse states endanger the routes forward. They can pose what may seem like impossible road-blocks. If help is not forthcoming, 'Fair is foul and foul is fair' may not so much be a passing slogan as an entrenched way of life.

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'I don't know'

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ABSTRACT

The stimulus for this paper is an expression, often used by adolescents, not untypically in psychotherapy. The expression, 'I don't know', is both endearing and infuriating to psychotherapists whose benign intention is to know, to explore and understand. This paper seeks to make sense of the developmental significance of this expression. Fundamentally, it is seen as a necessary form of communication that allows for internal acknowledgement of the adolescent's 'knowledge'. It is seen as an assertion of the need for privacy, in which to register the complexity and newness of experience. It is taken as a plea for time for contemplation. Issues of identity and integrity are seen as being contained and processed through this expression, the adolescent finding space to discover the nature of his knowing and not knowing. In the psychotherapy of adolescents, an approach of 'negative capability' is proposed, appreciating the particular meaning of the adolescent's 'I don't know', rather than seeking to interpret it as a resistance.

Key words unthought known, Christopher Bollas, adolescent experience, transition, negative capability

A 14-year-old boy has recently been expelled from school. He has been involved in a series of fights for several weeks and the schoolteachers have had enough. They feel they cannot contain him, and he is referred for psychological assessment and alternative placement. It turns out that his parents have recently separated, having endured a long, acrimonious and violent marriage. His younger sister has been sent away to live with relatives. He now lives alone with his depressed and bitter mother.

Amongst other things, he is eventually ushered into psychotherapy. He and I sit in guarded anticipation of each other – he, reluctant, confused and angry; I, interested, unsure and wondering what difference I can make. He tells me the gist of his story well enough – a flat, factual account of his family life and a complaint of injustice at school. He doodles a bit, mostly cartoon figures holding balloons (but with no captions). As the initial weeks go by, we

catch up on latest events and although not much is said, we more or less agree to meet until the following summer (a three-month stretch, on trial as it were). Our weekly life together is for the most part rather awkward, ungiving and unforgiving, and it is as much as I can do (or he) to keep sufficiently engaged to carry on. In fits and starts, wherever I see an opening, I make some comment or suggestion about how he might be feeling – to establish some form of contact, to touch on what might be beneath the gloom. Sooner or later I ask him about the different aspects of his life that he has told me about – his fights, his expulsion, his parents' divorce, their violence, the loss of his home, his unhappy mother. What does he think? How does he feel? His answer: 'I don't know.' I carry on with similar questions or thoughts as best modulated and unintrusive as I can; again I meet the same response, 'I don't know.' At suitable distances, I try to take it further. I say, for example, 'I should think you are getting worried about what is going to happen next at school, whether you are going to go back or what.' 'Dunno.' I say something else in a similar vein, but drawing more on what might be his anticipation or experience of seeing me. 'Maybe it's not easy for you to trust me – maybe, in view of what's happened, you can't imagine that I might care.' 'I don't know.' Whatever variant is used – 'Suppose so', 'Whatever' – we are pretty well left in the dark – he uncommitted; me baffled.

To those who have entered into this kind of psychotherapeutic tangle with an adolescent, the challenge cannot be unfamiliar. It is one that consists of many imponderables, seemingly impenetrable. The sound of 'I don't know' has a ring of finality, an end of sentence; yet, too, of possibility, a sentence poised for the next (whomsoever's sentence it may be that takes the conversation further). The 'I don't know' may be momentary, a passing, a necessary pause, quietly reflective. Or it may be pervasive, more entrenched, characteristic, a dominant feature of communication, for weeks or months.

'I don't know.' Three little words – innocent enough, a phrase more or less familiar to most of us. We know, or think we know, what it is that we know. We know too our sense of not knowing. We are simply ignorant of some things; and curiously unknowing about others – experiences that, at a pre- or unconscious level, may be known but not yet revealed or thought. The complexity of our experience resides in the many layers of acknowledgement of our knowledge. Bollas (1996: 6) has drawn our attention to tacit assumptions, built in the course of mother–child intimacy, that become part of what is known. These he refers to as 'unthought knowns' and he sees 'the evolution of life, in part, as gradually realizing the bases of one's unthought knowledge'. Of central significance is the process of realization or recognition of what is 'known'. Bollas writes '. . . the primary repressed unconscious is full of unthought known forms of knowledge waiting for developed forms of thinking to evolve, so that part of what is known is eventually available for representation in speech, imagination, affect or enactment'. Such 'unknowing' becoming known over time is clearly in the nature of the growth of human awareness.

It is a thoroughly perplexing yet intriguing process, even more so, perhaps at certain transitional periods of life. The capacity to say 'I don't know' and to bear waiting to know may be of crucial developmental significance, serving the purpose of integration – the integrating of what has been, and has yet to be, discovered.

In adolescence, young people are engaged in a very critical transition. They are in the midst of a kind of internal migration, leaving behind their childhood bodies, familiar dependencies, earlier trusts and certainties of latency. So much 'disappears' that many lament that 'nothing will ever be the same again'. At the same time, in transit, they are moving forward – 'passing over, or across or through' – reaching, changing, making their own way. Their passage into uncharted territory is fraught with unknowables. They have no way of knowing the way and can do no more than keep curious and hang on to find out. Their discovery of each new experience, moreover, is precious: something fresh being found that is personal, unique in its meaning for their emerging selves. Each experience consists of aspects of the unthought known, together with those of the unanticipated – unexpected sensations and capabilities. The adolescent needs to safeguard for a while what he or she knows, and hold his or her distance from those who might impinge or take away. With all this in mind, the adolescent rightly and frequently says in his everyday life and inevitably in psychotherapy, 'I don't know.' It is his or her marker of identity, as well as a plea for time to contemplate. It is something to be respected – not berated, disbelieved or tackled as a resistance to be overcome. Adults and psychotherapists have to allow for the indeterminacy inherent in the adolescent experience.

In many respects, these observations and comments sit oddly in the throes of a contemporary youth culture in which assertive upfrontedness shouts through teenage minds and confronts the adult kingdom in bewilderment. In lyric after another, in magazine upon magazine, in one video beyond the next, loud certainties proclaim themselves, underpinned by the sharp edge of technology's increasing potency. 'The knowledge' about sex, life and death is all up there in your face; teenagers seem now to know more than past generations ever dreamed. For many, in the way they appear to know, they seem to know it all. And it is the adult who, caught off balance, says, 'I don't know (what to make of my child).'

And yet, in the ordinary daily business of emotional living, it is likely that not too much has changed. Within adolescents, pubertal bodies still startle in all of their mysterious ways; some begin earlier, others become bigger than others. But at the heart of the matter, fears of the sheer physical power of these changes, of losing control of new internal pressures, and the dread of growing onwards without limit into some sort of monster or freak remain. There is of course excitement, empowerment, exhilaration – but uncertainties persist and the shadowy underside continues to torment. Compelling commercial images of monumental and desirable men and women may fill teenagers'

screens, preen their fantasies, and shape their imitations. But beyond all this, in the aloneness of the bedroom, the shape of the nose, the size of the breasts, the hardness of the penis, the flow of the menses, the countless other encounters with the phenomena of the body remind them of the vivid, unprecedented newness of growing up, and too often of the inadequacy of words to account for it all. In the fumbling and wandering forays into early conversations, there remains, for most, an inarticulateness in catching hold of the things that are novel, fascinating, but essentially unknown and yet to be discovered.

Much of this discovery cannot be readily shared. It is private, bodily private; intimate in the solitary bedroom, filled with ruminations about normalities, adequacies, differences. Whatever the teenager aspires to be or is supposed to look like, there is invariably an anguish, a kind of despair in never, ever being quite perfect or even good enough perfect. The teenager ultimately has to settle for the genetic and hormonal truth of his or her own puberty – and to accept it as his or her own. His or her body is for sure no longer 'theirs' – those parents, who have assumed naturally enough over the years due care and control. 'This body is mine,' says the teenager, 'to do and play with as I see fit. Keep off.' Independence has its roots in this bodily ownership – well fortified by well-known adolescent defences against the regressive lure of incestuous ties (A Freud 1958: 268). And yet of course such insistence on privacy carries with it its own fears – of loneliness, loss of dependency, of self-exposure. The teenager is faced with a profound prospect of growing into an adult: separate, distinctive, filled with unnerving questions about who and what he or she is to become. These and many others abound – and despite the supreme confidence of the stars and heroes of our times, seemingly unfettered by any hint of equivocation, the teenager in his or her own private domain is left with few clear answers. There is much that he or she does not know, yet.

The predicament of adolescence is thus not a certain one – growing up 'alone', in transition between the relative order of latency and the limitless breadth of adulthood, frightened by the intensity of incomprehensible feelings and excited yet dismayed by the prospect of 'becoming'. Adolescence in more ways than one is caught in its disconnections and contradictions. The teenager feels curiously detached from all that held him or her together in the past, yet loosely connected with any sense of a future or adult identity. He or she seeks refuge in narcissistic fantasy and sits in wonder about his or her place in the world, waiting to discover something about him or her self that has yet to happen – something 'that is born or awakened in adolescence that was not generated in childhood' (Frankel 1998: 49).

In the midst of such complexity, it is simply too difficult for adolescents to know for sure about themselves or their intentions, and certainly out of the question for most of the time to answer other people's queries about such matters. Lewis Carroll (Carroll 1965: 49–50) captures sharply the quandary. In 'Advice from a Caterpillar' in *Alice's Adventures in Wonderland*, he lights up a

conversation that in essence is not untypical of the discourse of the adolescent and psychotherapist. Alice and the Caterpillar are talking to each other. Both carry the characteristics of each other and both are bewildered and frustrated by each other.

> The Caterpillar and Alice looked at each other for some time in silence: at last the Caterpillar took the hookah out of his mouth and addressed her in a languid, sleepy voice.
>
> 'Who are *you*?' said the Caterpillar.
>
> This was not an encouraging opening for a conversation. Alice replied, rather shyly, 'I–I hardly know, Sir, just at present – at least I know who I was when I got up this morning, but I think I must have changed several times since then.'
>
> 'What do you mean by that?' said the Caterpillar, sternly. 'Explain yourself!'
>
> 'I can't explain *myself*, I'm afraid, Sir,' said Alice, 'because I'm not myself, you see.'
>
> 'I don't see,' said the Caterpillar.
>
> 'I'm afraid I can't put it more clearly,' Alice replied, very politely, 'for I can't understand it myself, to begin with; and being so many different sizes in a day is very confusing.'
>
> 'It isn't,' said the Caterpillar.
>
> 'Well, perhaps you haven't found it so yet,' said Alice: 'but when you have to turn into a chrysalis – you will some day, you know – and then after that into a butterfly, I should think you'll feel a little queer, won't you?'
>
> 'Not a bit,' said the Caterpillar.
>
> 'Well, perhaps *your* feelings may be different,' said Alice: 'all I know is, it would feel very queer to *me*.'
>
> 'You!' said the Caterpillar contemptuously, 'Who are *you*?'
>
> Which brought them back again to the beginning of the conversation. Alice felt a little irritated at the Caterpillar's making such very short remarks, and she drew herself up and said, very gravely,
>
> 'I think you ought to tell me who *you* are, first.'
>
> 'Why?' said the Caterpillar.

In this encounter, Alice, perhaps with the greater precision, 'hardly knows'. The diversity of who she is, the unpredictability and changeableness of it all, are all too much for her – and indeed for the Caterpillar. Her (and his) puzzlement about who she is, her inability to give a clear fixed answer to a question, pervades and overwhelms the conversation. Both her identity and integrity are at stake. Whatever it is that makes up Alice is not settled yet, not ready to be decided upon, what with 'so many sizes in a day'. There is still much left unaccounted for, and no amount of 'explaining yourself' is going to compromise Alice's truthfulness to herself. Saying 'I hardly know' is a hard thing to say – because her knowledge about herself is so elusive, so difficult to

grasp. She might as well say to the Caterpillar, 'If I did (hardly) know, there wouldn't be anything left to know about'; or to transpose what she might say to the therapist (Caterpillar), 'If I did know what the problem was, I wouldn't be here to 'explain' myself to you, in the first place.'

It would of course be misleading to suggest that adolescents 'know nothing'. There is, in fact, much that is going on during adolescence that is forever expanding a body of knowledge of all kinds. Beyond the broader understanding, through education, of the external world, there develops a greater conscious intimacy with the body, and more perceptive awareness of the nuances of family life and friendship. There is a greater cognitive capacity. The attainment of formal operational thought (Piaget 1954) in early adolescence, enables the adolescent 'to encompass the awareness of the discrepancy between the actual and the possible', and to discover that 'the actual is wanting' (Elkind 1968). Within the adolescent's family, the eyes of the adolescent are invariably the most discerning, much to the discomfort of those under observation.

With so much going on, the adolescent's 'I don't know' has an essential purpose – to make clear the state of complexity and to demand not to be rushed. In its simplicity it says many things. 'I am confused, there is too much to know, so I don't know.' 'I may know but I'm scared to tell what I know.' 'I am not supposed to know so I don't know.' 'If you knew what I know, you wouldn't want to know, so I don't know.' 'I know what I feel, but that's mine – it's not for you to know.' As one adolescent put it most succinctly: 'If I were to share some of my thoughts with someone else, it would be like losing something private . . . like my thoughts would not be mine anymore.'

Throughout, there is an inherent demand to be given time and freedom from commitment. In this, there is ultimately a fierce insistence, a defiance of those who might trespass on private property and extract premature answers. 'Who are you?' asks Alice, to demand an explanation of the richness of what I am. In the assertion of 'I don't know' is the affirmation and preservation of the nature of the adolescent's own identity, or in Winnicottian terms, of the true self. To say anything otherwise would be a betrayal of what one is, or of what one was at the last count, or of what one might be at the next.

