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THE JOURNAL OF THE BRITISH ASSOCIATION OF PSYCHOTHERAPISTS

VOL 38 ISSUE 2 JULY 2000

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JOURNAL OF THE BRITISH ASSOCIATION OF PSYCHOTHERAPISTS
Volume 38 Number 2 2000 ISSN 0954-0350

Journal of the British Association of Psychotherapists is published twice a year (in January and July), by Whurr Publishers Ltd for BAP.

Subscription rates for 2000: Individuals £25/US$45. Institutional: £50/US$90. Add $15 per subscription for airmail postage if outside Europe.
All subscription orders and correspondence regarding service should be sent to:
Whurr Publishers Ltd, 19b Compton Terrace, London N1 2UN (telephone 020-7359 5979; fax 020-7226 5290). This journal is distributed in the USA by Whurr Publishers Ltd, PO Box 1897, Lawrence, KS 66044-8897.

Design: Stephen Cary
Printed on acid-free paper, which conforms to the international standard ISO 9706 1994, by Hobbs the Printers of Southampton, UK.

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Guest editorial

This issue of the *Journal* sees the introduction of an Arts Review section. It is hoped that this new feature will provide a forum where psychotherapists may apply analytical and psychoanalytical insights to the arts and where the arts may enhance the understanding of our work. The application of psychoanalytical ideas to an arena beyond clinical practice also allows for the exploration of the wider relevance of these ideas.

James Fisher has written the first review essay on 'Jonathan Miller's *La Traviata*' where he uses the Oedipal constellation to cast a different light on the unfolding drama in this opera.

In future issues of the *Journal* we plan to include review essays on film, opera, music and the visual arts. We see this new applied section as an important contribution to maintaining a creative dialogue about ideas that underpin psychotherapy.

We are also happy to include the first of a new series of occasional invited papers that have been given at conferences attended by BAP members. The paper by Mauro Rossetti was given at the international conference in Florence in February 2000: 'A Developmental View of Psychoanalytical Method: theoretical and clinical studies of Donald Meltzer's contribution to psychoanalysis'.

Lastly, we welcome a paper by Dr Paul Roazen, who gave the *BAP Journal*'s First Annual Public Lecture.

The Arts Editors

Journal of the British Association of Psychotherapists, 38, 83–92, 2000 © Whurr Publishers Ltd

Edward Glover: An outsider on Wimpole Street

PAUL ROAZEN

Of all the people I met during the course of my interviewing work on the history of psychoanalysis, it is a special pleasure for me to put together some of the material that I gathered from Edward Glover (1888–1972). When I met him in the mid-1960s he was a well-known and influential writer, especially because of his contributions to the issue of therapeutic technique. Even now in North America Glover is considered a sound and important theoretician of the so-called mainstream in psychoanalysis. Yet in London he is relegated to being an outsider.

Glover played a leading role in the early history of psychoanalysis in Great Britain, and was a long-standing officer of the International Psychoanalytic Association (IPA), of which he was Secretary from 1934 to 1944. Although he was originally taken with Melanie Klein's ideas, he came to view her as a heretic. He found support in this from Melitta Schmideberg, Klein's disaffected daughter, as well as from Anna Freud and her allies, and he shared Freud's view of her as a 'deviationist'. When Glover resigned from the British Psycho-Analytical Society in 1944 after the 'controversial discussions' over Klein's ideas, it was largely because he felt that training analyses were being manipulated in a partisan way. He had also grown weary of being an officer in an organization that he felt had inconsistent convictions. Ernest Jones was irritated enough to replace him as Secretary of the IPA (over Glover's objections) with Anna Freud. Both Glover and Anna Freud applied for membership of the Swiss Society. Jones, however, objected that their Swiss membership would be illegal. After Anna Freud worked out her own training programme in the British Psycho-Analytical Society, she decided to make her Swiss status an honorary one only. Glover's membership, however, was regularized only several years later when Jones finally stepped down as President of the IPA.

As pleasant a man as I found Glover to be, I knew about his combative book against Carl G. Jung, which alerted me to the existence of a polemical

---

Dr Roazen gave the *BAP Journal*'s First Annual Public Lecture in April 2000. He has a forthcoming book on Edward Glover.

side to the mild and courteous man I met. (A Jungian psychiatrist, Michael Fordham, told me that whenever he wanted to see what was wrong in Jung, he looked it up in Glover's book, *Freud or Jung?*(1956).) Jung himself read Glover's 1950 pamphlet and responded to Glover's indictment in a letter to an American:

> Glover's book – apart from its more venomous qualities – is quite amusing: it is exactly like those pamphlets people used to write against Freud in the early days. It was quite obvious then that they were merely expressing their resentments on account of the fact that Freud had trodden on their toes. The same is true of Glover. A critique like his is always suspect as a compensation for an unconscious inclination in the other direction. He is certainly not stupid enough not to see the point I make, but I touched on a weak spot in him, namely where he represses his better insight and his latent criticism of his Freudian superstition. He is just a bit too fanatical. Fanaticism always means overcompensated doubt. He merely shouts down his inner criticism and that's why his book is amusing. (Adler, 1975: 31)

It is impressive to me how Jung was able to take Glover's indictment in his stride. One observer notes of Glover's writing against Jung that it 'is antagonistic, witty, sarcastic, and animated. And there is intellectual substance beneath the acidic surface; he has a deep acquaintance with Jung's ideas, and he provides the most thorough case against Jung that has ever been written' (Anderson, 1991: 6). Jung's reasoning, that *too* decided convictions betray a latent unconscious inclination in an opposite direction, has been said to forget how bellicose Jungians have been among themselves. A critical biography of Jung has recently credited Glover for having mounted 'the most sustained attack on Jung's theories of psychological types' (McLynn, 1996: 265).

Glover, I think, would have defended himself over his critique of Jung because, like Freud, Glover thought that it was important to be aware of the 'dangers' of analysis being 'watered down' into an old-fashioned conscious psychology. The idea was that psychoanalysis is a unique system under constant threat of being lost amid alternative approaches. In his Freudian period Jung too could be combative, but his response to Glover was either a sign of how smug Jung could be or of how well he had matured. For example, while Jones was writing his biography of Freud, and planning to pursue Jung as a 'renegade', Jung himself had appealed to Jones (without success) to let bygones be bygones. Glover told me that he was willing to go along with the traditional principles of psychoanalysis rather than 'rush into new concoctions'. Glover was one of the most literate of traditionalists, and clear enough as a writer for Cyril Connolly to have commissioned him to write about Jung in *Horizon*.

During the summer of 1965, after my initial interviews with Anna Freud, I stayed in London to gather background on the history of psychoanalysis (Roazen, 1993). By good fortune I stumbled across Jones' papers that eventually went to make up his three-volume biography of Freud. Everything was kept in the basement of the British Psycho-Analytical Society and was as Jones had left it before his death in 1958.

I also had several meetings that summer with Geoffrey Gorer, who recommended that I interview Edward Glover. Gorer, a fascinating figure, was an intelligent commentator on British psychoanalysis. He was a fine writer who had been a friend of people such as George Orwell, W.H. Auden and the Sitwells. Among Gorer's books was one on Russia he had co-authored with the analyst John Rickman. He had once been taken through Freud's house in Maresfield Gardens by his friend Ernst Kris, and was on good terms with Freud's grandson Lucien, who was already then a leading artist. Gorer had a deep interest in cultural anthropology, knew Margaret Mead well and insisted that it was 'a sociological law' of all fieldwork that 'mavericks' make the best sources of information. By 1965 Gorer saw Glover as someone who had drawn a particularly bad hand in life.

Glover lived to the age of 84, dying in 1972. He gave me nine separate interviews in 1965, and then I saw him for two more when I returned to London in the autumn of 1966. Afterwards, we exchanged some friendly correspondence, and he suggested another early analyst on the continent who I should see. It was typical of Glover's style that he wrote to me: 'If you write, mention my name. I knew him well: he had a voice like a brass band but very nice and helpful.'

Glover's office, where he had practised since 1926, was in a medically posh part of London, 18 Wimpole Street, which is near the more internationally famous Harley Street. Unlike Freud's arrangement in Vienna, where there was a separate entrance and exit for patients, Glover's patients sat in a large waiting room with other physicians' medical patients until a receptionist announced that it was time to go in. In my notes I described his office as 'Miss Haversham's place', thinking of Dickens' *Great Expectations*. His office was a kind of living tomb. Books and papers were piled all over the place, almost tumbling in on themselves. The well-used furniture was largely eighteenth and nineteenth century.

Personally, in contrast to someone like my patron Helene Deutsch's lively set of witty *bon mots* (Roazen, 1985: 254–5), I found in Glover an air of sombreness, which seemed like a comparative absence of humor. Although unlike in *Great Expectations* Glover's quarters had no literal cobwebs, I did have the feeling that I had stepped back into the past. His analytic couch, as was customary in the London analytic consulting rooms of the earliest pioneers, was by North American standards enormous and obtrusively placed. Glover was himself a reserved old gentleman from Glasgow, with a quietly striking Scottish accent. Surprisingly, in an otherwise excellent set of editorial notes to a fragmentary diary of Freud's, he is referred to as an 'English' analyst (Molnar, 1992: 276).