Psychotherapists working with adolescents, however much under external pressures, or driven by time imperatives, have to respect the dignity of the adolescent's 'I don't know'. If the adolescent is to be assisted to know enough about him or herself to make more sense to gain greater mastery – rather than to be cajoled or manipulated into rectifying certain pieces of his or her behaviour – then the adolescent and the therapist have to wait. They have to bear the not knowing. In a seminal paper, drawing upon an essay by Camus entitled 'Between Yes and No', E. James Anthony (1985) emphasized the importance of 'an immersion for a short period in an environment of ambiguity and reticence [that] could well facilitate the healing process'. In this paper, he saw

the value of an experience 'of suspension of activity, decision or committed views' as therapeutic, essentially guarding against false solutions and defensive acting out. He argued, in particular, for the therapist to exercise 'a negative capability' that Keats (1947) had earlier defined as the capacity to endure ambiguity, doubt and mystery 'without an irritable reaching after fact and reason'. He sought to find an in-between area between the dictates of definite 'yes' and 'no' positions to allow for the adolescent to pursue his own 'maybe' line of enquiry. Other writers, sensitive to this process, have stressed the importance of ensuring space and privacy – careful always not to get caught up in the intensity of the moment or the panic of the crisis. Frankel (1998: 170), for example, describes movingly his approach to helping an adolescent deal with his anger, through giving 'form to the anger, finding out how it is shaped, discovering its rhythm, and sense of timing, and most importantly what it is seeking. This approach fosters the adolescent's ability to bear the tension between repressing anger and discharging it.' The focus here is not so much on 'explanation' as on facilitating through different senses the adolescent's awareness of his knowing.

Anthony (1975) commented at one point that 'this method of ambiguity has a valuable corrective function for certain types of therapists who suffer from a morbid condition of wrapping up a case before it has been started and who cannot wait to impart their certainties to the patient'. It is undoubtedly a method or approach that may help many psychotherapists who, though possibly not so pressing or omniscient, nevertheless experience, at times, impatience in the face of the persistence of the adolescent's 'I don't know'. However talkative and often insightful an adolescent at times may be, his or her expression of not knowing (however momentary or sustained it may be) may well at times confound us. It counteracts all of our best legitimate intentions to explore, open up and understand. It sits there in all of its recalcitrance to be confronted and interpreted. It may well look like a repression resistance, or a culmination of obdurate transference to be interpreted and worked through. Clearly, in all young people there is much that is being kept back and much that is being transferred – and all of this needs to be borne in mind. However, in the psychotherapy of adolescents, it is essential to take heed of the peculiar nature and purpose of the adolescent 'I don't know'. It is of a different order and quality to the adult's not knowing. It is something other than a defensive clinical manifestation. It is much more a developmental assertion of integrity (that contains its own requirement for privacy). Not knowing in the adolescent is a form of necessary being, an essential mode of communication that for the time being can be taken no other way.

In the following case, an illustration is given of a therapy in 'negative capability' in the midst of a whirlwind of frenetic acting out of an adolescent who was unable to say 'I don't know'. The process of therapy essentially was one that facilitated her to say 'I don't know' enabling her in turn to think about what she had known.

Case illustration

Sarah, a 16-year-old girl, lived a life that was in perpetual chaotic motion, interspersed by times of morose inertia. Her mother was on tenterhooks, wondering what would happen next. Her brother was furious with her irresponsibility and her closest friend described her as 'desperate'. Sarah, meanwhile, seemed not to care. She danced, she raved, she stayed out late at night, she drank, she took drugs. She flung herself into reckless, wild situations. Her schoolwork deteriorated and her health became precarious, often undernourished by erratic feeding or overstimulated by drugs unknown. She was in many respects beside herself – and at times collapsed exhausted in her room, tearful, angry, scratchy – receptive to her mother's comfort.

Her early childhood had been enjoyable in a secure, intact family. She had always been an active, lively, tomboyish kind of girl, and though at times tiresome, she had been much loved. Two major events, however, unsettled her life. When she was eight her mother contracted cancer, and for two or three years was worryingly ill, under constant medical supervision. When she was 12 her father died unexpectedly of a heart attack. She is reported to have 'adored' her father, and his death truly came as a blow. Following his death, she became for a while more subdued than usual and especially close, at times clinging, to her mother. However, at the age of 13 something 'came over her', almost overnight. She 'snapped' and before anybody could do anything about it she was tearing about everywhere, flinging herself into abandoned and destructive behaviour.

She was referred for psychotherapy at a point when her mother felt that she could no longer carry on – and when, indeed, she became ill again. I saw Sarah for a year on a weekly basis. I had regular contact with the mother on the telephone during this time, and was also in contact with the school.

The therapy in the beginning was for the most part a race. Sarah sort of hurtled her way through sessions, full of accounts of new clubs that she had been to, endless boyfriends that she had met and hair-raising incidents that she had put herself through. Unusually, she seemed unconcerned about recounting all of these activities; it was all very much in the open, 'a blast', a boast. For many weeks I found it impossible to establish any real contact with her, to acknowledge with her what indeed might be a problem. Everyone, including she and I, was at sea and the question grew: where were we all going? Sarah seemed to be in full flight in a world of defiance, in masterly denial. In such illusory command, she 'knew' that she was all right – that the dangers that she underwent were harmless, that the people that she met were trustworthy, that her mother and brother were 'fine'. There was no problem. Her enduring refrain was, 'I know (what I'm doing).'

It took about four months to reach any kind of point of meeting with her. This happened, by chance, following a break. Her close friend, who had

described her as so desperate, wrote me a letter – a brief letter, but one with some urgency, wanting me to know that Sarah had spent the last week at her home crying all the time. Sarah had been unable to say why she was crying and the friend was very frightened that Sarah might kill herself.

With the friend's permission, I shared the letter with Sarah. Although Sarah had told the friend that she hadn't minded her writing to me, when she read the letter with me she was initially furious, feeling betrayed and misunderstood. She said she didn't know what the friend was on about. She didn't know anything – why she was coming, what she felt, what she understood. She resented my interest because in effect, like the Caterpillar, she felt that I was asking her to explain herself. Suddenly she and I entered an unexpected and critical phase in the therapy. Quite unlike before, she presented me with an emphatic volley of 'I don't knows': they greeted me at every turn. My thoughts, my enquiries, my raising of possibilities – it was as if she were drawing a blank or a blanket over everything. After a few weeks, something of the manic pressure of her earlier anecdotes subsided – but what predominated was an apparent refusal to know (what she knew). The therapy entered a state of suspension, a necessary impasse. Sarah did in fact know the fact of her crying, but it was as if she could not bear to know too much about it, to know the depths of what lay behind it. In many respects her 'I don't know' had all the hallmarks of a repression resistance. However, beyond that, what seemed most largely at stake in her 16th year was her need to keep to herself her knowledge, to both protect her 'ignorance' and to retain a kind of loyalty to her father and to her childhood in her own privacy.

By way of therapeutic duty, I had to pursue what lay beneath the complicated adolescence – and yet I knew for some while that I had to expect little, I had to play with time, I had to wait. It would be no good to chivvy her along and untimely to interpret. Whatever the alarms ringing in the outside world, still Sarah 'hardly' knew. Eventually however a passing remark touched a chord. In what was a slightly dismal session in which Sarah complained of nothing ever happening, of her friends no longer caring about her and increasingly leaving her, I quietly commented, 'But I am still here. I am not leaving.' Suddenly she was in tears, gasping, unlike ever before in a session – and very much like how her friend had described her in her letter. She couldn't find the words, she felt awful, she didn't know . . . and yet, as if talking aloud out of a dream, she uttered 'But my dad did.'

In this moment, we seemed at the centre of her grief, beneath the realm of 'I don't know', close to her knowledge that had found its time, as it were, to be known, to be spoken. She recalled wretchedly and in detail her memory of her father's death, her bewilderment and rage, and the gamut of guilt that was confused in it. The session ended as if in a gush – a release of emotion that had been there all along, known yet unknown, that had broken through the preserve of 'I don't know'.

She regained her composure in subsequent sessions. Enough had been made known; there was no need to make things 'more public'. Her thoughts remained her own and she hated to think that I now 'knew all about her' or that what 'I said then, I believe now.' She held on to her own experience and I once more was to be kept at arm's length. She was again in a position of 'I don't know' and this I respected. It was a protection of the privacy of what she knew; she needed time for reflection, uncomplicated by any consideration of transference. Gradually, she allowed herself to share more of her sense of loss, of her playful childhood memories with her mother, father and brother, of her terror of her mother dying and her dread of the future. It was she herself in the end who made the connection between the feverish, blind desperation of her manic behaviour and her thinking that she knew it all. She could see that she had 'found more of myself' through her greater uncertainty and acknowledgement of what 'I didn't know'. As she and I decided to end therapy ('for the time being', as she put it), much of her reckless behaviour diminished, much to her relief as well as her mother's.

Conclusion

Winnicott (1961) introduced the image of the 'doldrums' to describe the state of adolescence. He wrote of 'a few years in which the individual has no way out except to wait and to do this without awareness of what is going on. In this phase, the child does not know whether he or she is homosexual, heterosexual or narcissistic. There is no established identity and no certain way of life that shapes the future and makes sense of graduating exams. There is not yet the capacity to identify with parent figures without loss of personal identity'.

It is in the nature of the adolescent experience that the expression 'I don't know' prevails as an essential communication. However much it may threaten to stultify therapeutic exploration, it is a necessary expression of the complexity of knowing and not knowing and an assertion of the adolescent's integrity and privacy. However mindless, blank, and obtuse adolescents may seem when saying once again that they don't know, they are communicating in fact how mindful they are – keeping in mind their profusion of feeling, their identity in flux, their opportunities yet to be explored. It can well be said that the capacity to not know is a crucial ingredient in the culture of adolescent mental health. The converse is a false knowing and, through distorted integration, a greater possibility of acting out.

The case example illustrates a course of psychotherapy that went through different qualities and layers of knowing. It moved from an initial omnipotent 'I know (what I'm doing)', associated with destructive behaviour, to the emergence of a chorus of 'I don't knows', seeking to hide painful memories, yet containing and permitting over time their personal acknowledgement. It was

through a process of not knowing that Sarah could hold in mind, in her own time and with dignity, what she felt. Psychotherapy was made possible largely through the therapist's recognition of the nature of knowing and not knowing in the adolescent and through a degree of forbearance and 'negative capability' that allowed room for the next steps to follow. Psychotherapy in this sense is a waiting game – always interesting in anticipation but not always without its boredom. Adam Phillips captures best the spirit of this experience in his essay 'On being bored'. He describes boredom as:

> that state of suspended anticipation in which things are started and nothing begins, the mood of profuse restlessness which contains the most absurd and paradoxical wish, the wish for a desire . . . So the paradox of the waiting that goes on in boredom is that the individual does not know what he is waiting for until he finds it, and that often he does not know that he is waiting. One could in this sense speak of the analytic attitude as an attentive boredom. (Phillips 1993: 71)

This is no more so the case than in the psychotherapeutic attitude in work with adolescents. In adolescents, it is in the boredom that the transition of adolescence takes place. It is in the 'I don't know' that the knowing proceeds.

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Clinical Material: Luke

This session takes place six months into the therapy.

Luke, 16 years old, is pale and seems agitated as he walks with me to the therapy room. He sits in the seat he usually chooses, diagonally opposite mine. He stretches his arms in front of him, as if trying to squeeze tension out of his muscles, then relaxes them and says that he thinks the police might be after him. I give him a questioning look and he tells me that he has come here directly from school after having had a fight with another boy. A bad fight. I ask him how it happened.

> He had it coming to him for a long time. He's a wuss. Poncing around the place like some great toff. He's a queer – he likes other boys. I saw him coming out of the classroom at break time with his wussy friends, and he laughed at me, so I just snapped. I walked straight up to him and gave him a giant punch in his silly, mummy's boy face. He fell flat on his back. Then I gave him a kicking. A teacher saw me then and dragged me away. I ran off. X [the assaulted boy] was lying there, moaning like a little fairy. I don't even know if he was unconscious or whether they took him to hospital.

Despite the swaggering bravado in his tone, Luke looks nervous as he tells me this; his hands are shaking. I am speechless. Or rather, the outraged condemnation I feel welling up inside me is unsuitable for broadcast. I find myself zooming in on the signs of nervousness in Luke, hoping that they might be put to good use as germs of regret, remorse and reparative wishes. Luke lays the boot in to these fragile hopes of mine and asks aggressively, 'What's up?'

Somehow or other, I find some words. I say that I'm trying to work out what he was looking at when he saw that boy come out of his classroom. Luke explains, in a tone which attempts to position me as a fellow ally in the masculinity police:

> The kid's a wussy little mummy's boy. He gets brought to school every morning by his mummy. I expect she still wipes his bum for him and tucks him into bed every night, too.

I ask Luke how he knows that this boy was a mummy's boy. How well did he know him? Luke tells me that he didn't have to know him, all his mates

can see him for what he is at just one glance. He bets I could see it if I saw him. Feeling that I am up against something very raw and very dangerous in this encounter with Luke, I experience a moment of paralysis. He seems almost desperate to have me collude with him and I feel choreographed by him to adopt either one of two equally useless binary opposites: collusion or condemnation. Silence seems highly risky, and yet speech seems like throwing a lighted match into a petrol tank, especially as the words clamouring for expression in me are all of the 'condemn a little more and understand a little less' variety. I have to think my way through this and yet time is not on my side. I do not feel that the space I am in is conducive to creative thinking.

I find myself thinking of Robert Young's (1994) notion that the psychotherapeutic conversation depends upon the availability of a 'congenial mental space,' a space for steady, playful self-and-other observation. With Luke, congeniality is seriously under attack. What would he see if he allows himself to really look at himself?

Luke stages a performance. 'What?' he asks, or rather, accuses, before theatrically giving up on my wimpish speechlessness and slowly sitting back in his seat, letting out a casual belch at the conclusion of his movement. I more than half expect him to press his finger against a nostril, snort on the floor, and lift a buttock to release a fart, so hammed up is this depiction of Neanderthal machismo. I say that I was thinking that, no matter how many mummy's boys, fairies and wusses he beats up, even if he wiped all of them out, he couldn't stop himself from hating himself that way.