At the outset of our relationship Glover had asked me to draw up a prospectus of questions. Such an ideally rational approach proved unnecessary, however, since every time I saw him I had more than enough enquiries to keep the interview moving and, as I remember it, specific issues I raised ahead

of time invariably did not interest him. Flying by the seat of my pants proved a more successful way of ensuring his spontaneity. Early on he pointed out that he was 77 years old and could not know how much time he had left. He would gladly, if someone would pay him $20 000 a year, do nothing else but write about the early history of psychoanalysis.

After our first meeting I noted that Glover had done almost all the talking. He told me that there were about 20 other members of the British Psycho-Analytical Society in its early days, but in his view few of them really mattered. (We both knew that he was not including Jones in this group.) We spent a good deal of time going over old membership lists of the British Psycho-Analytical Society, which revived memories of past associates for him.

Of his own writings, he lent me copies of an autobiographical manuscript, an unpublished paper of his about his own analyst in Berlin, Karl Abraham, and a pamphlet called *An Examination of the Klein System of Child Psychology* (1945), an abbreviated version of which had appeared in the first volume of *The Psychoanalytic Study of the Child*. He explained in passing that it was proving difficult to find a publisher for a piece about himself by Melitta Schmideberg. (Politics can play more of a role in the acceptance of psychoanalytic papers than one might expect, and extends even to the nature of the bibliographies that are considered advantageous for getting articles accepted in professional journals. But by 1965 Schmideberg was wholly out of sympathy with psychoanalysis, and indeed psychiatry.)

I never discussed with Glover the details of the personal tragedies in his life. His autobiographical paper told me that his first wife had died in childbirth and that the baby was stillborn. Those traumas preceded his decision to go into analysis in late 1920. After his wife's death he was able to go to the continent to undertake the training necessary to join a new field. Later in 1926 his admired older brother, James, who was an analyst before Edward (both were tubercular), died from diabetes. (A reliable analyst maintained that James drank, which would be deadly for a diabetic; on the other hand, one incident in which James was picked up on drunk-driving charges was attributed to an insulin deficiency.) It would be a sign of Edward's own extraordinary professional isolation that although his brother (who published little) had a nine-page obituary in the *International Journal of Psychoanalysis*, the journal allowed Edward's own death to go virtually unrecorded. Instead of the usual obituary notice it published an appreciative biographical sketch by Lawrence S. Kubie, which had been intended as a tribute to Glover's 85th birthday, and also an examination of Glover's work (Kubie, 1973; Wallsh, 1973).

Glover's second wife had given birth to a daughter who had Down's syndrome and who was mentally retarded. The Glovers kept the girl at home, caring for her themselves, in order to let her develop as far as she could, and taking her with them on visits to analytic colleagues with whom they felt at ease. Glover's wife eventually became bed-ridden, which put even more of a

burden on him. When I later happened to hear that she had died, I wrote him a letter of condolence. He replied with a kindliness I had come to expect: 'Many thanks for your letter. I was much touched by it. It is the end of a long story for me. How are you getting on? Well I hope.'

Although we never talked about his troubles, we both took for granted the reality of his current professional isolation. It took courage on Glover's part for him to leave the British Psycho-Analytical Society in 1944, and was in keeping with his quiet convictions. At the time I knew him he was not only a member of the Swiss psychoanalytic group but an honorary member of the American Psychoanalytic Society. His prior contacts in the international movement had enabled him to find safe havens abroad. Glover had, however, been voted down as President of the IPA in 1957. The English analyst, William Gillespie, who was proposed by the nominating committee, won the election, in which Glover's name, along with that of a French analyst, had been proposed from the floor. After Glover's defeat on the first ballot he declined to stand for a Vice Presidential race. I never saw in Glover any bitterness about his situation. If all true believers share a horror of excommunication (and each of the pioneering analysts had to be fanatics to some extent to overcome the barriers to their undertaking new careers), Glover seemed content enough with his self-imposed exile and to have a busy clinical practice. Others told me how he had resisted invitations to get him to lecture once again at the British Psycho-Analytical Society.

When I enquired into his ideas about the contrasting ways psychoanalysis had been received and changed in different national cultures, such as Britain and the USA, he responded that my question sounded like a 'racial' theory. Instead of taking a national character line of reasoning, Glover preferred to trace whatever differences there were to 'the influence of individuals'. Freud had his own reasons, as a Jew struggling to escape from the narrow confines of his background, for insisting on universalizing what he thought about human psychology.

When I saw Anna Freud, I had mentioned a psychoanalytic group in Japan, but she thought it was impossible to be sure what was going on there under the rubric of psychoanalysis. I wondered whether greater clarity between the Japanese and the rest of the psychoanalytic movement might only have risked the expulsion of the Japanese from the IPA. Jacques Lacan in France had suffered the fate of being excluded, but then Paris was so close to London as to seem threatening, whereas perhaps having a Japanese society looked good for the international and cross-cultural standing of psychoanalysis. Glover had, in fact, analysed Yaekichi Yabe, founder of Japanese psychoanalysis, and I later discovered that some of the most distinctive contributions of the Japanese were in line with some Kleinian thinking.

Glover did comment about how good the situation of analysis in the Netherlands was. The Dutch society was largely non-Jewish, as were the Swiss and the early British groups, which was noteworthy compared with the rest of

the movement. The Dutch had welcomed Freud's ideas to an unusual degree even before the First World War, and by the 1960s psychoanalysis was flourishing there. Anna Freud had mentioned to me that some psychiatric professorships there had recently gone to analysts not 'in spite' of their Freudian allegiances but 'because' of them.

Later that summer, after an interview with Glover, I note: 'I've grown to quite like the chap – curious, though, how he announces the end of the interview; he just rises and expects me to know that I am to leave.' I have often wondered about the clinical effect of such non-verbal acts. Another example would be Freud's continental European custom of shaking hands with patients before and after every analytic hour. In his book on technique Glover discussed the issue of hand-shakes and the different ways it may affect different kinds of patients (1955: 24). When I saw Erich Fromm, he described Glover as a leading exponent of classical analytic technique, while joking about how helpless analysts are without the free associations of patients. Although I felt a power element implicit in Glover's way of terminating an interview, I was happy to undertake such a tilted contract between us for the sake of what I was learning. But the built-in authoritarianism in this way of ending an interview was accompanied by another oddity; for I never knew beforehand how long each interview would last, and it would vary from time to time (although on each occasion I had the distinct impression that I had been sandwiched between Glover's regular appointments).

At the outset Glover had been especially interested in talking about his training at the Berlin Psychoanalytic Institute, which was newly established in 1921. He felt that in retrospect he and his colleagues had taken for granted what had in fact been a remarkable experience. Glover had had to wait a year in order to get Karl Abraham as his analyst, and it took time to get visas after the First World War was over. (Although Abraham, unlike Ferenczi in Budapest, made no special point about writing on technique, Abraham was widely esteemed as a sound clinician.) I asked why he had not gone to Freud, but it turned out that Glover had heard from his brother James that Freud's list of patients was already 'full up', and Abraham was considered 'second best'. In those days, according to Glover, it was so pleasant when one went abroad that it was tempting 'to stay as long as one could'.

Evidently, Abraham took a personal interest in his patients and after a while he had invited Glover to his house. Yet even there Abraham, though 'gentle about it', 'never let up' interpreting psychoanalytically. Glover remembered that in one of Abraham's letters to Freud, Abraham was worried about 'slow progress' in a case, even though he had seen the patient only twice. Freud replied by saying that Abraham should not get discouraged too soon. (In my opinion Abraham is now an over-estimated figure in the history of psychoanalysis, a point that may be hard for Kleinians to accept since Klein herself thought that Abraham's work was a key to authenticating the link between her own ideas and those of Freud. Although it is true that Abraham

seems to have had a stable character structure, in his letters to Freud he often comes across as a boring straight-man, and his attitude towards Freud seems to me to have been, strictly speaking, infantile. None the less, Klein as well as Glover and many other early analysts had chosen to go to him for an analysis.)

I asked Glover whether Abraham, like Freud, talked about the early history of psychoanalysis. He said that he had not but that he was 'always crazy' about Wilhelm Fliess. (Freud's own falling-out with the Berlin physician, Fliess, took place in 1902, but Fliess had played a notable role in Freud's creation of psychoanalysis. Although Fliess' last-known contact with Freud was in 1904, Fliess stayed abreast of psychoanalysis, and one of Fliess' sons later joined the field, at least for a time.) Abraham had talked to Glover quite a lot about Fliess' theory of periodicity, and ideas on psychosexual development, which had been an influence on Freud's views. But mainly Abraham would use illustrative material, 'thumb-nail sketches of other cases, to help you open up'. In Glover's view any technique which helps 'overcome resistances' is in itself a valuable approach, and he thought that Abraham's technique as an analyst was 'an easy, quiet, standard' one.

In 1965 Glover had just written the Introduction to the Freud–Abraham correspondence, a book that I was reading in page-proofs that summer (Glover, 1965: ix–xvi). I knew from James Strachey that important letters had been censored from the book, but I tried in vain to find out from Glover what had been left out. Glover may have been an outsider in reality, but he was still behaving as a loyal establishmentarian.