Luke reacts as though I have punched him in the face. 'What are you on about?' Dr Meltzer's suggestion that one should 'tiptoe up to mental pain' occurs to me. I feel as though I may be stomping around in size 10s but something leads me to believe that Luke is searching for something brave and resilient in me right now. I do not feel afraid of him at this point, I feel, instead, that he is being internally held hostage by a fascist thug. Inwardly bracing myself for some kind of physical eruption, and feeling like a bomb disposal technician trying to decide whether to cut the green wire or the red whilst the countdown approaches zero, I speak. Perhaps it is more realistic to say that something in me speaks – I cannot claim to be approaching this from a position of Knowing.

I say that I know Luke will find what I'm on about hard to take, but I think he also knows that I'd be of very little use to him if I just agreed with everything he talked about. Luke agrees and I sense that he is now interested. I say that I think he is telling me about his hatred of ordinary human vulnerabilities, which he has to caricature into something called a wimp, or a mummy's boy, or a fairy, and heap on the loathing. The violence he just described had nothing to do with a boy walking out of a classroom – it was an act of despair. Despair that neither I nor anyone else could recognize his need for caring attachment and friendship. As a person with needs, he thinks he's on his own.

There is a dreadful, wounded silence, as Luke stares at the wall on the opposite side of the room. Words come and go in my mind as I try to find a containing interpretation. In the end, I realize that my speaking now would be for my benefit, I feel horrible for plunging him into this agony and I want to feel as though I can make it better. A Winnicottian realization occurs to me – if the patient is unable to use an interpretation (make something personally meaningful out of it) it will be at best pointless and, at worst, an impingement to which he will only be able to react (Winnicott 1971). I opt for sitting quietly. Eventually, Luke mutters, 'I am alone.'

I speak quietly – he now looks terribly sad – saying that it can be terribly lonely to look behind the big and tough versions of ourselves. In trying to be big and tough all the time, we're working hard not be something else. Luke shrugs and looks utterly dejected. I remain quiet with him for a few more moments. His voice choking with emotion, he says: 'My problem is that my parents don't love me. You can't cure me of that, can you?'

I say that I think the parents he has in his mind make him feel unloved, and he carries those parents around with him wherever he goes. He feels unloved all the time. Luke says, 'My mum just shrieks at me or freezes me out; my dad just doesn't want to know me. All I've got are my mates, they don't treat me like shit, like everyone else does.'

I say that I thought he was half expecting me to treat him like shit when he came here today, to be disgusted with him or to not want to know him anymore. It's natural to seek friendship, to have a sense of belonging. But I think he's doing something very destructive to his own need for belonging and companionship.

Luke tells me that a teacher at his school had talked to him the previous week about his aggressive behaviour. His mum was present because the school was thinking about excluding him. The teacher wanted to know why he was so aggressive all the time. Luke had replied that it was 'his defensive shield'. The teacher had dismissed this and had said, 'No, you've got an offensive shield and you're going to get into a lot of trouble with it unless you drop it.' Luke parodies the teacher's voice so that it sounds pompous and arrogant. Again, I feel invited to join in rubbishing the teacher's observation. Luke looks to me for support.

I say that it's always a bit humiliating when someone in authority seems to criticize you and I think he's really worried that I'm going to humiliate him right here by disrespecting his ways of coping with his insecurities. But I think the teacher did have a point. To my surprise, Luke looks downward, propping his head up with his hands, which form a curtain at the top of his forehead so that I cannot see his face. In a sad and despairing tone he says, 'Yes, I know.'

After a pause, I talk quietly and gently – he seems very dejected now. I say that somehow or other, he and his mum and dad have invented a way of protecting themselves from the hurt of not getting the love they want from one

another: they act angry with each other all the time. I say that it's like they've all opted for a 'better the devils we know – don't openly acknowledge the need for love, just get angry when you don't get it' kind of approach. I add that I'm sitting in the room with someone who desperately wants to be valued and needed but who hates his own need for this, like the need itself is some terrible, humiliating weakness.

There is a silence. Luke wipes his face, where tears have silently coursed from his eyes. He is clearly feeling a little embarrassed that he has cried in front of me. For a while he cannot look at me, as though he doesn't want me to see any evidence of tears. I say that I think his shield is an anti-humiliation shield.

His voice quite tight with emotion, he tells me that it wasn't like this always. A few days ago, his mum showed him photographs of him when he was little: 'There was this happy little kid running into Dad's arms in the garden. My Mum was in the background laughing. It was me, but I don't remember it.'

I say that he might not remember it but that perhaps that kind of experience was still in him somewhere, he was sitting in this room with me now, talking calmly about very painful and upsetting things, and that suggested that he'd been able to preserve a belief that not everyone would beat him up if he showed them how vulnerable he can feel. That belief couldn't just come out of thin air, he must have experienced being cared for and thought about somewhere along the line while he was growing up.

Quietness again. My impression, though, is that the sharp-edged defensive anger of the early part of the session and the forsakenness of the latter part have lifted.

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Clinical commentary: Luke

MONICA LANYADO

This session is a wonderful example of what Ann Horne refers to as working 'on the edge' (Horne 2001). Adolescents, particularly those who are more prone to acting out, manage to produce 'edges' all over the place, and this therapist is masterly in treading this tortuous path. The session is dramatic, painful, frightening and I suspect, exhausting for therapist and patient. It travels a great distance in a short time and at the end of it there is a sense of a turning point having been reached. The question is, will Luke be able to absorb and integrate this change when he leaves the session? Will external reality have overtaken what has happened embryonically in the session? Has he really beaten up a boy so badly that he might be unconscious and in hospital? He was too frightened to stick around to find out. Are the police really after him? If so, what role will the therapist need to play externally if the case goes to court? It is very significant that Luke, in this desperate situation, chooses to go to his therapy session and not to run away and hide. Whilst he starts his session in bravado mode, he has very clearly come to seek some understanding of what has happened as well as to seek a refuge from the external world that he feels persecutes him. So, the first 'edge' that the therapist is dealing with, is the complex interaction of internal and external reality.

The second 'edge' I wish to draw attention to, is the impact of the powerful non-verbal communication that takes place in the session. The difficulty of putting feelings into words underlies a great deal of the pressure to act that is so typical of adolescence, often resulting in anti-social behaviour. For the therapist, the technical problem is when and how much to put communication into words, and how much of the communication needs to stay at the

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experiential level. It is also clear from the material, that the therapist has many thoughts that it would be unwise to share with Luke, or that the therapist feels would be inflammatory. The pressure on the therapist to 'act' in a destructive way is enormous in such situations. I think there is an example of this in this session, when the therapist makes an interpretation that he feels punches Luke in the face. (From close reading of the session I have made the assumption that the therapist is male.) It certainly was an interpretation that had me feeling 'Ouch'! However, thankfully it is more often what the therapist feels, thinks and does *following* moments like these, that is the most crucial.

Leading up to this point in the session, the therapist is aware of being manoeuvred into a potentially dangerous position, which he tries to keep out of. He feels he is with an explosive and violent adolescent. The therapist feels paralysed and trapped. He knows he needs to think, but finds himself unable to do so. He feels he does not have the time or creative space in which to do this. During this part of the session, Luke is powerfully projecting the feelings he is experiencing, into the therapist. We could postulate that unconsciously, as well as partially consciously, in the past and present, Luke has felt forced into a dangerous position in which he felt trapped and possibly paralysed and that this was what prompted the fight at school. There are suggestions in the therapist's account and responses that Luke may have felt humiliated in the past and now deals with these feelings by humiliating others. There are indications in the session that Luke knows somewhere in himself that if he could think about what he is feeling, he might find a better way out of this terrifying place. But in the school situation, he couldn't think, so he 'blew'.

The therapist manages to hang onto his thinking until Luke piles on the pressure by becoming more personally attacking and denigrating of the therapist. Before he knows it, the therapist 'blows' and gives an interpretation which he feels punches Luke in the face. He has a vivid experience of doing and feeling what Luke has just done to the boy in school. Now what? The therapist is horrified at what he has done and at his own insensitivity. He fears the worst – presumably that this hyped-up boy is physically going to punch him back – but despite this, the therapist somehow manages to speak, or as he puts it, 'something in me speaks'.

At this point, I think the therapist opens up and speaks from the heart. It is this processing of Luke's projection that demonstrates to Luke that there are other ways of responding to pain and violence, than further aggression. On an emotional level, this is what I think Stern and his colleagues would call a 'moment of meeting' (Stern et al. 1998) and it is this which opens up the painful but authentic communication of the latter part of the session. It is what I have come to think of as evidence of the 'present relationship' which is a significant part of the whole therapeutic relationship (Lanyado 2001). The therapist is not only highly 'present', but is also at this particular point in the therapy, drawing on a very personal part of himself to reach out to Luke. In

this instance, this is part of a reparative move, in which Luke can feel that the therapist genuinely and personally wants to help him. This goes beyond the professionalism of all that the therapist is offering. I think that it is this personal wish to help and reach out that is communicated to Luke and which enables him to say 'I am alone'. Paradoxically, this can be expressed because he has just experienced that he is *not* alone. The therapist is trying his best to be there with him. From this point on in the session, this violent and potentially dangerous adolescent can say 'My problem is that my parents don't love me. You can't cure me of that can you?' and 'My mum just shrieks at me or freezes me out; my dad just doesn't want to know me. All I've got is my mates; they don't treat me like shit like everyone else does.'

There is yet another 'edge' that can be seen in the precarious balance between Luke's violent 'defensive shield' and his despair. This also has repercussions in terms of internal and external reality, as we are shown in the teacher's response to Luke's attempt to explain why he is being so aggressive in school. The teacher, in Luke's eyes, seems to parody Luke (who in turn parodies the teacher) by dismissing Luke's explanation and saying that he thinks that Luke has an 'offensive shield'. The therapist, who shows he is able to see behind the shield finds that Luke is surprisingly easily able to acknowledge that his behaviour could well be seen as offensive. It is then that the therapist suddenly finds himself face to face with Luke's despair and pain, leading to the tears that movingly course from Luke's eyes. The therapist is able to name an important quality of Luke's defensive shield by suggesting that it is an 'anti-humiliation' shield. It is at this point that paradoxically, hope rises again, in the form of images of a time when Luke was little and had his father's arms to run into, with a happy mother in the background completing the picture. I think this association was prompted by the male therapist being able to provide this kind of safe and all-embracing place in the therapy, both as it had progressed in the six months before the session, and particularly during the session itself. The silence that follows has a different quality to the tense and dangerous silence at the start of the session ('the defensive shield') or the 'dreadful, wounded silence' that precedes Luke's feeling that he is 'alone'. This material gives a vivid understanding of why some young offenders are so vulnerable and have to be carefully watched to prevent them from committing suicide whilst in custody.

The session material does not indicate whether Luke's parents are involved in the treatment plan. This is yet another 'edge' which requires careful negotiation by the therapist. There is however a sense that the therapist 'knows' them, in the way he talks with a conviction, which seems to be not only gained from the transference relationship, about a past in which Luke did feel loved and valued. I wonder if this 'knowing' is reinforced by any parallel work that Luke's parents might be having with the therapist's colleagues or any family work that the therapist might have been involved with. Issues of confidentiality and boundaries become very complex in such situations, but the value

of engaging the parents in this kind of therapeutic work, far outweighs the difficulties. Fortunately, Luke still seems to live with his mother and possibly his father. It may be that his parents are separated and the loss of relatedness with Luke's father is being expressed in Luke's desperate behaviour and feeling that his father 'doesn't want to know me'. Indeed I wondered about Luke's relationship with his father and the role this might play in the victim/aggressor scenario. Has Luke's father humiliated him at times, and was Luke 'identifying with the aggressor' when he attacked the boy at school. Did this possibly follow some form of humiliation that he was trying to expel into his victim? Does Luke long to be fussed over by his mother in the way that he believes his victim is? Was the attack also partly fuelled by envy?

This leads me to speculate about a difficulty in resolving Oedipal issues in the family. There is a glimpse of Luke's mother's possible bewilderment about what has happened to her family life, when we hear that she has been looking at the old family photos, possibly trying to connect the happy little boy in the photos who loved being with his parents, to the angry adolescent who may well seem to be rejecting them and all they stand for. There are few parents of adolescents who do not reflect at times in this way. We hear that Luke's mum (not his dad) went to the school to discuss his deteriorating behaviour. (There is also the impression that the school was trying to avert exclusion and that somewhere Luke knew that the teacher was really trying to help him.)

In ordinary development, the issues of how to separate from parents and establish a sexual identity are central to Oedipal development in adolescence. To the adolescent, the urgency of breaking away and avoiding unconscious incestuous fantasies can lead to all kinds of desperate measures in order to create a clear separateness from the parents. Anxieties about sexual identity might relate to difficulties in separating from mother, leading to a fear of being a 'mummy's boy' and a 'queer' which is what Luke is conscious of attacking when he has the fight. However, underlying these attempts to separate, can be a terrible loneliness and fear. It can feel rather like falling off a precipice into a void. The peer group becomes what feels like the only source of security – and as it is composed of youngsters who are similarly trying to break free from their families, it is far from reliable. Ordinary adolescence can be a lonely time. I found myself wondering whether these ordinary oedipal issues had been recently exacerbated by external trauma in the family, or whether there were long standing problems from early childhood, of which Luke's current difficulties were only the latest expression.

Finally, I have to come back to external reality. If Luke has seriously injured the boy at school, he will have to face the repercussions of his actions. What part will the therapist play in this? Thoughtful case management with the therapist's involvement may be crucial in determining whether the important work of the described session, gets a chance to be followed through and consolidated by external behaviour. This is yet another 'edge'. I would argue

that the therapist is in the best position to judge Luke's capacity for change, as well as his vulnerability. The fact that he ran to his therapist rather than ran away after the fight at school, plus the fact that he has managed to come for therapy for six months, are both hopeful signs. Holding the therapeutic space whilst acting wisely on Luke's behalf, possibly with the legal process involved, is both complex and necessary. Whilst it is possible to see the potential for change in this session, society at large is not able to be so tolerant and is more likely to veer towards the condemnatory stance experienced at one point in the session by the therapist.