Glover mentioned, in reminiscing about his Berlin days, that Karen Horney had been prominent then. He thought her ideas had eventually 'died out' in the USA, although in future decades the feminist movement would carry her reputation to altogether new heights of prominence (see Quinn, 1987; Paris, 1994). Glover had written critically of her work in which she suggested that Freud's biological approach needed a cultural corrective. Glover considered that what he took to be the American tendency 'to let everyone have their say' was better than the British way of splitting into separate training groups because of theoretical differences.

I do not think that Glover knew much about the USA. He did appreciate the reaction official psychiatry had had toward psychoanalysis in the USA as opposed to Great Britain. Even before the First World War psychiatrists in the USA were using Freud's concepts in their clinical practice. US receptivity to new ideas partly helps account for Freud's early impact. The US tradition of psychotherapy was optimistic and reform-minded. Although by the 1970s the clinical tide would be going away from Freud, up until then US psychiatry and the whole general culture had been thoroughly imbued with at least a surface level of psychoanalytic teachings. In England, on the contrary, both neurologists and psychiatrists had, by and large, stood aloof from Freud's influence, relying instead on their own traditions of dealing with clinical issues. (Neurology has been one of the glories of British medicine.)

The anti-US issue came up time and again that summer, in a number of different interviewing contexts. Anna Freud's own prejudices were mild compared with the diatribe against all things American that I heard from someone like Masud Khan (Roazen, 1995). (Glover was impressed by Khan, although he was mystified that Khan could successfully navigate between Klein and Anna Freud.) Glover thought that US analysts were more 'generous' and 'democratic' about competing views than would be the case elsewhere.

Max Eitington was a memorable figure among the Berlin analysts during Glover's own training. Although Eitington was not the equal of the most famous Berlin analysts and, according to Glover, 'never spoke at meetings' (I learned from others that he had a stammer), he did have a great deal of money, which ensured his standing in Freud's movement. Glover pointed out that Eitington had been the first to join up with Abraham; and, like Abraham, had had some psychiatric training in Switzerland, which was unusual for analysts of that generation. (North Americans are still likely to underestimate the immense professional gap throughout Europe between neurology, the field in which Freud got his own training, and psychiatry; psychoanalysis was itself a wholly separate discipline.) Evidently Abraham viewed Eitington as 'rather a dilettanti'. The only thing that Eitington did of 'any consequence' in the psychoanalytic movement was in the area of establishing an international training system for analysts. Glover thought that Eitington had been keen on 'a fairly rigid system', which later got rejected.

Eitington did have a strong tie to Freud, as did Hans Sachs, who was another luminary from Glover's Berlin period. He considered Sachs, who was originally a lawyer and not medically trained, to be a 'cultural *flaneur*'. Glover held it against Sachs that he had trained Franz Alexander for only 'three months'. Sachs then supposedly concluded that Alexander was 'a brilliant mind who needs no more analysis'. Glover insisted that it was simple-minded to decide on the basis of such a short time that Alexander was 'fully normal'. (Alexander later came to epitomize recommended changes in psychoanalytic technique that Glover detested (Glover, 1960: 73–82), and Anna Freud did too (Sandler et al., 1980: 70, 96, 111), which may help to account for Glover's singling out of Sachs' so-called clinical misjudgment. Alexander was to be the life and soul of an interesting period in the history of analysis in Chicago, but Alexander is unduly neglected by historians today.) Glover felt that by 1965, three months of analysis, as Sachs supposedly gave Alexander, would be deemed only the beginning of things.

Yet at the same time Glover could fall into a curious contradiction; for he asked in the context of Alexander's brief analysis with Sachs how it can be, if we know so much more now, that people got well in the early days of psychoanalysis. He liked to quote A.A. Brill as having been 'not far off the mark when he expressed the opinion that psycho-analysis was already a finished product in 1907' (Glover, 1960: 80). In 1931 Glover had published a well-known paper on 'The Therapeutic Effect of Inexact Interpretation: A

Contribution to the Theory of Suggestion' (1955: 353–66), which was more than a shot at Melanie Klein (which is the way it is usually seen). Glover meant to say that basically we do not understand much more about therapy than in the early 1920s. But the example he offered of Alexander's short analysis did not at all prove what he wanted to demonstrate. For, if in the 1920s Sachs had in fact been naively optimistic about treatment, then perhaps the state of psychoanalytic therapy in the old days left something to be desired. Glover, however, was insistent that the early analyses had been too short; and he illustrated this proposition with the instance of Jones, who Glover recalled being with Ferenczi in analysis for only 'four months'. (Newly available evidence indicates that Jones was actually exaggerating how long he spent with Ferenczi (Brabant et al., 1993: 489). I have no doubt that it was true that, in the beginning, a nine-month analysis was, as Glover contended, considered a long one.

Sachs was Viennese and had gone to Berlin not out of any discontent with Freud's immediate circle but rather to 'lift' some of the training 'burdens' from Abraham's shoulders, once the Berlin Institute was under way as a training centre. Whenever Sachs went on vacation in those days he would be accompanied by a 'caravan' of trainees, who in turn had their patients with them.

Glover of course had his idiosyncrasies and blind spots, but I found him one of the most refreshingly direct of all the early analysts I interviewed. Despite his reputation as a polemicist he seemed unusually even-handed about most of those he talked about. I suppose, in thinking back on it now, that his relative isolation in London made him more receptive to responding to my historical enquiries. It seems remarkable that British scholars have not been more inquisitive about what Glover might have had to add to the saga of the early days of psychoanalysis. People with different interests to my own would doubtless have elicited from him a rather separate set of responses; yet I always remained grateful for the time he was willing to give me, and what he enabled me to learn.

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'Once bitten, twice shy': The complexities of the search for a good object in a patient who has been abused

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ABSTRACT

This article explores the difficulties involved in helping someone repair their internal world when they have experienced abandonment and sexual abuse in infancy and childhood. The article explores the difficult journey towards trust in the therapeutic relationship and shows the correlation of this to an ability to make trusting relationships generally. The problem of the sexualization of the transference is discussed. Finally, the inevitably imperfect and ordinary nature of the therapeutic object is explored. In this case the therapist became ill and was absent for a period of time. Was this an environmental failure too far or a situation that could be explored therefore allowing the foundations of the relationship to be clarified and strengthened?

Key words sexual abuse, good internal object, perverse internal object, sexualized transference, trust.

Introduction

Recovering from abuse involves major repair work in the internal world. Disclosure is a crucial step out of fear and secrecy but is only the start of a long and difficult psychological journey. In this paper I am going to explore why the pursuit of a good internal object can cause anxiety and terror when there has been serious neglect and abuse in the care given to the baby and the child. Repair cannot be achieved by just giving somebody a new and better environment and relationship; this is something that all therapists, foster and adoptive parents and carers find painful to accept – it makes us feel helpless. A better environment is, of course, vital but is not enough in itself. The trusting of a new relationship is what is so problematic. If an unreliable, confused or perverse object is what has been known, then the appearance of a potentially

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reliable, loving or 'good' object with its seemingly grand and unlikely promises usually causes distrust and suspicion. Any new caring relationship has to be endlessly tested.

My patient was trying to recover from the traumas of abandonment at birth and sexual and emotional abuse in her adoptive family. From the beginning the transference was steeped in projections and associations surrounding the issue of whether I, an unknown person, and a man, could in any way be safe to trust. Her past traumatic experience was re-experienced and re-examined in the transference as a way of trying to negotiate this. From the beginning it became clear just how important the regular rhythm of the sessions was.

Towards the end of the second year of treatment I had to take three months off work to have a major operation. This caused a deep and painful impingement on the therapy, which affected the trust that was beginning to be established. In the therapy my patient had been given a reliable experience which had enabled her painfully to conclude a few months earlier: 'I now realize that actually I have never been looked after.' In one sense my sudden disappearance to hospital was the nightmare scenario: the good object that offers reliability and then lets you down. I will, towards the end of this paper, look briefly at the effect that this event had on the patient and on myself as a therapist, and how the work of trying to understand the feelings involved allowed some trust to be re-established.

Jane's family background

Jane was adopted when she was a few days old. Her adoptive mother and her husband adopted four children. My patient is the eldest. Jane thought her mother's keenness for adoption was partly to try to keep her husband from having affairs. When she was seven the adoptive father suddenly moved to Spain to live with another woman. This had a shattering effect on her adoptive mother and shortly after this she sold the house and with her children and little money set off in an old van in pursuit of her husband. Jane suddenly had to behave in a very grown-up way and as the eldest child she looked after her depressed mother. The reunion with father was acrimonious, violent and terribly disturbing. They lived with father and his girlfriend up in the mountains, 10 miles from a school, and the old van would break down regularly on the pot-holed road. Jane would be first up in the morning and made all the efforts to get the children off to school.

After two years of this her adoptive mother returned to England with the children. They were homeless for a time, eventually finding fairly derelict accommodation in a large city.

Jane found out before starting therapy that her adoptive father had sexually abused her adoptive sister since she was very young. He had interfered sexually with Jane in a lesser way, getting her to masturbate him when she was in

bed with her parents, and she had seen photos that he had taken of himself touching her when she was a baby in a way that she felt had been pornographic. During the course of the therapy the extent of father's sexual and emotional abuse towards her two brothers became clearer, leaving Jane full of hatred for him.

Jane had various physical symptoms. She had suffered from phobias and faintings since she was young. She described her dissociated states in various ways – 'strange flu', 'ME', 'feeling tired', 'lying down' and, as she became more frank, she has agreed that it was like fainting or being paralysed while being to some extent conscious of life going on. The dissociated states intensified during the early stages of therapy but then receded as their unconscious psychological meaning was metabolized in the transference.

The clinical experience

1. Her fear of an uncommitted and unreliable object

After a month of treatment I had to cancel a Thursday session and I offered the Friday instead. The session started with a 10-minute silence. Then in a quiet voice she said that it was difficult to believe that her adoptive mother was dead. She commented that she had always kept a smile on her face and looked on the bright side of life but actually her life had not been happy.

I commented that it had been difficult for her to speak to me today. I thought she was telling me that she felt let down and rejected by my having not seen her the day before, that perhaps she was putting a good face on it but underneath had felt unhappy about it.

At first she denied that this was so and said she hadn't missed me. Then she thought for a bit and said that, well, actually, she had had a dream the previous night:

> In the dream she had gone to see her general practitioner and had had to wait for one and a quarter hours in the waiting room. She had felt frustrated and angry that the doctor had not been there and finally she had gone to complain to the receptionist. She said that she was going to give the whole thing up. The receptionist had asked her about her symptoms, which were of cystitis, which she had first had when she was 14. Paula, her friend, came and took her home, but she was very angry. She noticed that in the other part of the surgery another group of patients had a ticket number machine and were all being seen in order. As she left she worried that her doctor, Dr S, might refuse to see her, as she did really want to get some help.

I took up with her that this, the first dream she had brought, seemed to show how much disappointment and anger she felt at my not being there for her the previous day. It made her feel uncertain about my reliability. She seemed in the dream also to be worried lest her anger with me might lead her to retaliate and stop the therapy with me.

She agreed with this quite straightforwardly and mused with interest about

the difference between conscious and unconscious thinking. She had thought that she liked things free and easy, that she was glad she had not got a nine to five job. She found it strangely confusing that the dream seemed to point out something else.

I have related this early session because it illustrates just how sensitive Jane was to inconsistency and just how strong was her defence of looking on the bright side. But it also shows how open and available part of her was to bringing the more vulnerable feelings of a child longing for consistent attention but accustomed to unexpected breaks in care from the beginning. In the dream she looks, rather longingly, towards the other surgery room where everyone is being seen in fair rotation. The cystitis hints at the primitive rage and helplessness of the infant she wants help with.

The picture of a sadistic therapist was suggested when straight after the following weekend break she told me that as a very young child her father had dangled her over the top-floor banisters while laughing at her mother's helpless protests. He had insisted, as he apparently often did, that she really liked it.

As the first holiday break approached, Jane's panic and anxiety increased. Dreams flooded out of her about unreliable men. A plane she was on was crashing and the man next to her was on fire and was not wearing a seat-belt. She came to the session experiencing symptoms of whiplash in her neck as if she had actually been in some sort of crash. It seemed that the sudden realization about the holiday may have linked with the anxiety that 'the man next to her', myself in the treatment, was out of control, had lost any kind of internal safety-belts and that the therapy was crashing because of a feared re-enactment of abuse. In the same session she talked about how pleased she had been in reality that her husband had tidied up the bedroom for once, although when she opened the wardrobe door all the mess had tumbled out on to the floor. There seemed to be a feeling that I excited her, that I raised her hopes that I was someone who could contain her and help her to sort out her difficulties. Unconsciously a wary part of her experienced any gap or inconsistency as a sign of my shutting the door on her and leaving her to clear up the mess.

As the idea of me as a tricky and dangerous therapist gathered momentum she had a dream that I think gets close to one of her central anxieties that to some extent she had actually experienced in reality as a child with her adoptive parents. She said it was a recurring childhood nightmare:

> She was in the park with her mother and she wanted to paddle in the paddling pool. Her mother wanted to go for a walk so left her to paddle on her own. Slowly the paddling pool divided into two parts: the clear blue part and the dark awful part. She kept getting drawn into the dark, black part and woke up screaming without being rescued.

From the dreams and associations it emerged that when she experienced me as unreliable or as abandoning her I changed from being a protective

internal figure to a dangerous, black, incestuous father abusing the depressed and damaged child.

Over the next two years of therapy she often brought dreams that contained images of clean water which would turn into black, tarry, filthy pools which she would be drawn to bathe in. At the end of one session where we were exploring this she cried out about an incident that worried her when she had been angry with her partner, 'When I jumped out of the car and ran into the park, why did I run into the darkness into the arms of danger? I could have been knifed ...' She was beginning to realize that danger existed and that she could be drawn to it when she was angry with me. During the first two and a half years of the therapy she would often announce that she had started a new affair when I gave her the holiday dates. These urges seemed to be fuelled by a complex mixture of deprivation, perversity and Oedipal anger. Part of the work in the transference was about trying to enable safer splitting at a primitive level so that the good and protective could slowly be held on to and the bad projected. But at any point of real acute anxiety, for instance when I had to take time off to recover from illness, there was the terror of being left with an abusing and unprotective internal parental couple.

2. The birth of a baby

In the second term of treatment my patient became interested and curious about her own birth and babyhood. This interest had to survive the wave after wave of fainting fits and paralysed states that seemed to sweep through her at this time. It seemed that a fundamental primitive defence of dissociation was being opposed by a part of herself that wanted a more truthful picture of her life. The facts of her unwanted birth and early adoption lay even more deeply buried than the problems linked to her adoptive parents. At times these exhausted faintings threatened to undermine her capacity to look after her children. Near-faintings on the underground when she was with her children led to her missing her home stop, and paralysed collapses of an hour or more at home meant that the children were at risk. I became worried that the loosening of this defence might be too disturbing for her. She rationalized that 'all had been for the best' and that her adoptive parents had given her 'a good start'. This whole theme of the idealization of her foundations has run through the therapy. She idealized her origins, and she has at times idealized the therapy, wanting it to be a perfect new start which would remove her physical symptoms and make her better.

Six months into treatment, two weeks after I had given Jane my summer holiday dates, she came to her session complaining of how terribly exhausted she was. She said she was trying to fight against these overwhelming urges to faint and that she was only just managing to look after the children. The day before she hadn't dared to sit down as she felt she would have gone out like a

light and would have missed collecting her youngest child. The house was chaotic and her husband was complaining. She said that her older child was having a friend round to play today and they would surely trash the house. Despite these anxieties, she returned to her thinking about her birth and adoption, saying that she had always accepted the circumstances and that she felt lucky to be adopted, but she added that she must have had some response to it, some feelings. It was at this point when, courageously and movingly, she agreed that there had been something wrong with the foundations. Together we talked about the fainting fits as a way of trying to blot out these thoughts and memories. There was a longish silence and then she told me that she had had a dream:

> She described a place that had occurred in a dream a long time ago, about a valley with steep sides, a tropical rainforest with green plants. She said that there was another word for it but she couldn't remember it. She was trying to climb up the sides and in the end she managed to scramble out and came up in Hampstead and walked into a clothes shop where there was a sale on. She didn't want any of the jumpers as she had her own clothes. I pushed her about this word that eluded her and finally she thought perhaps it was 'a crater', and then she remembered the park of her childhood and this steep bank with all the exposed roots of the trees. She said lightly how she used to enjoy playing there.

I commented on the thinly idealized world hiding an awful crater with all these raw and exposed roots, the shaky foundations of her birth and adoption. The shop in Hampstead with the sale on, I said, was perhaps her decision to have some therapy to get help with the foundations. The dream seemed to suggest that she had her own past ways of coping, that she wasn't sure whether the therapy was helpful, especially as the holidays were approaching and I was felt to be selling out on her. After this session she referred to the idea of a baby experiencing something very disturbing about adoption and the idea that her dissociated states might be connected with trying to blot this out as 'these new ideas'.

I think that the crater was also her feeling that I was repeating her early abandonment in the holiday situation. This period of close co-operative work in the therapy began to fall apart towards the end of term as I became more connected with violent and rejecting figures: a rapist jumping up and down on her, a young motorcyclist who, when she was an adolescent, had driven too dangerously so that she had been thrown off. She had thought she was going to die for she was completely winded. There were also comments about a doctor whom she hated who gave her sinister, cruel, 'dark treatment'. Her unconscious finger pointed at me but in another way I felt she was the one giving me a hard time, some 'dark treatment'.

What interests me is how this slow and important adjustment in relation to her birth, allowing her past baby experiences an emotional reality, opened the door to her beginning to risk bringing the baby of her unconscious inter-

nal world into the transference, allowing me to see and get to know this vulnerable and hurt part of her self. The day after the crater dream she told me another dream:

> She had been carrying a very young and sweet baby of a friend of hers in a sling. Unusually for her the baby was facing outwards, away from her. Suddenly she had looked down; the baby had gone, vanished. She was desperate, distraught; it reminded her of a dream of losing her youngest child. There was some ineffective and unsympathetic general practitioner in the background who tried to help her, but she collapsed on the floor and fainted. In the end the baby was found.