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Clinical commentary: Luke

NICK BENEFIELD

In considering case material without, contextual details, I am reminded that I depend upon a range of information in my thinking and understanding of the interaction between therapist and patient. We know only the gender of Luke and neither the age, race or gender of the therapist, all of which may influence the interactions between them. However I also know that it offers an opportunity to take the material as presented.

My first reading of the session left me with the sense that this encounter was not quite real. It had me wondering about the length of time the patient had been in therapy with the first half of the session being so markedly different from the second. Having not worked with adolescent patients for so long I think I had forgotten how alive and 'in your face' the encounter can be. The therapeutic relationship with young people is often more intense in the quality of their 'swinging' and contrary states. The pace of emotional development in a session can at times come at breakneck speed with a potential for significant strides or therapeutic disaster within a dynamic of dodging and weaving, avoidance and flight.

Luke presents himself dramatically into the session: straight from the street, a world of pseudo-adulthood so often characteristic of vulnerable adolescents. He arrives bringing a physical tension into the consulting room – excitement and drama with which he shields his vulnerability: the fear of engagement. I assume that this may often characterize the start of his sessions. He needs some defence against the potential of the therapist to reach through or around the mechanisms that protect him from the pain of being and feeling alone and in despair which will result from the deepening relationship with the other.

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The first critical moment in this session is the point at which Luke's anger and retaliation is matched by the wish for retribution in the therapist. In response the therapist steps away from collusion and addresses the internal events as they are, rather than as Luke would wish to believe them in order to justify his actions: 'it (the violence) was an act of despair . . . that anyone (else) could recognize his need for attachment (and friendship).' This is a great moment in the therapy. After six months, in which we can reasonably expect work has been done to focus on establishing an alliance, the interpretation can be unequivocal, going to the heart of this defensive aggression.

I feel some sense of shock at the pace with which the interpretations pack in behind this first decisive moment. Within the initial silence the therapist understands the pointlessness and danger of impingement, acknowledging that silent thought is the best way to stay with Luke. It is then followed by a rich outpouring from Luke. In this situation it is difficult to balance the significance of timing further interpretations. In seeking to deepen the therapeutic relationship by articulating further understanding of Luke's internal world the therapist identifies the critical awareness that timing is all. This first interpretation is stark. It acts as the trigger to a process of deintegration while the later events in the session offer a potential for reintegration with a gain in consciousness.

In James Gilligans' recent book (Gilligan 2000), he develops an analytic understanding of violence through his treatment work in prisons and state hospitals in North America. I would not wish to equate the position of these serious offenders with any likely outcome for Luke: however, there are I think important dynamics here which the therapist has engaged with considerable success.

An enduring theme in Gilligan's dangerous and volatile individuals is their almost 'super-sensitivity' to any behaviour or attitude in the other that can be felt as having the potential for humiliation. To be 'dissed' (disrespected) is the common reason given by men who have perpetrated non-psychotic acts of catastrophic violence. Gilligan firmly asserts:

> I have yet to see a serious act of violence that was not provoked by the experience of feeling shamed and humiliated, disrespected and ridiculed, and that did not represent the attempt to prevent or undo this 'loss of face' no matter how severe the punishment. (Gilligan 2000: 61)

For Luke the perceived act of humiliation 'he laughed at me so I just snapped . . . and gave him a giant punch . . .' exposes the small and the powerless in him, evoking a powerful and overpowering image. The archetypal giant dominates and obliterates his own vulnerability projected into the 'mummy's boy'.

The key issue is the violent act as symbolic language. Freud's insight that thoughts and fantasies are symbolic representations of actions can, in Gilligan's analysis, be set against its opposite:

> Actions are symbolic representations of thoughts . . . they can take the place of thinking in words, if the behaviour is never interpreted or translated into words and ideas. (Gilligan 2000: 110)

The humiliation felt to result from being disrespected has its roots in the vulnerability and 'smallness' of individuals. In Luke we see seeds of this dynamic in the way he builds up an internal rationale, a story as to the reason and reasonableness of his attack. In his victim he sees the vulnerability and softness he both desires but associates with mental pain and humiliation. We can reconstruct the experience of, and evidence for, his painful neediness. In the early part of the session we have a picture being described by Luke that creates in the therapist the anger and desire for attack that Luke himself felt towards the 'wussy boy'.

Viewing the satisfaction and righteousness of his actions he then experiences anxiety at the extent of his rage whilst his bravado 'a teacher . . . dragged me off . . .' shows Luke's nervousness that we might assume relates to his concern at the effects of his rage rather than simply his outrageous pride. His envy of the care and attention of his victim is graphically described – 'he is brought to school everyday by his mummy' (a wonderful denigrating reenforcement – 'mum' or 'mother' would not have done). This attack simultaneously on both envied infant and hated mother who '. . . never loved . . .' is finally completed by demeaning the envied object using references to toilet training and bedtime comfort, both aspects of infantile vulnerability, dependence and attachment.

In each violent act we can say that Luke's own infantile vulnerability is further attacked and buried. In such events it may be that the fear of what he experiences as his weakness is buried deeper. Denial can build a very strong wall, but his despair at the separation – the gap between his internal infantile needs and his growing adult persona – increases, just as the sense of despair at his isolation and 'aloneness' generates the hope of recognition and acknowledgement from the therapist.

The therapist's words at this point in the session give us a great sense of the importance and depth of emotion present in the room – 'something raw and dangerous'. There are images of binary opposites and explosive ingredients: 'bomb disposal technicians'; evil smells and waste products invading the analytic space; 'fascist thugs'; reactions that are experienced as a 'punch in the face'. The move to relocate the meaning of the events back inside Luke with '. . . he couldn't stop himself from hating himself that way' works to halt this burial of the infant within. The reference to the act of despair and Luke's aloneness tips the balance and he can now reflect.

It is important that, as therapists, we can have the sense of when to push on and when to wait for the patient to be ready for that next shift. Whilst I think this therapist was right in their concern about this decision, the evidence is that the timing and intervention have been got right and the session now holds Luke in the emotional location in which he most needs to remain at that moment. The difficulty, particularly with an adolescent, is how to do this without creating a later retaliation against the self when the containment of the therapist and the session are no longer there. My concern is that if this degree of insight is achieved in the session I could not be certain that it would not be at risk of later retaliatory assault on the internal infant or a further projection of that object of ambivalence into another victim. The quality of containment in these circumstances is all and we must beware our denial of the other 23 hours in the day when acting out is a real matter in a real world in which the capacity for thought and reflection may be limited.

The concept of 'aloneness' and the difference in 'being alone' and 'being alone in the presence of the other' (Winnicott 1958: 61) is well illustrated here in the session. Luke arrives as he always is in the state of aloneness that lies beneath his bravado. As he reaches the capacity to reflect on his state, his tears and distress can be tolerated in a way that cannot happen without the presence of the therapist's containing function. The bullying nature of his internal relations give him little help in his attempt to put things right and repair the damaged state of affairs he describes in his relationship with his parents. The therapist is able to stand up for the victim within him and support the shift he needs to make from identification with the aggressor to that of the good parent able to nurture and support his emotional development. All this is done in a way that allows Luke not to experience this as a further humiliation. He is able to bring his own childhood into the session with the reference to the photographs of when he was 'little'. In this moment we can assume that some memory of successful attachment and happiness is re-experienced and the therapist is able to speak of that experience still being within him.

In effect we can see Luke's act of aggression as a communication of hope that in some way it is still worth the unconscious effort to draw attention to his internal state of affairs, bringing this communication to the therapy. I would suggest this unconscious hope is that he can still sustain his macho, 'fascist' carapace but offer up the chance that the therapist will not only see the state of affairs as they are within, but not be frightened or intimidated from acting to intervene. To take on this challenge is to develop an understanding that any and each violent act is a complex expression. Any explanations that this therapist, or I might have, need constant revision as we uncover the layers of meaning behind each unique event. The danger lies in the simplistic nature of our wish to develop a linear, causal route and deny the complexity of influences to fulfil our hopeful expectations of change.

In the context of a society where the growth in offences of violence in young men is increasing, this fragment in the treatment of an adolescent has

the hallmarks of impulsive aggression driven by a possibility of complex interacting factors. Vulnerability is one factor and we can see in this case example how developmental disorders in adolescents can be effectively addressed in psychotherapeutic treatment and the development of potential for repetitive and self-destructive behaviours reversed. To be both rigorous and realistic we need to acknowledge the degree to which these defensive behaviours form part of an ego-syntonic structure for the individual personality. To confront such volatile and complex structures safely can require lengthy, careful and consistent interventions over time, in settings where the fragile identity and capacity for thought can be supported within and without the psychotherapeutic session.

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Clinical commentary: Luke

JEANNIE MILLIGAN

What are the distinctive features of psychotherapy with an adolescent patient rather than an adult or a child?

I found this clinical material a rather compelling example of some common adolescent difficulties which merit psychotherapeutic help. Luke's evident anxiety about identity, sexuality, being loved, feeling helpless are part and parcel of growing up. But presumably something is making it difficult for him to negotiate these distressing but ordinary issues on his own with the normal support from family, school and peers.

The question of why some adolescents founder and others do not is complex. Equally interesting is the question of why some cannot accept help when they find themselves suffering or in trouble and others – including some who may have very inauspicious backgrounds and turbulent histories of loss, trauma or neglect – manage to seek it out. Some may need long-term intensive therapy to address the depth of their problems and others may be able to get back on the developmental pathway relatively quickly.

What has gone wrong for Luke that difficulties requiring attention from a therapist emerge at this point in his life? We do not know from the material why he is in therapy, how he got there or how the match between him and this particular therapist was made. My guess is that the therapist is male, but in terms of therapeutic functioning during the session reported, features of both paternal and maternal functions are evident. One tricky matter for the therapist is how to technically make use of these object relationship identifications in the transference and counter-transference without leaving Luke feeling either overly challenged, intruded upon or lost and abandoned.

Because it comes without a history, I found it helpful to place the material within the context of adolescence as a phase of human development.

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Adolescence is an inevitable, distinctively problematic period of life, likely to involve unpredictable highs and lows, with 'the doldrums' (Winnicott 1986) in between. There may be rapid shifts in mood, for example, from feeling vital and optimistic to feeling overwhelmed by desires or fears; from feeling appropriately sad and concerned to feeling blank and empty. The individual making the journey from the appropriate dependency and relative stability of childhood towards the independence and autonomy required to achieve a reasonably satisfactory adulthood is confronted by unavoidable psychological and bodily changes, which amongst other things entail unlooked for returns to infantile states of mind. Fears, anxieties and desires are now re-evoked in a new context where it is physically possible for phantasies to be enacted in the real world. The triumph and humiliation inherent in the game 'I'm the king of the castle, you're the dirty rascal' become imbued with actual physical danger (Winnicott 1986: 158). We are no longer in the realm of playroom activity and toys where, for example, Oedipal phantasies of possession, murder and potency may be pursued symbolically. The onset of puberty and the concomitant increase in physical strength now permit real sexual intercourse and the use of serious physical power to occur. These developments can feel, of course, exciting and rewarding, in terms of opening up choices and different directions for increasing capabilities but they can also feel alarming, uncontrollable and difficult to understand. This is true not just for the adolescent who is personally negotiating the inherent challenges of this notoriously difficult period of life, but also for those adults who witness the process – and especially those with a parental or professional responsibility for him or her.

The clinical material about Luke highlights some of the painful and charged encounters between representatives of both sides. What sort of conversations can take place, what shared understanding may be possible when there is so much volatility around? As a therapist working with an adolescent one is likely to find one's position in, and responses to, the engagement with the patient shifting about with such rapidity that it is sometimes extremely hard to track where one is at any one time in the transference and countertransference. There are, therefore, particular challenges in considering how to deal with the material technically. At times, one feels one is flying by the seat of one's pants in the experience – and while this may usefully reflect aspects of the adolescent's own tenuous hold on fragments of sense, something more grounded is desirable if one is not to find oneself in over-identification with the adolescent's position. This would risk leaving him feeling insufficiently contained and out of contact with an other who might help him do what he cannot yet fully manage himself – i.e. to identify, negotiate and modify unbearable feelings so that they become more tolerable and ultimately integrated into the self.

Paying attention to what kind of object the therapist is perceived to be by the adolescent patient is of course crucial, as is the understanding of why transformations in this occur at particular points in the session. These two

considerations are usefully addressed by Meltzer when, in distinguishing between work with latency children and adolescent patients, he says:

> Where the child *externalizes internal objects* [my italics] in his acting out, the adolescent *projects parts of himself* [my italics] and thus enters into a far more narcissistic type of acting out in which collusion plays a great part. This distinction is of great importance in understanding why children are relatively easy to induct into the analytic process while adolescents, more like psychotics, are so difficult'. (Meltzer 1967: 5)

It is for these reasons that Luke's therapist is rightly sensitive to the need to 'tip-toe up to mental pain' and to be alert to the danger of either being collusively recruited as an ally 'in the masculinity police' or being experienced by Luke as the cruel deliverer of narcissistic injury. The therapist writes the material in a lively fashion, which conveys well the fluidity of movement between these dangers and how difficult it is to deal with some of the very powerful feelings evoked along the way.

Although we are given no information about the quality of the therapeutic relationship during the previous six months of work, in this session Luke appears very involved with his therapist. He immediately presents the perpetrators of the violent act he is about to describe, (his arms) and follows quickly with the thought that the police may be in pursuit. It is as if one part of him knows that another part of him has been involved in something 'bad' and that this merits being brought to the attention of the therapist. The police represent the superego function of enquiry into this criminal activity between Luke and X and the part of Luke which allows himself to feel in danger of being accused becomes nervous and shaky. Luke's aggressive enquiry during the ensuing silence seems to strike the therapist as unconnected at that point to guilt and he (the therapist) seems to feel disappointed as well as outraged. However, my reaction was more positive because I felt Luke's question was a very proper one, however brusquely presented. What indeed is 'up'? This question seemed to me to be inviting the therapist into a different kind of alliance from a collusive one, one where there is some hope that the therapist may be able to, as it were, sit alongside the adolescent, who is actually conveying how frightened he feels about what he has done. Together they might then be able over time to explore what underlay Luke's need on this particular day (when X apparently had had it coming to him for a long time) to move from simply seeing X 'for what he is' to something having 'snapped' so that Luke shifted into concrete action intended to annihilate X and put paid to what Luke perceived as his mocking stance when X laughed at him.