I think that this dream referred to how, as the holiday approached, the identification with a loving parent in the therapy became exploded and replaced by the old scenario, being abandoned and not looked after, which she identified with in the old way by blotting out the pain by fainting. The baby held outwards seems to be about the analytic situation where very easily I was felt to be distant, out of touch and unhelpful like the general practitioner. But I felt that she was beginning to bring her internal baby self for help even though it felt so dangerous to do so.

After nine months of therapy her tentative interest in a good parental object seemed to link in her mind with the birth of a baby. Her dreams began to be full of babies. The baby first emerged in a dream as an ill and damaged baby that needed attention and resuscitation. Jane discovered this baby in a yellow plastic bag. In another dream a vulnerable woman with a baby was at the mercy of some violent Arabs. This woman had been forced into marriage against her will. In the same session she reported a dream about moving from a cramped flat to a larger house and at last moving out of negative equity, but this new house quickly became claustrophobic. In dreams, babies were left unattended in parks while she was asleep and babies were given away by nannies, and once a baby on a white table was threatened by two men in a way that hinted at sexual abuse. An internal perception of a concerned and safe parental couple was largely unknown and what struck me with such force was that the possibility of experiencing safety in the therapy was itself felt as frightening, unsafe and persecuting. There seemed to be no proof that a good object could be reliable. Despite this a baby was being brought for our attention.

3. *Flight to a perverse sexual transference*

I have indicated already the ever-present quality of the feared bad sexual experience in relation to a father without safe sexual boundaries, as well as, at times, her attraction to this kind of a figure. I am trying in this paper to understand something about the core of my patient's fear of a good internal object and I think an internalized perverse sexualized counter-culture is central to this.

We know that in her environment as a baby her father took pornographic pictures of her. We know that as a very young child she was encouraged to masturbate her father as a natural and 'good' activity. We know that she admired her father's charismatic, magician-like persona and how he would spend hours with her getting her to solve strange puzzles. We know that terrifying experiences such as dangling her over banisters were regarded by him as experiences that she should be enjoying. When she was a five-year-old her father used to parade her around the park in very short skirts and she felt uncomfortable. He would often give her love bites and would 'brand' her with his signet ring, which had a lion rampant on it. When she was 10 years old he made her wear a T-shirt with a picture of two naked adults and a caption underneath that said, 'Whenever you feel like doing it, do it'. She felt uncomfortable but endured the laughter of her father and his friends. What is clear in all this is not just an abusing father but the absence of a mother who could in any way control the cruelty and abuse of her husband, and who indeed went looking for him for further abuse when he left the country. My patient had no experience of a parental couple that would provide secure nourishment and protection for their children.

After two years of therapy, as if waking from a dream, Jane seriously began to wonder why she had allowed some of these things to happen. What I am trying to describe is the subtle and not-so-subtle initiation into a perverse sexual culture that bound her like an enchantment to this way of being, a sort of perverse branding of the child's soul. In this way the perverse culture is taken in, in a deeply unconscious and primitive manner, and the self is under the sway of a perverse object. Under pressure she would often fall back on this inner culture of being free to do whatever she wanted, which equalled the right thing, a do-it-yourself sort of affair, and she was suspicious and at times scathing about what she began to pick up from me about another universe where right and wrong existed, and where some thoughts and actions were damaging to oneself and some promoted internal health and security.

My patient has always been extremely sensitive to changes in the framework. In the first year of treatment I worked bank holiday Mondays. It was after a May bank holiday that I began to observe the confusion for my patient. On the Monday itself it was difficult for her to say much to me at all, but towards the end she spoke about twisted men who took pleasure in playing around with the roots of bonsai plants. I had an uneasy feeling that I was connected in her mind with these crooked men.

On the Tuesday she was able to describe for the first time a full-blown fainting fit at home which had happened on the previous Saturday before the bank holiday. She had become paralysed; her knees had turned to jelly; she had a feeling as if 20 elephants were jumping up and down on her chest; there was this heavy weight on her so that she was unable to breathe. It had lasted for an hour and the children had been in the house. As she was telling me

about the force of her experience I had a vivid and unpleasant picture and experience in my countertransference of a child being suffocated by a pillow while being sexually interfered with. At the end of the session she remembered arriving on the bank holiday Monday, coming through the deserted streets, noticing people and VE Day bunting in the next street, which had been blocked off so that she had felt rather trapped. It seems that the anxiety about coming to therapy on a day when most of the world was on holiday precipitated a terrible confusion about my intentions and unconsciously she felt pulled into a seduction. It seems to me the massive fainting fit was connected with her anxieties about the forthcoming session, the blurring of the social and work perspectives, and that this seems to have thrown her back into terrifying experiences of early childhood with her father which she had had violently to blank out.

At times I had strange moments of daydreaming seemingly disconnected from the present reality of what was going on in the room but, in fact, I think very connected to it. There was a session towards the end of the first year where I had quite vigorously helped her to see how she had been attacking the therapy. In the next session she talked about her fear of her father, how she was terrified he would come back, how damaging he was, how clever he was in a diabolical way; he could prove that black was white in such a reasonable way. There were long silences and I became dreamy and began to have various pictures in my mind; one was of a large fish being caught by the back of the neck by a dog. I could hear her talking about her father and how people wouldn't believe what he was really like. They would go on about their own parents, but she would say 'Try my Dad for size'; at this point she laughed bitterly. As she said this I had an image of a huge whale driven by a large motor boat crashing into a small harbour. At the time I was too paralysed to process this clearly and to make the link that if I tried to help her in a vigorous way, I became in her mind, in a concrete manner, someone whose thoughts and comments were felt to be sexual, intrusive attacks by a demonic father. This experience of me turning bad for her after sessions where some kind of struggle for insight had taken place was something that became a common pattern and that helped us begin to clarify what was actually good and what was actually bad. The experience for her internally of a father with omnipotent powers of control, sexual possession and intrusiveness was a powerful unconscious reality against which she had to fight continually and which we had continually to examine in relation to the shifting transference. In her dreams she would try to escape from this kind of father, but he could still get through walls and into her bedroom.

In the second year of the therapy these claustro-agoraphobic oscillations in the transference between good and bad, secure and terrifying, safe and sexually invasive, became more and more extreme and faster and faster. At one moment her appreciation of her therapy appeared in a dream where a child had moved from a cupboard under the stairs to a new bedroom in which a large window had been built affording a much better view. But in the same

session she told me about another dream, which showed that the new understanding that she was gathering in the therapy was terrifying:

> I was in a basement restaurant eating a meal with my sister. There was a small hole in the wall through which I looked in horror into a dark gothic room where there was a huge, black prehistoric pterodactyl. I screamed and fled out of the restaurant.

I think the appreciation of greater understanding could easily get swept away by terror. The world of clear thought associated with a good feeding at the breast could shift so quickly to an anal world full of terrifying and cruel persecutors – cupboards under the stairs.

As these oscillations increased I was consumed at times by anxiety about being able to contain my patient and worried that she would act out in a damaging way, particularly by starting dangerous new affairs. I think she at this time became more depressed and disturbed by the work of looking into herself and her past, and she would become confused as to whether I was a helper or a torturer. The continual reworking of this ground helped slowly to build some clarity and trust. What became clear was that unconsciously there was a more perverse adolescent part of my patient's self that at times wanted to embrace perversity rather than do the slow and difficult work of building a healthier and stronger internal world.

During this time I often felt that I was walking on eggshells and that I could easily lose my patient through one of her headstrong actions. This conflict between seriousness and excitement meant that there was a continual pressure on me to act in a manner that took us away from the serious work to something lighter and more flirtatious. The question of the temperature of the therapy was always an issue. There was often a hot sexual atmosphere that needed containing and cooling down. In certain dreams the idea of a refrigerator appeared, often one containing milk. In one dream the refrigerator had suffered damage because a heavy weight had fallen on it and all the control knobs had been broken. In this session she seemed unconsciously to be examining and testing my capacity to keep things cool and fresh, and to be able to distinguish reality from illusion, truth from lies, as well as helpful attention from sexual excitement. She feared that her impact on me would destroy and damage my good internal qualities. She was wanting to find out if I could provide for her something of the experience of a loving and mature parental couple.

Internally my patient struggled with a part of herself that hated good sense. This is clearly illustrated by a dream from the end of the first year of treatment:

> She was in a department store and was buying a piece of material which she described as about a quarter the size of my consulting room. It cost £400 and she suggested to her husband in the dream that it was so nice that she could turn it into a double duvet cover. Her husband said that he thought that was not a good idea. With her was a friend's au pair who was very keen to buy an exciting red jersey with a V neck. At this

> point she laughed as she noticed that she was wearing a red jersey on this day. In the dream she was trying to persuade the au pair not to buy the jersey, but the au pair was headstrong and insisted. She went back to the shop to return her material and get her money back. She got into the lift to go up but the lift went down and down and down and she could not stop it.

I think one can see in this dream a headstrong adolescent part of herself which overrides the safe parental voice and chooses the red sexual jersey. The double duvet cover seemed a clear reference to the wish for a double sexual couch for me and her, and it is interesting that the material was never returned to the department store. The pull to the old incestuous kind of parental relationship was at this moment preferred to the sober careful thinking of the therapy which I think was experienced as leading to a path that would lead her ever deeper into depression. But it is important to note the concerned adult part of her trying to create something safe and secure.

What I think is impressive about my patient was her capacity to keep bringing the internal confusion and conflict for analysis and understanding. This bloody-minded, headstrong part of herself came more and more to the fore and I think its appearance was a sign of her growing confidence in the process and in myself. Over the four and a half years there was a continual sense of ongoing therapeutic struggle. At no time did she opt for some unreal truth; she always wanted the proof of tried and tested experience before making an internal shift. In her external life she showed a growing capacity and wish for a trusting intimate relationship.

4. The impact of my three-month absence because of illness

When the therapy had been going for one and three-quarter years, I went into hospital for a major operation shortly after a summer break. I had a brief period of time to prepare her for my absence, which I think took a little of the edge off the shock for her. I was able to return to work at the beginning of the next term.

There is no doubt that my unexpected absence made a large hole in the security of the therapeutic process and there followed a long, slow struggle to try to rebuild some of the trust. I was not at full strength and was still recovering physically and emotionally. I had always rather omnipotently imagined that if I had nothing else to offer I had the ability to be reliably sitting there for my patients. This clearly had to be rethought. The first thing she told me was that she had separated from her husband and while this may have been in one way a healthy decision as it seems that he was an oppressive and unsupportive man, it was also, I felt, a communication to me that the therapeutic marriage was over and that it was better to be on your own and not rely on anyone in that kind of way. Throughout this time, not surprisingly, there was an increased phobic quality in her response to me. Her attachments to men in

the external world were extremely unstable and reactive. She was thrashing around, desperate for sensation and warmth but without a capacity to tell who was reliable and helpful and who wasn't. This was also the kind of anxious attachment she had to me in the transference. She had a dream that she was with a good friend in an old car with two steering wheels so that she could steer as well. This seemed to sum up her feeling in relation to me at this time.

After two months back she managed to convey to me how she had experienced my illness unconsciously. She came that day feeling very depressed, with an awful feeling that she didn't want to get up. Towards the end of the session she began to speak, 'about the three floor boards in her house that were all splintering and broken'. She was worried that the children would get splinters from them and hurt themselves. One day she decided to take them up and looked down into a hole 'this deep' (she demonstrated 3–4 feet with her arms) where she saw central heating pipes and some old bricks and mortar that held up the house. She said that it was almost rude to look, as if you somehow shouldn't look, as if you should believe that the floor is the floor and not that the foundations are underneath. She had been able to get only two new boards from the builders. I think that this helpful association showed how hard it was for her to face looking into the foundations of me as a person and therapist and to give up some of her defensive idealization of me. The three boards clearly stood for the three sessions and the one board which was still causing trouble I think referred to the Thursday session which I had been having to shift to Fridays on two occasions because of other commitments. Perhaps she also needed to keep her eye on my foundations. This led to us both being able, with some relief, to talk about my illness and absence in a close and real way and for her to acknowledge how much she wanted to feel completely safe with me like with a perfect, powerful and ideal parent. In this way she was able to acknowledge how much of a shock my illness was for her.

Future holidays opened up the wounds again and the whole question of the foundations became, I think, a useful central preoccupation for my patient. Actually, the examination of the foundations of her therapeutic object had always been the central issue for her and one could say that the plus side of this unfortunate impingement on the therapy was that it focused our minds on her central internal dilemma. As long as I remained able to think about and process her communications, it offered a chance for important developmental work. It was a surprise that what felt like a disaster could become bearable and even helpful. This eased for me the inevitable guilt I felt about letting her down so sharply. By the end of the summer term I felt there was, once again, much more of a sense of her allowing herself to be a patient and me to be the therapist.

During the next six months she slowly let go of her confirmed, safe position of being on her own, and started a serious, loving relationship with a man who loved her in return and seemed a stable and concerned partner to her and her children. They shared an interest in their emotional lives and decided to get married. There were some attempts at destructive splitting and idealization

with the therapy on the negative side of the split but this was not acted out and the therapy with me was still felt to be useful to her as she tried to reach greater internal security. I think that this marriage was a real achievement on the part of my patient, a sign that her inner world was more trusting and less persecuted by abusing figures.

Conclusion

In this paper I have tried to show why the pursuit of a good internal object can cause anxiety and terror when there has been a serious deficit in the care given to a baby. In *The Psychoanalysis of Children* Klein (1932) shows with vivid conviction how she discovered the primitive internal world of the child full of fantastically good and fantastically bad figures and how at the heart of this picture was a parental couple, a mother and a father sometimes in good relationship, sometimes combined in terrifying and cruel sexual intercourse that filled some children's nightmares with monstrous fears of annihilation. The constitutional envy and hatred of a child towards its parents could mean that this nightmarish picture of the parents was one that came largely from within and was at odds with external reality. But the maltreatment and abuse of the child could also facilitate the building of this paranoid internal world. My patient had been badly treated and she did not suffer from primary destructive envy, but she certainly had internalized a paranoid world. It seems to me that in the paranoid-schizoid position, the abuser is closely allied with the death instinct. Leonard Shengold in *Soul Murder* comments:

> Sexual abuse, emotional deprivation, physical and mental torture can eventuate in soul murder. Brainwashing keeps the condition of emotional bondage going. Children are the usual victims, for the child's almost complete physical and emotional dependence on adults easily makes possible tyranny and therefore child abuse; because he or she cannot escape from the tyrant torturer, the child must submit to and identify with the abuser. ('The cut worm forgives the plough', Blake, 1793: 96) (Shengold, 1989: 2)

In George Orwell's *Nineteen Eighty-four* O'Brien says to Winston Smith: 'You will be hollow. We will squeeze you empty, and then we shall fill you with ourselves' (1949: 262). Janine Chasseguet-Smirguel in her book *Creativity and Perversion* talks about how the abuser tries to destroy all difference:

> Subversion of the law, the parody of a religion devoted to the worship of God, seeks to reverse the way leading from indistinctness to separation and demarcation. Here we are very close to the worshippers of Satan and the religions of the Devil ... In my opinion, this reversal of a system of values is only the first stage in an operation whose end is the destruction of all values ... My hypothesis is that perversion represents a similar reconstitution of Chaos, out of which there arises a new kind of reality, that of the anal universe. (Chasseguet-Smirguel, 1984: 10)

My patient's parents were in a perverse intercourse where the father had taken control and was imprinting a perverse universe on the family. My

patient's dreams were full of black, sticky, terrifying stuff. She had to be woken out of a dream from this other universe. Luckily she was resourceful and her sense of what was good had not been completely subverted. In the perverse world the only law is to break all laws, particularly the law against incest; as my patient's adoptive father counselled, 'Do what you like'. In the universe of values and rules about emotional and physical behaviour, all is hard work and achievement. The move out of the paranoid-schizoid position is hard work that has to be maintained for a lifetime and is totally different from the 'do as you wish' culture of perversity. In the therapy the struggle to begin to internalize a good object had to be negotiated against all the force of the perverse system that says the hard, regular, concerned work and values of therapy are unnecessary and wrong. As Milton said: 'Long is the way and hard, that out of hell leads up to light' (*Paradise Lost II*, l. 432).

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Journal of the British Association of Psychotherapists, 38, 107–117, 2000 © Whurr Publishers Ltd

What cannot be controlled must be expelled

ROBERT W. K. FLEMING

ABSTRACT

This paper explores the history of a patient who only very slowly emerged over three and half years of three times a week psychotherapy and who prematurely ended the work in an evacuative manner. Retrospectively the applicability of the claustro-agoraphobic concept was discovered. The belated link with this model led to speculations on the relationship with the other main themes of this patient – namely, of control and expulsion. By the end of this work there is a discovery that the patient's preoccupation with his body and its pain, together with his controlling mode of relating, served to protect him from his terror of actually having a relationship. As the therapy progressed the patient came to a point where he might have given up his somatization but at the same time then found himself in a therapeutic relationship that he was not able to control. At that moment his anxieties overwhelmed him and he evacuated the treatment itself.

Key words Rey, claustro-agoraphobia, Abraham, anal defences, expulsion, premature ending.

Slowly emerging

There was an important lesson to be learned in the way that this man's history gradually took shape in the consulting room. His essential life events were confused and reluctantly offered. It was as if his personal narrative was being held back and constrained.

Andy referred himself for treatment for chronic bowel pain and general discomfort which he felt had a psychological origin. He was not achieving success in his chosen profession; indeed, often he felt quite incapable of producing anything. He felt that his problems had begun when he was 19. He had had sex with a woman who had then suddenly dropped him for another

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man (as he felt his depressed mother had done when she quickly remarried after divorcing his father when he was four years old). His perception was that he had been explosively and humiliatingly evacuated by the woman. The experience seems to have been immediately somatized with the development of a painful and chronic 'blocked' feeling in his bowels and lower abdomen. Over the years numerous medical examinations failed to reveal a physical source of the gastrointestinal pain.