Given that adolescents who cannot articulate their feelings in words are prone to use their newfound physical potential to act out instead, had something gone on in the previous session which Luke found he could not manage on his own during the interval before the session described? The implication is that something 'raw' was touched on about the state of being a 'little mummy's boy', with the attached conflictual and ambivalent mixture of

longings for and hatred of infantile dependency needs. If Luke is indeed well established in his therapy, might he be finding himself in exactly this predicament in relation to his therapist? If he is finding his therapist reasonably trustworthy and helpful (as suggested by his repetitive curiosity in this session about what the therapist might be thinking, ('What's up?' 'What?' 'What are you on about?') he has to confront the dilemma of valuing something over which he has no direct control, i.e. the structure and frequency of the therapy sessions and the therapist's opinion of him. This looms large for the adolescent, who is not so far away from childhood helplessness and probably feels far away from adult competence. Therapy, because it inevitably stirs up anxieties about precisely these issues so that they may be carefully examined and attended to, may at times feel insupportable. For example, it may be very painful to recognize that in the therapeutic relationship, when one is feeling most little and lost, one is dependent on somebody who is felt to be enviably much bigger and stronger. Additionally, the more this figure is felt to be helpfully thoughtful and supportive, the greater the fears are about being cut off from such resources. This may lead to desperate attempts to prove that one can omnipotently manage by oneself.

I wondered what the therapist's thoughts might have been about such matters, since there is no direct reference in the material to the previous session in relation to the apparently sudden violent incident with X. For example, might it have been an unconscious attack on a therapy which, only six months in, may at times be perceived defensively by a threatened Luke as being 'wussy' and 'poncy'?

If I am right in presuming the therapist is male I also wondered what the transference meaning was of the initial material being, as I saw it, redolent with homosexual anxiety. Because the body features so centrally for the adolescent and because sexual fantasies and activity are (usually) relatively new and highly preoccupying, there may be particularly heightened concern about getting close to the therapist related to the possibility of an eroticized relationship.

With all the attendant dangers – to both patient and therapist – in the matter of close engagement it is not surprising that a 'congenial mental space' cannot be found. The therapist feels assaulted by the information about the attack. Luke is feeling hunted. The positions of perpetrator and victim rapidly change between them. It seems to me that Luke's nervousness was in response to having projected his own self-condemnation into the therapist because he could not deal with it himself, given his confusion about the shifting positions in relation to belittling attacks (which the therapist explains later on, when referring to Luke's fear that he too will treat Luke like 'shit'). However, an interpretation about what is going on between them in the session appears difficult to make at this point – the therapist conveys vividly how in the face of such turbulent feelings it is a huge struggle to think. I thought the

impossibility of a transference interpretation may be why Luke continues – impressively – to seek out the kind of response he needs, by the three 'what' questions.

Because the therapist recognizes the danger of wanting to expel the unpleasant feelings provoked by Luke's account and push them straight back into the patient, he manages instead to sit it out in a state of considerable anxiety, uncertainty and helplessness until it feels possible to give voice to how Luke himself is battling with these same feelings. Acknowledgement of the sadism in the therapist's 'condemn a little more and understand a little less' response leads to his understanding of Luke's position of 'being internally held hostage by a fascist thug' who wants to 'heap on the loathing'. In the face of this, the therapist then sees that he has to be 'brave and resilient'. Winnicott (1986: 166) is speaking about this quality when he says, 'Confrontation belongs to containment that is non-retaliatory, without vindictiveness, but having its own strength.'

This stance avoids the danger of 'the anti-social act not being recognized as something which contains an SOS' (Winnicott 1986: 90) and allows Luke's underlying despair and loneliness to be spoken of by both therapist and then patient. The change in atmosphere of the session is palpable, evidence of the hard won movement away from the paranoid schizoid splitting and projection earlier towards something more depressive where painful feelings can be actually experienced and thought about together. Posturing and explosiveness are left behind and Luke's hurt and anger about his perceptions that the love of his parents has been withdrawn can be addressed and linked with his need to have an anti-humiliation shield.

The therapist is careful to refer to Luke's fear that the therapist might make him feel humiliated for being needy, i.e. little, helpless and not knowing. I think this could link back to the violent attack on X at the beginning of the session. X is a boy whose mummy brings him to school every morning and who is degradingly caricatured as a kid whose infantile needs may still be attended to physically by his mother. Luke, by comparison, describes having a mum who pushes him away with shrieks and frigidity. When this mother does involve herself in his difficulties in growing up, by going to the meeting at the school, we hear nothing about her sympathizing with his plight and he seems to feel called upon to take entire responsibility all alone for working out how to avoid trouble with his shield. In an internal world peopled by such figures, the function of X is not only to be the recipient of projections of neediness but also to be the object of envious attack. However mollycoddled, X has his mother's attention and this is likely to provoke envy in Luke, stimulated by his own infantile longings to be attended to reliably and consistently by an ever present maternal figure. But in the external world, such desires hark back embarrassingly to younger days when he had the right to be dependent and not to expect to have to look after himself: it is very unsettling and confusing

to have them impinge on his present 16-year-old life, especially when he now feels painfully unlovable to his altered parents. So Luke tries to either hide his need for loving attention behind a shield or to disown it by locating it firmly in someone else where it can be denigrated and ridiculed in envious attack.

If this material is not atypical of Luke in his therapy, these are the kinds of dilemmas he and his therapist will be struggling with during his treatment – dare he hope to have his dependency needs understood and met by the therapist without feeling unbearably small and humiliated? What will happen if he allows himself to get close to the therapist who he hopes may be able to attend to him unconditionally? Accordingly, what are the implications for the therapist's technique and management of his counter-transference?

This material suggests a therapy which is full of life, likely difficulty and promise. It stimulates curiosity about what happened in the following session to the one we are given, and about the subsequent development of the treatment, particularly in terms of the therapist's use of transference interpretations. Luke is fortunate to have a therapist who is clearly up for the rocky ride ahead.

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The End of Abuse: a play about psychotherapy

JOHN WOODS

A play about psychotherapy? – about adolescence, abuse, drug addiction, suicide? – And a failed treatment at that? *Not* a very promising combination, perhaps more a recipe for disaster! At least those have been my worries each time a performance drew nearer. In the event however I have been amazed at the positive responses it has received. By this point, after five performances on different occasions over the last 18 months, I can be a little more objective. I can now accept the approval of people like Bryan Boswood, Anne Alvarez, Brian Martindale, Mario Marrone, Tirril Harris and Estela Welldon, all of whom have supported presentations of the play. These took place firstly at psychotherapy conferences, and most recently, sponsored by the International Attachment Network, as an event in its own right. I have now been invited by the BAP Journal to write something about how I came to write *The End of Abuse*.

Who is who?

I did not start out with the intention to write a play, so it is not surprising that the text is not exactly a drama. The characters do not speak to each other, but since they are fictional, derived from real people I have known, they have taken me into the realm of art. I was originally writing a more conventional clinical discourse about adolescents who drop out of treatment, or who never engage. The process started with a particular adolescent whose voice demanded to be heard. Since he was in my imagination, I felt I could let my defences down and allow him to represent not only the young people I may have failed, but also the failed young man I could have been. Poems came to mind that seemed from him, not me. Here was a different version of myself. But at the same time I had not really been that self-destructive young person and so I had to think what would have happened to have made me so. Who would his mother have been? As she too became real her voice became clearer and I knew then that she had killed herself, and was still consumed with anger.

That was the anger and the protest that echoed down the years and was burning up this boy. For a time I found myself dreaming what seemed to be her dreams. Thus she in turn became another inner voice, another self-possibility. I have been asked whether *John*, the group therapist is actually *me*, or is *Sylvan*, the adolescent boy, really *Woods*? *Helen Price*, the junior therapist certainly undergoes an initiation into malignant staff group dynamics very similar to my own, a few years ago. She pays the *Price* of being a therapist. But I also had great sympathy with *Hermann*, who is the 'baddy' in that conflict. He has the courage to say the necessary 'No'. So when Nancy Brenner of the Anna Freud Centre said that she could hear my voice in all the characters, even though each was believably different, I felt I had received the greatest compliment.

Creativity and adolescence

McDougall says that 'there is always a risk that a creative act will be experienced unconsciously as a crime against the parents . . .' because '. . . one must assume the right to be both fertile womb, and the fertilizing penis' (McDougall 1977: 101). *Sylvan* proclaims art as 'the only important thing'. He is using his creativity as an alternative to reality. Poetry is his area of omnipotence, and he rejoices that he does not know what it means, i.e. that he has no responsibility to relate it to the reality of the rest of his life. Coming from a family of artists I know that art is far from automatically good and healthy. It is characteristic of adolescence to try things out, to test limits, to seek outlandish experiences, and then after a while, to work them through in something like psychotherapy. As a therapist one is both managing the 'acting out' of a young person in treatment, but also trying to prevent 'foreclosure', as Laufer and Laufer (1984: 181) called it, of the developmental process, because adolescence is itself the creation of an adult personality. For *Sylvan*, however, his creativity draws upon his hatred of the parents, and his self-hatred, and he is left without a safe haven.

As psychotherapists we are navigating between science and art. We are expected to subject our work to the rigours of scientific measurement, which is right, when possible, but I also believe that there are certain problems of psychotherapy that are only accessible through creative means. The effectiveness of treatment may depend on unmeasurable qualities, like the capacity for empathy, or the ability of a therapist to be guided by their own internal process. This brings us up against our subjectivity, our wishful thinking, and our own omnipotent solutions to the clash between fantasy and reality. However art cannot exist in a solipsistic universe. If it is to be effective and good, i.e. *communicable*, it too has to accommodate to reality.

In one of Estela Welldon's comments after the recent performance, she described an extraordinary coincidence with an episode from *The End of*

Abuse. She had been struggling with a difficult case, an assessment report of a young mother for the Court. At the time she visited an art gallery and saw a Giacometti that perfectly expressed the emptiness at the core of the maternal relationship that she was contemplating. In my story the therapist is preoccupied with her feelings about *Sylvan*, and she sees a Rodin sculpture of the Prodigal Son; this arouses her hope that in some way her patient, will, after all, find salvation. In each case there seems to have been a moment when the therapist steps back emotionally and detaches herself. In *Helen's* case she is able to be more self-critical about the fantasy of being able to save the patient. By doing this she finds a communication which is both from outside and within her own world, a perception of art that makes sense of the separation *and* the involvement. It seems to me that the therapist is being told, in this aesthetic experience, that he and the patient at some level *are* the same; the privileged self of 'therapist' gives way momentarily, to the underprivileged self of 'patient'. The victim comes out from beneath the abuser. The end of abuse comes when there is no longer a victim.

Individual and group: the psychic and the social

The story ends with *Ruth* in her therapy group where she is able to adapt her regrets and sorrows about the past into a creative impulse for the future. Through some treatment at the earlier stage of her adolescence, she had recovered from some of the worst effects of abuse and loss, but was left as an adult with much rage and self-destructive triumph, ruthless both to herself and others. I have been asked if I am saying here that I believe only in group therapy. No, like much else in the text, it just seemed right in that context. I felt at that time that writing about individual therapy was going to be more difficult and I was putting it off until a later date. But the group also came to mind I think because it represented, as it does now, my own need of the family, friends, colleagues, and our 'therapeutic' community, who have sustained me. No psychotherapist can go on indefinitely with 'individual' work without regular recourse to his or her own group, of whatever description. And in the case of the play the product of my 'individual' imagination was made real by a group, a complexity of several groups, too numerous to mention here. The real group contains the imaginary, and becomes symbolic of other groups, whether they are patients with whom we failed, lost relationships or lost aspects of ourselves. The group nurtures these neglected children. What happens in the end of the story, what I felt I was witnessing as it came to me, was that which had been prevented in the family of origin, a healthy separation and growth, an adolescent blossoming at last. Ruth is released in the end of the story when she accepts she cannot have the therapist to herself, even though she had never been able to bear the traumatic separation from her mother.

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The End of Abuse: a review

GILL BARRATT

This is a powerful play, written mainly in the form of letters by members of a dysfunctional family. The play unfolds a shocking story of intergenerational abuse, and the struggles of professionals to break the cycle of trauma. The letters are read by different actors taking the parts of the family and professionals. The characters are fictional, based on people encountered by the author, John Woods, in his work as a child and adult psychotherapist and group analyst. He has chosen to write the play in the tradition and style of dialectical theatre, and thus it becomes a vehicle for movingly demonstrating the cycle of family trauma and its repercussions. Dramatization is a creative way to grapple with the hopelessness sometimes engendered by such work.

The story shows the family's attempts to find help for themselves and their ability to undermine and defeat their helpers. Finally one of them, the daughter, begins to work through her despair and rage and to start a healing process.

Firstly we hear from the single mother of two young children, reading the suicide note she has written to her social worker. Her own mother had committed suicide during her childhood. She has struggled with motherhood until her children were taken into care. Now she feels defeated, and defeats the help offered her. In the letter she describes her attempts to deal with her problems, which are the legacy of her own failed family history, through a number of failed relationships, including her hopes that pregnancy and children might offer a solution.

We then learn of the fate of the children; the son, now 18 has been abused in care and has in turn abused his sister. He has been offered psychotherapy but does not attend. Instead he reads his letters and poems written to his therapist. He demonstrates the adolescent's longing for someone to help, as well as his deep ambivalence and resistance to accepting help. The play shows how he evokes complicated counter-transference responses in his therapist and in her team. The head of the clinic team is a bit of a caricature, an archetypal rigorous consultant: the therapist who takes on this difficult case is young and inexperienced and could be expected to fail. The team projects its sense of hopelessness into her and she becomes the sacrificial lamb. Perhaps it is a case

of projective identification where the therapist identifies with the team's projections. She is thus a casualty herself. She seeks support outside the clinic by writing to a friend to whom she pours out the self-doubts evoked by the case and the situation she is in. The boy finally takes an overdose. It is left unclear if this was accidental or intentional.

The final scene is about the daughter's attempt to get help following her experiences. She is now grown up and has become an artist. She is attending a psychotherapy group. The last letters of the play are to her group therapist. There is an angry outburst against the therapist and the group, written just before the summer break, but eventually she comes to recognize that she has internalized something good from the therapist and the other members of the group. She has also been able to gain some knowledge of her mother and brother by getting hold of a copy of her mother's suicide note. Through the letter she is able to get to know her mother more fully and to understand some important things about her. This enables her to begin to be able to mourn. The play ends with an emerging idea of creating a sculpture which will integrate some of her developing insights.

Dramatization is an excellent way of portraying the power that such cases have to reproduce their hopelessness and despair in the counter-transference. It also demonstrates the strength of negative therapeutic reaction. Each of the family members seeks help only to undermine it, attacking the help being offered as well as the helper. We do not hear from the social worker in the first scene, but we are left to imagine the devastating effect on him, and his attempts to help, by the suicide of his client. His efforts are entirely obliterated. To the Child and Family Clinic, the son communicates a negative therapeutic reaction, which the team and the therapist become caught up in through their counter-transference reactions. The staff group re-enacts the family deprivation and abuse between the team leader and the young therapist. Finally the daughter in her outpouring against both therapist and group shows her attempt to make them fail her. She attacks the therapist in his capacities as therapist and also the group in its attempts to care. However the writing is itself therapeutic and leads to the development of understanding and a way forward through artistic endeavour. This in itself demonstrates the value of art as a medium for change and transformation. I suspect that writing the play had this same value to the author, which is then shared by the audience through their participation in being there. It must resonate with all therapists, and with others who are not.

Books reviewed

Psychoanalytic Psychotherapy of the Severely Disturbed Adolescent

Edited by Dimitris Anastasopoulos, Effie Laylou-Lignos, Margot Waddell
London, Karnac Books, 1999, pp. 189, p/b £18.95

It is said that 'travel broadens the mind'. It is, in reality, exhausting, expensive and exhilarating. The best journeys are those in which the exhilaration outweighs the first two. This book is a complex journey into familiar and rewarding territory but at times it crosses deep into foreign lands that made me reach for the maps and phrasebooks.

The seven chapters in the book draw from the very broad heritage of psychoanalysis in Europe. As one of the editors, Dimitris Anastasopoulos, makes clear, 'The cross-cultural nature of the book is, in particular, a symbol of the prospect of a Europe without frontiers and of the development of the theoretical basis and clinical practice of psychoanalytic psychotherapy beyond ideological classifications and obstacles. That, I believe, was also the purpose of the foundation and operation of the EFPP' (xiv). (This book is published by Karnac Books as one of the series of Clinical Monographs for The European Federation for Psychoanalytic Psychotherapy in the Public Health Services.)

The book begins with a well-written paper by Margot Waddell in which she describes her work with a young man and his eloquent dream material. Margot Waddell is a master clinician and has a formidable talent for bringing her clinical work to life in print. Her literary references bring more depth to the material that describes the necessity of having a psychic space of one's own. The young man Margot Waddell so sensitively worked with struggled with a perversity that prevented a capacity to think and to really claim ownership of his feelings. The tentative success of this work outlines the young man's move from a projective identification to a more healthy introjective identification.

In Chapter 2 Philippe Jeammet presents the familiar problem of dependency and narcissism in the work with adolescents. However, his solution to the problematic link between external and internal reality of psychoanalytic psychodrama was one I was less familiar with. He writes, 'The whole set up of

a psychodrama is designed to support work that the patient's pre-conscious cannot perform on its own and which the transference solicitation of classical psychotherapy runs greater risk of hindering than of helping' (46). I found myself reaching for the guidebooks to better understand psychodrama and felt slightly defensive about the alleged shortcomings of 'classical psychotherapy'. I wondered if the challenge set by severely disturbed adolescents could not still be met by a version of psychoanalysis that held on to the transference within one relationship rather than a series of clinicians as described by this author. By the end of the chapter, however, I had been convinced that this was an important attempt to work with a very difficult patient group.

Chapter 3 contains Dimitris Anastasopoulos's extremely useful overview of the conceptual background to 'trauma'. He presents us with carefully and clinically argued material that develops his thesis: that is, that adolescents are particularly vulnerable to trauma. He suggests that if the trauma came after early childhood or has not been worked through, there is a requirement for more intensive and longer lasting psychological assistance. Adolescents with earlier psychological problems but which have been sufficiently worked through can, despite the severity of the presenting problem, respond well to shorter term psychotherapy. Anastasopoulos uses his case material to further suggest that the adolescent in acting out is creating a traumatic situation for themselves as well as their victims.

My enjoyment of Chapter 4 was slightly reduced by finding that my copy of the book had notes at the end but no reference points within the text. However, this chapter was intriguing. Julia Pestalozzi uses a multi-theoretical approach to describe the psychic struggles in the therapist as she strives to fully understand her patient's inner state of turmoil. In her single case study she brilliantly describes her own state of mind when the patient reaches a watershed moment. She writes, 'It would be naive to think that all we need to do is name those impulses that fragment time, the body, and the representation of self and object and then these schizophrenic symptoms will disappear. Instead, I think, as do Searles, Benedetti, and so on, that the integrative work has to take place in the therapist's psyche first' (104). The moment Julia Pestalozzi when acknowledges the fantasy of pregnancy from the patient is the mutative moment of movement for the patient. The courage of the psychotherapist in this work shines through this chapter. She includes some psychiatric notes on dysmorphia (the particular syndrome of the patient) at the end of the chapter which are separately interesting.

Chapter 5 is a rewarding account of the joint authors' ideas about young adults who have been placed in custody for serious crimes of violence. This setting is not really one where psychoanalytic psychotherapy can be used. However, the clarity of the thinking about the young people and the deconstruction of their stories was enlightening. The authors argue that although

the two young people they describe were not psychotic, there were 'psychic structures which powerfully evoke the concept of breakdown'. Both of the cases describe young men who could not resolve unconscious conflicts by anything other than extreme action. 'These adolescents realize that their psychic growth is stymied, and they fantasize overcoming this deadlock at a stroke, leaping over the entire gap separating them from the prized objective of a more adult status' (138). The authors are very clear about the unacceptability of such violent actions but suggest also that at least this contains some notion of 'psychological growth'.

Chapter 6 describes the psychoanalytic psychodrama used by Alain Gibeault. In a fascinating manner he outlines the role of the 'double' in psychic life. He feels that there are certain types of patients who need psychoanalytic psychodrama rather than classical psychotherapy. The half hour sessions include more than one psychodramatist. Alain Gibeault describes the work with one adolescent who responded very well to this work having failed to engage with two years of more traditional psychotherapy. The work is well argued and the rationale for the setting is clear. I must admit I found myself being slightly worried about the 'lateralization' of the transference and would have liked to hear more about this and the earlier traditional approach that was said to have failed.

Chapter 7 brought this reader back to familiar territory. Helene Dubinsky's description of the breakdown of three adolescents she has worked with felt rich and rewarding. The common theme in all three case studies was the lack of internal resources as a result of the absence of a containing maternal object compounded by the introjection of a bad internal father. Faced with the re-surfacing of Oedipal matters in adolescence and a barely adequate internal parental couple, the three separate adolescents tumbled into psychosis. Helene Dubinsky's work provided the three with a containing experience which facilitated a better integration of their personalities.

This book will appeal to all those working with adolescents and especially those working with adolescents with severe disturbance. I read it with fascination and admiration. On reflection, I do not think the book is a 'distillation' of the broad heritage of psychoanalysis in Europe as suggested in the foreword. It does however present an intriguing and broad picture of how senior clinicians in different cultures have developed the model in different situations. In two of the chapters on psychodrama, I did feel as if I had stumbled into an unfamiliar version of the psychoanalytic culture. However, being able to make a tour of all these approaches provided, in the end, the inspiration for some creative thinking about some central problems in offering psychoanalytic psychotherapy to adolescents.

ROBERT FLEMING

The Invisible Matrix: An exploration of professional relationships in the service of psychotherapy

Edited by Sasha Brookes and Pauline Hodson
London, Rebus Press, 2000, pp. 230, pbk £19.99

This is in some ways a daring book. It focuses upon the cement between the bricks in the various houses of psychotherapy. Not only does it consider the relationships between patients and psychotherapists, it looks at the relationships between therapists too, as well as between others involved in attempting to provide an environment that facilitates the development of the person some call patient, some client.

It is put together as a collection of papers covering a variety of clinical settings, private practice, group therapy, marital/couple therapy and even a residential therapeutic community. Issues affecting assessment and supervision are also addressed.

The Invisible Matrix itself derives from the Latin and refers to the uterus, the place of breeding. In the nineteenth century, the term was used mathematically for a rectangular arrangement of quantities or symbols. The authors of this book certainly adhere to a notion of psychotherapy involving complex factors that influence what develops between patient and therapist, namely, that behind this two-person relationship reside a variety of relationships. Just as the growing foetus is affected by much that goes on outside the womb, both physically and mentally, so too, the consulting room (womb) and the therapist (mother) derive much of their creativity (or negatively, their destructiveness) from influences affecting the therapist(s).

It almost goes without saying that 'a good analysis' is the most important factor affecting the training and development of psychoanalytic psychotherapists. This necessarily is a private affair. Nevertheless there is too little written about the wider psychoanalytic environment and its influence on professional identity. This book raises many important issues that contribute to understanding this area.

I started by saying this was a brave book because it is more common to read about patient pathology than the vulnerability of professional relationships. Stella Pierides writes movingly about 'Robert', a seriously ill patient taken in by the Arbours Crisis Centre. Despite the complex array of individual and group therapy available to residents, Robert does not co-operate and refuses to attend most of the sessions on offer. Staff views are divided as to whether to allow Robert to stay at the centre. Not surprisingly, the ability of the staff to contain and think about what was happening was stretched to the limit. 'Group and individual therapists were in danger of being at each other's throats.' Despite this, Pierides shows how the group perseveres in trying to understand its difficulties in the light of Robert's projections. She also recog-

nizes the ups and downs of the staff group and the effect staff changes have on patient outcome (to use a jargon term!).

Herbert Hahn's paper on 'The Task of the Assessor' raises a number of challenging points about the relationship between the assessor and the therapist receiving the patient. Hahn is quick to point out the 'invisible' presence that the assessor may have in the therapy, long after the assessment has been completed. He describes an interesting case of a patient writing to him while already embarked upon her therapy and asking to see him occasionally. My first response was that this 'acting-out' was likely to undermine the therapist's work. However as I read on, I began to see that if the assessor and therapist could work together, acknowledging 'the invisible matrix', the likelihood was of helping the patient to understand herself more fully. This approach requires substantial trust between the therapists. It is also a smack in the face to rigidity. In a field that operates in a cloud of secrecy this kind of approach offers considerable challenge.

Much of the thinking in the book builds on the work of psychoanalysts like Nina Coltart. It does much to demystify the dogma so often promoted in the rituals surrounding therapy, bringing it back into the field of those trying to utilize their environment as well as their personal resources in the service of their patients.

An interesting subject but not one much written about, is the chapter Susie Orbach contributes entitled 'The private public therapist'. Here she explores her own position as 'well-known' and considers the impact it has on her patients, particularly those who are also 'well-known' in their lives. She raises a variety of issues that are likely to influence the thorny question about how patients 'knowing' about their therapists' lives affects their therapy. She says she sees it, 'for the most part, as a kind of artefact, a medium for the transference which absolutely cannot be ignored'. For those who are themselves well-known, she subscribes to the view that having a therapist who has, herself, some experience of being able to 'think about being famous' is of itself a kind of 'benign matrix' and therefore helpful. I wasn't quite sure whether, by extension, this inferred that it was better to place 'like patients with like therapists'. This would have enormous implications in the areas of social class or race, for instance.

Nevertheless putting the spotlight on the therapist's matrix rather than that of the patient is a fruitful idea. Much else in the book is worth reading. Penny Jaques writes about working alongside a variety of other therapists – some analytical and some involved in other areas, aromatherapists, for example. She makes some important points about the tension inherent in working with the demands and pressures of the external world whilst maintaining the focus on the internal world. In a world of increasing medical complexity, the psychoanalytical psychotherapist can ill afford to sit on the fence of analytical purity for the purpose of avoiding brushing up against others calling themselves therapists.

Penny Jaques works outside London and her realistic approach to running a practice outside the capital is a useful reference for others who work in an increasingly pluralistic therapeutic group.

By way of setting the tone for this book, the foreword is contributed by the late Robin Skynner, who has popularized and made accessible the value of family therapy. He highlights the difficulty as well as the importance of trying to maintain the boundaries of each therapeutic discipline while simultaneously acknowledging the therapeutic community where therapists often work alongside each other, sometimes sharing the same patients.

Although the issues raised in this book may seem specifically contemporary, they are but the modern form of timeless matters. The editors of the book, Sasha Brookes and Pauline Hodson, put their ideas firmly in the context of Freud's writing about unconscious processes. In particular, his paper 'Formulations regarding the Two Principles of Mental Functioning' (Freud 1911) gives the authors the framework for seeing how unconscious pain cannot reach consciousness until 'it is spoken to'. Only then can it be thought about. This process enables the possibility of learning through experience to take place.

In line with Bion, the authors employ the concept of the 'container' being the vehicle that allows thinking to become a possibility, the role of the therapist(s) providing the unique structure for each individual patient(s) to remain 'in uncertainties, mysteries, doubts, without any irritable reaching after fact and reason' (Keats).

The development of psychoanalytic psychotherapy, more than one hundred years following Freud's first papers, is spawning many new forms. Inevitably so. *The Invisible Matrix* offers some valuable insight into the kinds of areas that therapists may well find themselves working in, both in the NHS and privately.