Andy described how he had been religious for 15 years. He was at that time routinely praying every day and was active in his church. He complained of being unable to pursue his career as an artist. Andy lived on state benefits and, although unofficially he earned some money from his paintings, he claimed financial worries.

In the first sessions of therapeutic work, Andy told me that he was preoccupied with the size of his penis. He felt it to be very small and in all his sexual relationships he felt compelled to seek the opinion of his partners about his penis size. It transpired that he also regularly felt compelled to masturbate using a particular image of himself. He felt humiliated in the telling of this story but managed to describe how he often did not feel real unless he had an erection and could visualize himself in this way.

During the first year of treatment he outlined the deprivations of his early years. He revealed more about the sudden departure of his father and the extent of his mother's devastation, which remained undigested. He recalled many times the night that his father appeared in the bedroom he shared with his older brother, to say that he was going away with another woman. My patient's perception was that his father spoke only to his older brother because the father did not think that Andy understood enough language to grasp what he was going to say. The trauma of his father leaving so suddenly was compounded therefore by his helplessness and his strong sense that he did not properly exist in his father's mind.

Significantly, during the early period of therapy his commitment to his religion slowly waned and then abruptly ended. I remember hoping that psychotherapy and a tentative search for a good intercourse had usurped his rather masturbatory use of his faith. His version of praying had felt rather like a circumvention of any need for the object and a denial of any suggestion of dependence. The sudden and complete expulsion of his 15 years of faith was certainly an indication of how he was later to treat his psychotherapy.

After two years of therapy he revealed that he had a considerable inheritance in the bank. He was embarrassed about this as he was at the lowest fee for the psychotherapy. Around the same time he let it be known that I was working for less than he charged for giving painting lessons. Abraham's 1919 paper describes this withholding nature in the consulting room. Abraham says of this kind of patient that, 'They pride themselves, as it were, upon being able to decide whether, when, or how much they will give out from their unconscious psychic material' (1919: 309). Andy clearly felt that he needed to

hold back his riches at many levels, a process that seemed both constipated and withholding, and more actively anal sadistic. I was both not paid adequately and then subtly taunted with his secret wealth.

In his third year of treatment my patient finally told me of his regular habit of relieving the pressure that he felt built up in his anus. Andy would massage the anus and then manually extract faeces with his fingers. (On one occasion he scratched the inside of his rectum with his fingernails and a tear became infected.) In relation to this concrete behaviour Meltzer (1966) comments that this symptom is an attack on the internal objects and denial of dependence. My patient's anal activity might well have been a symptom of his denigration of the object and his, at times sad, attempts to claim pseudo-maturity. This particular understanding of the symptom is entirely consistent with the struggle he had to enter a real relationship with me.

Claustro-agoraphobic elements

Working with Andy was not easy. He often sadistically treated me like shit – as he felt himself to have been treated when he was small and vulnerable. I often found myself being careful about my reactions and wanting to monitor any pull towards humiliating him as he had felt his father had done.

For weeks at a time it seemed that I was with a patient who wanted to do nothing other than describe his physical pain in great detail; how it made him unable to work and to use what he considered to be his enormous untapped talent. At times it felt like a monotonous dirge; a repetitive moan that would not stop to allow any thinking. I often considered this to be an aggressive attack on my capacity to think (Bion, 1959), which was designed to protect him from any sense of intimacy and related to his fear of being overwhelmed.

> *Session note*: After 20 minutes of a detailed description of how much pain he was in, I felt myself beginning to drift off. I felt quite sleepy and certainly not very concerned about my patient's lists of symptoms. Gathering my courage, I say that I thought that there was a sense in which he was treating me in the same way that he felt his mother treated him. So preoccupied with pain that thinking about anything seems very hard.
>
> He is silent for a moment and then responds by saying that he could see what I was getting at ... but surely I could see that this was only 'interesting'. What he was going through was too much to be able to have the luxury of this sort of stuff.

It was at moments like this, when the essential dialogue of psychotherapy was impossible, that my thoughts would turn to Andy's masturbatory practices. The urge to stand naked in front of his own image to ejaculate perhaps stood for many things, but I was struck by the anxious preoccupation with self that it conveyed. In retrospect it was possibly a communication about the lack of a relationship with an external object. Andy seemed trapped in a relation between a deeply anxious self and an image of a self whom he hoped would stand up for him.

The quality of this stuckness appeared often in Andy's material. Andy had a long-standing platonic female friend called Eve. She was considerably older than him and tended to mother him. Andy oscillated between hating the suffocating feeling combined with never wanting to see her again and then hating the loneliness and isolation at the thought of losing her.

This relationship to Eve can be understood clearly using the claustro-agoraphobic syndrome as described by Rey (1979, 1994). Over time I came to understand Andy as suffering painfully from this state of being, caused by his excessive use of projective identification. He was tortured by a fantasy of being trapped inside an object and then tortured by the solution of being completely outside the object and facing psychic disintegration.

This concept of claustro-agoraphobia arose with the post-Kleinian thinking about pathological organizations. Rey's work (1979, 1994) and close observation of many borderline patients led him to recognize the essential spatial quality of the mind. He used his considerable experience to describe a 'frontier' and schizoid state of mind, which led to a stuckness somewhere between neurosis and psychosis. For Rey the schizoid phenomenon is related to a constant fluctuation between claustrophobia and agoraphobia. Projections into the surrounding space lead the patient to experience it as hostile but to depart this very space is to court the terror of disintegration.

It is perhaps significant that this conceptual understanding of my patient really came to me only after the therapy ended and I was immersing myself in the material in a different way. Had I been thinking of the claustro-agoraphobic anxieties at this level and interpreting them more explicitly during the treatment, I wonder whether the outcome would have been different. On balance I suspect that it would not; the tendency to expulsion would probably have been just as strong.

Andy talked often and in great detail about Eve, who seems to have been constantly available to him. He would spend days drifting around to her flat and end up spending all the time lying on her sofa while she provided for him. He would feel intense hatred towards her when he felt that he was being suffocated and that she was holding him back from creating his perfect art. He felt that any articulation of this intense feeling was forbidden and he would simply 'pretend' to be OK while inwardly full of murderous rage.

This description seems to stand as an example of how Andy's relationships intensely oscillate between his fear of merging with the object and his fear of abandonment by the object. As Rey points out, 'The fear of separation from the object and the desire to penetrate into it and fuse with it into a primal unity can be so intense that it surpasses human understanding' (1979: 208).

Aspects of the relationship with Eve also illustrated the essentially psychic homelessness of this mental state: the claustro-agoraphobic dilemma. As Andy tries to have some sort of dialogue with the world, he feels terrified that he has lost Eve. At that moment Eve seems like the only place where he can defend against the awful black hole, the parallel universe of madness that he

feels will engulf him if he is not held together in some crucial way. He is terrified by the extent of his feelings of agoraphobia. However, as soon as he returns to Eve, her suffocation of him and her imprisoning of him make him feel desperately claustrophobic. As Rey put it succinctly, 'There is nowhere for the claustro-agoraphobic' (1979: 224).

The nature of the claustro-agoraphobic phenomenon is, as I understand it, a primitive one. Rey's work in this area addresses a fundamental and early spatial structure of the psyche. Andy's material suggested to me that the primitive anxieties of merging versus abandonment were certainly evident. However, it also became clear that Andy had many defences to fall back on, the most salient of which I came to regard as anal.

The relationship between these two aspects of my patient has interested me enormously. Was the control only an expression of the anal sadistic dimension of Andy? Or did it also function partly to keep the more primitive and even existential anxieties at bay? Speculatively, I have had thoughts about his controlling aspect being the manifestation of his desperate attempts to hold himself together as his terrors of a real relationship (merging and abandonment) engulf him. Control might therefore also be seen as an attempted defensive brake on the oscillations between claustrophobia and agoraphobia. In the earlier stages of the therapy I was allowed tiny glimpses of this dynamic in the transference, but the most intense re-enactments occurred outside the consulting room. The full intensity of his fears and conflict became evident in the terminal stages.

Anality

Andy's chronic pain in his bowel was never understood by the medical profession. I suspect that this patient will continue to return to them in an increasingly desperate attempt to have a simple physical diagnosis that will help him evacuate his pain (or more worryingly have it cut out by surgery). There is a wealth of psychoanalytic writing in this area of anality from which to draw. As far back as 1909 Freud gave us the idea from Little Hans that faeces could be equated with babies, and both Abraham (1924) and Klein (1946) developed the idea of the sadistic manner in which faeces could be retained and evacuated.