JANE WHARTON

The Fabric of Affect in the Psychoanalytic Discourse

By Andre Green
London, Routledge, 1999, pp. 376, pbk £25

Andre Green is a distinguished member of the Paris Psychoanalytic Society whose extensive work has permeated psychoanalytic thinking in France, continental Europe, and Latin America. He has written 14 books and around 200 articles, of which only four (including this present one), have been translated into English (Green 1986, 1999a, 1999b). The bulk of *The Fabric of Affect in the Psychoanalytic Discourse* first appeared in France in 1970 under its original

title *L' Affect* as a report written for the Congrès de Psychanalystes de Langues Romanes and was published in France 27 years ago entitled *Le Discours Vivant* (Green 1973).

Green belongs to a particularly French psychoanalytic tradition that takes place in the context of a critical dialogue with philosophy. Some crucial themes discussed in philosophy reappear in his work such as absence, negation, negativity and nothingness. Andre Green is essentially an anti-reductionist and thinks that object relations theory is not sufficient to fully explain the structural movements of the mind (the interrelationship between the ego, superego and the id). The author is in search of both a theory and a methodology and returns to Freud's concept of drive to find these.

In this volume, Green offers a revision of the psychoanalytic theory of affect and of the place of affect in psychoanalytic practice. In this context, he undertakes a systematic examination of the contributions of Lacan, Klein, Bion and Winnicott and the relevance and limitations of their theoretical formulations. The boundary of the book is set around the theme of the connections between feelings and representation. To do so he concentrates on studying the links between the economic principle and the other three main principles of mental life, namely, the structural, the dynamic and the topographical.

The book is divided into three parts. Part I studies the evolution of ideas around the theme of affect since the beginnings of psychoanalysis. Part II examines the role of affect in different clinical structures. Part III is devoted to Green's own contributions to the theory of affect. The book ends with a Postface and Postscripts, based on presentations delivered at various occasions.

Part I – 'Affect in the psychoanalytic literature' – deals with the evolution of the conception of affect in Freud and post-Freudian work. Green reminds us that, according to Freud, the vicissitudes of the representation are different from affect. The former, for instance, can move away or disappear from consciousness. The latter can be either the result of a repression of the drive or of a transposition of the psychical energies of the drives. Representation and affect are thus linked to different systems: the first to a level of memory trace, and the second to a level of discharge. From a topographical point of view, Freud believes that the perceptual passage from unconscious to conscious is different for content and affect. The first must pass through language, whereas the second can bypass it.

The best example of this can be seen when one looks at the difference between hysterical neuroses and anxiety neuroses. In the former, the capacity for symbolization exists, even though distorted, whereas in the latter, anxiety replaces a sexual affect that cannot be formed. In 'On fetishism', for example, Freud (1927) sees how the individual displaces his part object affect towards the mother's body into fetishes. Whilst the affect has not been repressed, it is

the connection between the instinctual impulse and the thought that has been disavowed and/or repressed. In 'On negation', Freud shows how the individual reveals the content of the ideas, but has reversed the affect from the ideas.

Green then proceeds to examine post-Freudian literature in both the English- and French-speaking worlds. Amongst the former, Green feels that Winnicott's work throws the most light on the role of affect. Winnicott posits the existence of primary affective states, which occur much earlier than those described by Klein. These primary affective states are formed by alternations of states of disintegration and partial integration of the self. Citing Hartman, Rapaport, and Jacobson amongst others, Green criticizes the North American School, for placing too much emphasis on genetics, adaptation and behaviourism in their approach to the role of affect and psychoanalysis in general. In France, Green examines the work of Bouvet and Mallet, and explains how their studies on affect were overshadowed by Lacan's influence in French analytic thinking. Lacan's over-emphasis on the role of language as the basis of the structure of the unconscious almost totally disregards the role of instinctual life and affect.

Part II – 'Clinical practice in psychoanalysis: structures and processes' – deals with affect according to the different clinical structures: neurosis, psychosis and borderline personality. In neurosis, the ego produces cathexes and anticathexes to separate affect from ideational representatives. Too much anxiety creates repression. Thus, in hysteria and phobic personalities, there is condensation and somatization. In obsessional structures, there is displacement and intellectualization. In all these structures, the repressed content is separated from the affective content in different ways.

In psychosis, the differentiation between affect and representation is less obvious. The ideational content is closest to the instinctual, affective state. The links between affect and representation are perceived through acting out and hallucination. Citing Klein, Green reminds us that in psychosis, the psychic elements are both ideational and emotional in nature (and often helping the patient develop a capacity to distinguish between the two is a gigantic step towards progress). In borderline personalities, the affect paralyses the development of representations. The psychic dilemma is between anxiety and mental pain. In other words, to think produces pain, but not to think creates anxiety and feeling of dread. In psychosomatics, the personality chooses to resolve the above-mentioned dilemma by transferring the mental contents into the body. In addictive, psychopathic personalities, there is a similar process of ejecting the contents of the dilemma into the external world.

In the second section of Part II, Green deals with the vicissitudes of affect and representation within the psychoanalytic process. In this lengthy and interesting chapter, he describes three types of personalities encountered in clinical practice in order to illustrate the interconnections between affect and

representation. Type one develops a parasitical type of transference, whereby the affect takes over and there is no representation. The patient usually tends to project his affect into the analyst and feels empty and dead. Type two is described as a personality that intellectualizes but does not feel much. All affects are displaced into thoughts and representations and the transference remains without mooring. In the third type, there is a bringing together of affect and representation. The patient wants to be heard by the analyst and seeks a response and a feeling of transference and dependence. Working through takes place, which leads towards transformation. Green refers to this as the evolution of affect stemming from the development of meaning. The evolution of affect pertains to transforming the quality of the instinctual forces as the ego proceeds little by little to conquer the id.

In Part III – 'Theoretical study: affect, language and discourse; negative hallucination' – Green expounds his own theories and thoughts on affect and representation. Green observes that affects begin in the body through self-observation of internal corporal movements and sensations of pleasure and unpleasure. These affects desperately seek psychic representation to which they can attach the energy stemming from the drive (it being the vehicle of the sensations). The aim is to contain the tension in the psyche that would normally seek discharge but cannot find an outlet.

For Green, the main vehicle to study the connections between affect and representation is the drive as originally defined by Freud. Bearing similarity to the Kleinian concept of unconscious phantasy, drive is the psychical vehicle of representatives of corporal excitations. Green conceives that the instincts, as soon as they cross the frontier into the mind, become representatives. He states: 'The drive is the result of a journey that ends in psychization' (169). The drive can further be conceived as a vehicle or electric circuit which takes the stimuli to the psychic world. However, as the journey begins, the stimuli transform themselves into ambassadors of the instinctual world. The drive can further be seen as the measure of the demand made by the body, and is the vehicle created between the body and the mind to decode and cope with the pressures of the demand. The drive splits into affect on one hand and representation on another under the impulse of the anti forces against the instinct.

Distinguishing between primal phantasy at a whole object level and unconscious phantasy life, at a part object level, Green sees how the former does distinguish between affect, representation and it implies a mutual influence between affect, and ideas. At a part object level, they are undistinguishable from each other, and the type of thought involved is ideographic. The author proceeds to examine the structural components of the psyche with respect to affect and representation. At the level of the id, affect is looking for representations and needs the drive to achieve that. At the level of the superego, after the ego damages itself in order to establish a sense of goodness and badness, it establishes, after the work of mourning, a self-representation that

can then distinguish between affect and representation. Thus, in Kleinian terms, it is only after the depressive position that this distinction can be achieved by the psyche.

The author describes how images are built. Progression occurs when the patient recognizes the image of a hallucinatory 'Other' as his own. In the mirror stage of Lacan, the infant has affects but no capacity to see an image. If there is no image of the 'Other', the corresponding affect is deadly, of nothingness, of death. The Psyche needs representation in order to survive the lack of gratification of its needs. Otherwise, it feels it is disintegrating. This absence of self-image is experienced as an hallucination of absence. Green posits the important concept of 'negative hallucination', a theme that becomes quite central throughout his later works which pertains to the presence of the absent. This concept approximates the idea of the nameless dread introduced by Bion, that which is felt but cannot be thought about, let alone named.

Having defined his method and subject matter, Green proceeds to examine the aetiology of affect. Primary affects are based on the pleasure principle. The pleasure principle seeks gratification and in its crude non-sublimated form, when it reaches its aim is at the service of the death instinct. The latter's goal is to exhaust life. Our primary affects cannot be refound; they have to be relinquished. By accepting life, one accepts death. Analysis, Green reminds us, 'is not a culture of suffering, but a process that aims at control of the affects of suffering by detachment from the drives that are its cause, that two headed body of pleasure and unpleasure' (229). The author acknowledges the epistemological instinct, and introduces a new concept, the 'genetic dimension'. In effect, the author says that the life instinct can either extinguish itself in a narcissistic fashion, or it can become object oriented and seek growth, reminiscent of Klein's thoughts that the life instinct seeks to unify, whereas the death instinct seeks to do the opposite, to fragment and break apart.

The Postface, based on a presentation he made at the Congrès de Psychanalystes de Langues Romanes in Paris in 1970, deals with affect and representation by examining the role played by language formation. Green states: 'There is an opposition between the language of the linguists, a formal system combining linguistic elements, and the language of psychoanalysis, which is made up of a heterogeneity of the signifier, which derives from the heterogeneity of the raw materials of psychical activity. And which I should prefer to call discourse' (299). Criticizing Lacan's exaggerated theory of the place of language in development, Green turns to Bion's work to explain the relation affect–language. Verbal thought is developed or created when the affects related to unconscious phantasies are contained. Language as such develops either concretely as a sign or as a signifier with meaning and with symbolism.

The untitled Postscript One, based on a presentation to the Paris Psychoanalytic Society in 1984, takes Green's thinking a step forward. He no longer thinks of affect as being the outcome of a chain of representations nor

as an outburst of energy stemming from traumata. According to Freud, that which is not representable, becomes repeated. He proceeds to distinguish the functions and qualities of both mental phenomena. Representation operates only in absence. Affect operates both in presence and absence. Affect cannot be disavowed but can be re-channelled. Representation can deceive, distort, delude.

In Postscript Two – 'The representation of affects and the consequences of our understanding of what we call psychical' – Green discusses the difficulties of reaching an overall approach to the study of affect because of the different theoretical assumptions made by different schools of thought. One of the major conclusions is that affects are a movement in expectation of some form. Green is tantalized by this idea, which again seems to be congruent with Bion's and Klein's thinking that affect can be transformed according to its evolution, for instance when love and hate come together, creating, via resolution or guilt, the depressive concern.

In the final Postscript – 'On Discriminating and not Discriminating between Affect and Representation' – presented at the 41st IPA congress in Santiago de Chile, (July 1999), Green concludes: 'Psychical representation of the drive, synonymous with the instinctual impulse, is what will give birth to affect, once the meeting with the object-presentation has occurred' (316). He realizes that it is through the study of borderline personalities that important discoveries of the relationship between affect and representation can be made.

Clinically, he observes how borderline personalities avoid learning from experience, and tend to avoid instinctual satisfaction. Their main system of defence is to stay away from pleasure and seek a state where needs are not existent. They introject an image of a partial object, which is blind and unresponsive. Therefore, the person has no representation or image of a responder. In these states, we have a situation where affect and representation are inseparable, because the unconscious and conscious are also undifferentiated from each other. Green states: 'The child has to internalize the mother and elaborate within his own imago and then allow transformative activity to take place with her. Failing that, there will be disavowal, splitting, denial. Through these defences, the personality tries to achieve a non-recognition of the self' (334).

In a small subsection towards the end of the book – 'Speculations' – Green reflects on Freud's conceptions of the constitution of the ego, and the perceptions of internal instincts as well as the evolution of the psyche towards perception of the preconscious thought processes. The author concludes that the personality libidinizes both the body sensations and the thoughts that are linked to language. Green finally speculates as to the nature of what he calls 'intermediary psychic processes', which translate the instinct into representation. This facilitates the development of symbolism. Green feels that the processes become constituted when the infant has the mother's cathexis or recognition of his own psychic work. Following Winnicott, the author feels

that the latter's conception that the child learns to play alone in the presence of the mother is essential for individuation to occur.

The author concludes that Freud's instinctual hypothesis remains still unanswered. We know, for example, that projection and projective identification are essential for the psyche to evolve its affective system, but we still need to understand the forces behind this, how it works, and what kind of energy is involved. For further research, the author proposes going back to the notion of drive.

Andre Green is a theoretician par excellence. The book is an exemplary treatise of metapsychological analysis. Undoubtedly the author makes a major contribution to the development of conceptual tools in order to study the relationship between principles of mental functioning, economic, topographical, structural and dynamic. The reader will be intellectually stimulated by Andre Green's questioning of the relations between instinctual energy and mental functioning. It is through the study of what the author calls 'negative narcissism' that Green opens up the questions relating to absence of representation and affect. In this way, Green seems to come closest to Bion's hypotheses concerning the aetiology of thinking and the distinction between thought and language.

I find Green's thesis, namely, that the psyche evolves out of a demand made by the instincts for working through and transformation, very interesting. This complements Klein's findings that there is an epistemological drive based on the life instinct which aims towards growth and transformation. Furthermore, the book offers the opportunity to revisit Freud and re-examine various issues pertaining to the unconscious, preconscious, affect and thought processes.

A major weakness of this book in my view is the almost total dearth of clinical examples, which makes the reading dry, austere and somewhat frustrating. It would have added to the book to read theory accompanied by application and illustrations of clinical work. Another misgiving is that it assumes a large amount of knowledge on the part of the reader about Lacanian terminology and theory. The phrases he uses are long and more in tune with French syntax, which adds to the inherent difficulty of the material.

Despite these misgivings, the book is challenging and intellectually stimulating. It also offers the reader a window into the French analytic world, which remains largely unknown in England. One of the attractions of the French analytic tradition is its interest and application to philosophical and sociocultural matters, something that is to a certain extent missing in the British analytic tradition. The book inspires the reader to see psychoanalysis not just as a form of treatment but also as a research tool into all human concerns, especially the role played by unconscious over determination. I recommend the book to all those engaged in theoretical research, practitioners and academics alike.

DR RICARDO STRAMER, PHD

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Politics on the Couch: Citizenship and the internal life

By Andrew Samuels
London, Profile Books, 2001, pp. 235, pbk £10.99

There have over the years been many attempts to relate or apply psychoanalytic insights to social and political questions. From the past names such as Wilhelm Reich, Franz Fanon, and Marie Langer come to mind, along with contemporary writers too numerous to list here. Beyond the explicitly political, there is also the extensive literature that touches implicitly on social and political issues. As a matter of course, analytic texts reflect on issues of power, equality, oppression and discrimination, the roles of men and women, the treatment of children, and the environmental preconditions for mental well-being. The starting point of British psychoanalysis is the social and relational foundation of the human individual, however this might be conceptualized by its various schools. The extension of clinical work into group and institutional settings provides another direct connection between these two spheres of thought and activity.

Samuels's contribution to this literature is written from a post-Jungian standpoint, and from a position of some authority. He understands that many may have turned to psychotherapy in some degree out of frustrated hopes of other kinds of political engagement and must be grappling privately with the relationship between the personal and introspective, and the impersonal and public domains. Over the years he has done more than just write and speak about political issues – he has formed organizations like the Psychotherapists and Counsellors for Social Responsibility, and Antidote, to provide the therapeutic community with platforms and outlets for their political concerns. He has demonstrated a particular concern with the social construction of gender, and the reform of gender relations.

Our anticipation of *Politics on the Couch* is further heightened by the cover description of the book as 'an accessible, lucid and stimulating account of the hidden psychology of politics and the hidden politics of the psyche' that 'offers trenchant and timely critiques of the crisis on contemporary politics'. The opening paragraph gives us an idea of his starting point and his agenda:

> Politics in many Western countries is broken and in a mess: we urgently need new ideas and approaches. This book argues that psychotherapy can contribute to a general transformation of politics. Therapists can ignore the demoralization in the political realm and continue to focus on personal transformation. Or they can try to transform self-concern into social and political concern, thereby helping to revitalize politics. (1)

The reader is thus primed to expect an analytic perspective on the state of current politics, and a critique of analytic theory and practice in terms of their relevance to political awareness and action. In the course of the book Samuels seeks to pursue this theme by considering our notions of leadership, the economy, national psychologies, and our responses to contemporary family structures and gender roles.

The idea fails. Throughout the book Samuels feels he is offering a 'new hybrid language' that will allow the irradiation of his two areas of interest, but in fact he is unable to provide a sound conceptual basis for using what he values in psychotherapy theory and practice to illuminate the social issues he takes up. A brief example will have to serve as an illustration of this point. Samuels describes workshops on 'transformational politics' in which participants are asked to list their early memories of the primal scene alongside their first political memories. Explaining the point of this, it is simply asserted that 'sexual conflict co-symboliz[es] political conflict' such that:

> if the parents' bodies are not in motion, then psychological and sociopolitical differences and inequalities between male and female need not enter consciousness. The denied primal scene signifies the loss of faith in the political nature of the human organism and of society itself. Conversely, images of vigorous, mutually satisfying parental intercourse – including, perhaps, some kind of struggle for power – reveal a private engagement with the conflictual political dynamics of the public sphere. (51)

He reproduces the questionnaire as filled in by one of the participants. Reading it I felt embarrassed, not for the participant but for Samuels who refers to exercises like this as 'research'. It would be easy to simply ridicule Samuels' efforts, not least by turning against the book precisely the same criticisms he makes of crude attempts by others to psychologize our social and moral concerns.

Samuels views politics and psychotherapy as two discrete areas of activity, and the task he has set himself is to realize the presence of each in the other and thus to liberate progressive and creative energies that will revitalize both. People who attend his workshops rage and weep – even retch – in their frustration and despair with the state of 'politics'. As we, the readers, are assumed to share these feelings Samuels skips the tasks of defining what he means by 'politics' and of analysing why it is in a mess (beyond the central assumption that it relates to the absence of a 'psychological' perspective). There is no recognition that progressives might despair because our unconscious motivations might link up with the forces of reaction to create formidable alliances,

that Alastair Campbell and Rupert Murdoch might be expert psychologists, and that, psychologically speaking, most of the cards might be stacked against 'us'. At no point do fear, envy, greed, destructiveness or even the consequences of deprivation and insecurity get in the way of Samuels' determined optimism. It is suggested that we all have a political drive, alongside our sexual and aggressive drives, and that this is fundamentally a force for radical progress.

He writes therefore as if the links between politics and psychology have yet to be forged, and as if (with the exception of certain feminist thinkers) there's an empty landscape for Samuels to people as he sees fit. The result resembles a well-meaning but fundamentally naive tract. From behind the 'depth psychologist's' pluralistic radicalism emerges a hectoring paternalism at once rationalist and prescriptive. The degree of failure emerges when one reflects on the organic linkages that do exist between the concerns of psychotherapy and progressive politics and how these are studiously avoided here, to be replaced by the gratuitous importation of psychotherapeutic concepts to be 'factored in' to those debates that constitute 'politics'.

The book seems to be addressed to the combined followings of alternative or single issue groups – a 'membership' running 'into the millions'. These are both his audience and constitute the force that will combine and which, armed with concepts provided by the psychologist, will 'resacralize' the political world. So, while there is an occasional nod to the power of international capital and the forces behind it, the focus is on those involved in environmental bodies, organic farming, complementary medicine, new spiritual movements, those promoting the rights of ethnic and sexual minorities, counter-cultural music and art, and so on. Samuels finds here a people keen to re-make the world, an unharnessed force for social regeneration. These starting points enable Samuels to proceed with an almost Rogerian view of human nature – positive and progressive if only it knew itself.

The language of 'transformation' and 'resacralization' belies the rather tame noises that emerge whenever there is a reference to political realities. The line that divides 'us' from 'them' runs between the Labour and Conservative Parties. One suspects it really runs between those willing to subject themselves to Samuels' political workshops and those who would shy away from them. Any idea that involves engaging with the imperatives of contemporary capitalism is avoided, even derided. Despite attempts to sustain a sense of radicalism through its evangelical terminology, this is in truth an unchallenging, extremely safe way of getting political.

Far more space is dedicated to persuading the reader that existing radical critiques – specifically socialist ones – are 'old' and 'irrelevant', than to advancing a meaningful psychological basis for a progressive political engagement. Indeed, while this is an angry book the anger is directed almost exclusively at those one might have thought would be Samuels' potential allies. He holds forth against those who engage in 'rectitudinous diatribes against the

free market' (141) and in parochial fashion writes as if we need to move on from such infantile concerns. Unnamed 'materialists' also get it in the neck: 'Those with a materialist outlook would assert that the psychological realm is utterly subordinate to the nitty-gritty economic forces that have inexorably constructed our world' (12). While one might be able to dig out a reference to substantiate this claim, it ignores, and enables Samuels to avoid considering, those materialists who – over many decades – really have been engaged in exploring the relationships between the economic, the cultural and the subjective. He can then propose (as if it were an original idea) 'a more dialectical approach' which would 'see the psychological and the social in fluid, ceaseless, unending, unresolvable interplay' (13). But never in any tangible form is this used to illuminate the processes going on within either reality. The ultimate impression is not of a dialectic between two domains, but of a position in which the reality of each is lost in being perceived as a reflection of the other.

Just as Samuels dismisses the efforts of the 'materialists' to understand the world without a mature psychology, so he pillories pre-existing attempts by those within the analytic community to contribute to political debate. These efforts are replete with 'seemingly incurable psychotherapeutic reductionism and triumphalism' (8). Unreferenced, dismissed as 'bungling' and 'disastrous', described in terms that lets us know they are beneath our serious attention, we are quickly moved on to abstract principles: we need an 'understanding that outer world problems contain emotional and fantasy elements as well, and seeing how the political and the psychological mutually irradiate' (9). One might suggest that this, perhaps, is what underlay various previous attempts to write about social issues from an analytic perspective. But Samuels has further reasons to reject past efforts. For not only does politics need a makeover, but so does analytic theory and practice. He has two objections to current thinking and practice within the realm of therapy.

First there is 'therapy's weddedness to normative and universalistic standards in relation to gender, parenting and sexuality' (9) and he repeatedly lambasts the therapeutic community for colluding in and underpinning oppressive social arrangements. The difficulty here is not his concern at the potential influence of cultural norms over analytic theorizing, but that his approach is so thoroughly that of the idealist. If a theory doesn't fit into our current political agenda, then change it. And the ways proposed really sound as crude as that. The notion of the growing child needing to 'separate' from the mother carries with it an attack on the mother, and on women generally, and should be disqualified. The fact that psychoanalysis might see certain kinds of masculinity as reactions to a felt need for protection from a maternal object is misinterpreted to mean psychotherapists telling their patients that they must become more machista (53). Analytic theory, for Samuels, is thus misogynist and culpable. This section, like many others, reads as if Samuels is saying, 'Let's reconstruct the unconscious on more acceptable lines.' The fact that a theory may be culture-bound does not, I think, in itself demonstrate

that it is responsible for the deformations of the culture, or that a meaningful advance towards changing the culture is made by reconstructing the theory to suit a current political agenda. As I read the book I felt a longing for Freud's dour indifference to the arguments of feminists and the promoters of particular explanations of homosexuality. From our present perspective Freud's claims to scientific objectivity may be questionable, but his dedication to extending the rigours of the natural sciences to the study of the psyche surely resulted in contributions far more revolutionary than anything being proposed by Samuels.

The second problem Samuels sees, particularly for psychoanalysis, is its attachment to developmental models, and particularly a view of human relatedness based on ideas about projection and introjection. 'The ceaseless play of movement from inside to outside and back again implies that individuals are regarded as first positioned in empty space, that is that there is nothing between us to start with' (129). In this way psychoanalysis is held to privilege 'the bloody struggle towards the kind of autonomous, atomized, de-spiritualized individualistic self that Western societies have espoused, and which is now beginning to poison them' (130). Samuels alternative is that 'we imagine instead something like a "social ether" ' (129). Object relations therapists may be irked to find themselves as the champions of a non-social view of human nature; others may be surprised at his characterizing 'psychoanalytic' theories as focusing on projection and introjection, with no mention of Winnicott's 'no baby without a mother', Balint's 'harmonious mix-up', or Little's 'basic unity' (to name but three). Moreover, despite his enthusiasm for 'critiquing' this and that, he nowhere acknowledges the existence of a literature of political engagement built on the basis of an object relations outlook. This necessity is implicitly disposed of by the superficial rejection of object relations theory itself, described above. This impoverishes the book and denies the reader access to other work concerned with its core themes.

So why was this book written? This may seem a strange question, but it is a pertinent one. In the preface Samuels describes it as 'the final volume of a trilogy that began with *The Plural Psyche* (1989) and continued with *The Political Psyche* (1993)'. It 'has been stimulated by reactions to the ideas I offered previously', and is 'the most ambitious of the three volumes in that it represents my attempt to work out a new language in which the goals of the other two could have been expressed had I had the words at my disposal' (ix). The book's 'language' is in fact a difficulty – suffice to say that it jars, contributing to the book's lack of readability. The language also implies a rigour that is lacking in the textual argument. More importantly, anyone who reads *Politics on the Couch* after reading *The Political Psyche* will be likely to suffer a profound sense of *déjà vu*. For it is, in fact, a slimmer, dumbed-down version of the earlier book. Gone are most of the references, the more academic style, the extended discussions aimed at an analytically informed readership. Certain subjects are left out altogether. But almost nothing that is present in

the latest volume is absent in the former, down to the same allusions, examples, illustrations, conceptualizations, and – yes – vocabulary. Rather than the result of a continuing struggle with his subject it emerges as a jaded popularization of well-worked ideas to which, as far as I could see, almost nothing new has been added.

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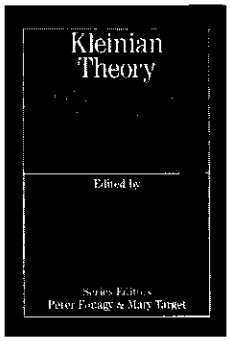

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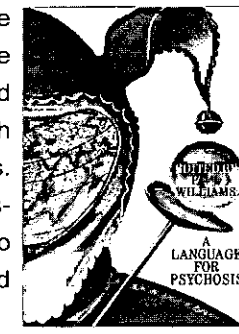

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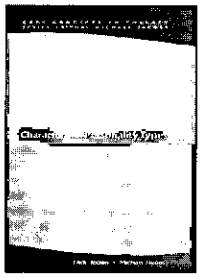

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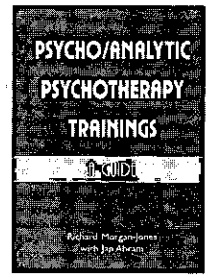

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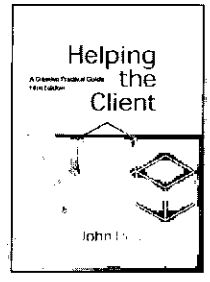

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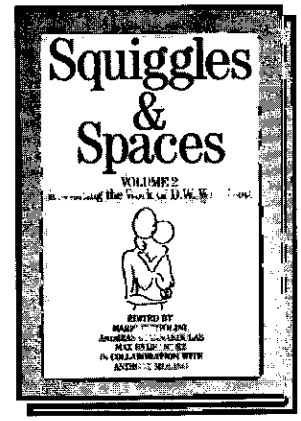

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VOLUME 1

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To celebrate the 25th anniversary of the publication of D.W. Winnicott's *Playing and Reality*, a number of organizations - including the University of Milan, the European Federation for Psychoanalysis, the Italian Association of Psychoanalysis, the Peruvian Psychoanalytic Society, and the Squiggle Foundation and Winnicott Trust - organized a major international conference on Winnicott's work, entitled "The Psyche-Soma: from Paediatrics to Psychoanalysis." Derived from that conference, *Squiggles and Spaces* looks to update and elaborate Winnicott's theoretical insights and clinical findings.

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