Throughout my work with Andy there has been a theme of control which has manifested itself in the retreat to 'blank' periods, his reaction to weekend and holiday breaks and most strikingly at the end of the work in his reaction to me changing the time of the sessions. I have found the works of Abraham illuminating while thinking about this. Abraham suggested that the retention of faeces is not only a relationship in which the child resists control *by* the object, but at a more symbolic level it is a relationship in which the child attempts to control the object *itself*. Abraham describes the symbolic equation of faeces and the object when he writes,

> Psycho-analytic experience has shown beyond a doubt that in the middle stage of his libidinal development (the anal stage) the individual regards the person who is the object of his desire as something over which he exercises ownership, and that he consequently treats that person in the same way as he does his earliest piece of private property, i.e. the contents of his body, his faeces. (1924: 425)

In the face of his early experience Andy may have attempted a psychic solution which much later has become a terrible problem. The loss of his father, the perceived emotional unavailability of his mother, perhaps even the Oedipal consequences of her then choosing another man over him at a crucial developmental stage, were all important factors. These may have led Andy to regress to an anal stage of relating. It may have been an attempt to control his faeces in order to develop the fantasy of being able to control his objects. As a consequence of this he has had to deny objects their independence and ability to have other relationships since their autonomy is felt to injure him constantly. This illusion of control of his objects also prevents the appearance in his inner world of a benign parental couple with the capacity for creative intercourse with each other. This has an impact on his own chances of having a truly intimate relationship with another based on mutual interdependence.

The quality of the desperation in the illusion of control was most evident at break times. On one occasion during the last week of a break he contacted me to confirm our return date. When told, he said he was glad as he had thought it was earlier and he was calling to cancel. On the correct date he arrived and was still confused. Had he already missed a whole week of therapy, he asked? After the same break he was late in paying the bill. He combined the outstanding amount with the cost of the remaining sessions for that month and paid both at the same time. He was in a state of mind in which he had wiped out the break with confusion and then grandiose overpayment. The latter seemed to come crashing down when I pointed out that he had wrongly calculated and had actually underpaid. Trying to understand the meaning of this with him was very hard as he could only perceive the humiliation in it for him.

When the omnipotent control of the object is in place, any evidence to the contrary presents Andy with enormous psychological difficulties. His preoccupation with a small penis might be explained by this. It may be that he feels that when he comes across a therapist whom he cannot control, he feels humiliated. I suspect that he feels castrated by my position of knowledge and control of the setting and this manifests itself in a doubt about his own potency.

Reconstruction might be redundant when we believe in the vivacity of the transference. However, the repeated evidence of the material over the years does suggest that Andy did suffer catastrophically from an experience of early loss in reality. It also seems that he resorted to a defensive omnipotent control of the object, which became concretely represented by the chronic pain of his bowels.

Perhaps the attunement that his mother could have given him in better circumstances was missing at crucial points in Andy's development. Alvarez (1992) wrote of the child needing to have a sense of 'potency' in the mother–child relationship. Perhaps as a result of this lack of psychological attunement, potency over an object was never his experience. In the face of this catastrophic failure he resorted to control over something he could control: his body. Having experienced failed potency with the maternal object the fantasy of omnipotent control is ushered in.

The issue of control is obviously related directly to Andy's aggression. Abraham's subdivisions of the anal sadistic stage both highlight the type of aggression that Andy was capable of presenting in the sessions. He was both destructive and possessive of the object. At times I could feel quite smothered by his long detailed complaints about the world. It seemed to destroy my attempts to think clearly about the meaning. At times I was very aware of his need to just occupy the couch and be 'blank' for session after session.

What cannot be controlled must be expelled

This patient ended the psychotherapy prematurely. The manner in which the work was ended threw many of the main themes of the work into sharp contrast. It was a painful and dramatic last six months for my patient and also myself as I witnessed the slow build-up to an eventual evacuation of the therapy. It is perhaps no surprise that Andy left in his fourth year. It was as if he had to do to the father/therapist what the actual father had done to him at the age of four. In a very real sense there was no psychic processing of the event and repetition in identification with the perceived triumphant abandoner was the outcome. The evacuation of the victim aspect of the self was into the therapist.

In this last phase it seemed that my patient was focused on only one thing: a terrible conflict and struggle about the nature of his psychotherapy. From the autumn of the third year he had railed against the therapy in one session only to change his position and acknowledge the importance of therapy in the next. There were many sessions in which his frustration reached enormous levels as he struggled with what seemed to become a 'fixed idea'. Often he would be in tears as he alternated between thinking that psychotherapy had become a 'sick joke' and recognizing that he needed his therapist. By the following spring, Andy was in a difficult mental state and had convinced himself that he had no choice but to get rid of his therapy. This premature ending took place at the Easter break despite my attempts to have the decision thought about or deferred.

At one point in the earlier years of the therapy my patient had requested that the early afternoon session times be changed to first thing in the morning. This was not possible at the point he requested it. However, in the last year of treatment my own situation changed and I had to work towards

changing his time to early morning sessions. When I spoke with Andy about this, his first unguarded reaction was that he felt 'relegated to a lower division' and he had no memory at first of his own request for this time. After this initial thought he later denied that the timing of the sessions had any importance whatsoever and then recalled that he had been the first one to request it.

However, one month after this change took place he began to lock horns with me about the change. It became conflated with other issues; that I insisted that we meet three times a week and that I had not agreed to him taking a break from therapy to 'see what would happen' as part of an 'experiment'. The issues seemed to represent evidence of me being outwith his control and became the source of much pain.

During this stormy time it was very hard to think with my patient, who seemed to be incapable of digesting my ideas. He would repeat his litany of accusations that I was preventing him from being creative, that I was stopping him having a life and that I had no idea of the extent of his potential as an artist (if I did I would accede to his points and allow him to come once a week only when he needed to). The accusations levelled at Eve were now focused on me. His grandiosity reached new proportions in this state of mind. He was convinced that he had mastered a painting technique so well that he felt capable of producing a piece of work that would be as good as, if not better than, the top European artists of that genre.

Around this time he ended a sexual relationship with another woman called Jane who had been very supportive of him and his condition for 12 months. She seemed to be quite loyal to him and was apparently devastated when he ended the relationship suddenly (having had no idea from my patient that the relationship was even being secretly questioned). Worryingly, my patient did not stop there. Having expelled his girlfriend Jane cruelly, Andy then proceeded to drop the work he had in a small studio. He also made it clear to the larger artists' co-op that he wished to participate in only a few of their (well-paid) exhibitions and in effect resigned. He seemed to be incapable of 'mentalizing' any of his feelings at this point and was locked into a state of expelling everything.

> *Session note*: I say that I thought his expulsion of so many things was directly related to his rage with me for changing the session times. I try to say that I thought he felt humiliated by this change but also not capable of thinking about it with me; it had to be simply got rid of.
>
> He tries to be thoughtful for a moment and then says that this might be true; it did make some sort of sense to him. However there were other realities; he needed to end his relationship with Jane because he did not like her, he needed to get out of the studio group because he hated it, he needed to be clearer with the artists' co-operative because they took liberties!

By the Christmas break the charges made against psychotherapy became more serious. By my position I was polluting him by forcing him to drive

through rush-hour traffic. By holding on to the principle of three times a week psychotherapy in the same location I was holding him back from the best art he would ever make. In short I had become a terrible persecutory figure. It had all the dimensions of a transference psychosis.

A manic bubble burst suddenly after the break when he was faced with the reality of not having me over the last Christmas period and had still not been creative. The first few weeks of the new term were full of sessions in which he unusually just did not turn up or cancelled at the last minute.

Around this time of collapse, he described how he had been working on a particular piece and having been exhausted by the journey to and from his therapy sessions, he had used the wrong material and completely ruined it. The difficult journey and the lack of any work in the therapy sessions were blamed for his fatigue and the consequent loss of his art. 'Three months of work gone in an instant,' he wailed. There was a psychotic quality to this accusation. I was the one who had painted over him.

At this time my worries for the safety of my patient increased considerably. He seemed to be expelling and evacuating everything including his psychotherapy.

In the last three months of this therapy the oscillations between wanting to end therapy and wanting to stay gradually ebbed and he came to a firm decision that he definitely wanted to end. There was no negotiation available and expulsion was his only thought. It was as if he could not stand his dependence and need of psychotherapy. It had become frightening for him in a claustrophobic manner. He arrived at a point where he could not metabolize or digest the experience of me changing the session times. He was furious with me but could not resolve it with me in a dialogue. Despite many attempts to facilitate thinking about this, I suspect at a primitive level he felt he was running the risk of being completely taken over by me or completely shut out by me and as a consequence had to expel me as quickly as he could.

The catalyst had been the change of session times in the autumn of the third year. This seemed to stand in his mind for my capacity to get on with my own life, for my relationships that he did not know about but felt deeply excluded from and 'relegated' from. This seemed to me to exist in an Oedipal fashion but *also* in a more primitive way. I was both a father in the transference who went off to more exciting relationships but also an object with whom he could not have a relationship of constant merging and expulsion. Despite interpreting this in many ways and getting to some point of understanding with my patient about this dynamic, he held fast to his decision to end.

Session note: At one point I break into his tirade to say quietly that this premature ending had to be thought about. After a pause he agreed. Andy said that he had heard me yesterday saying that he was like his father who left him when he was just little. I say that there was another facet to it. His growing desperation to leave despite some ideas about what it might mean in relation to his father, suggested that he felt quite trapped

> in the therapy and perhaps *in* me. It was as if he had to quit the therapy in a diarrhoea-like way. He laughs and tells me that this sort of rang bells for him but he had to get on with his life nevertheless.

Abraham faithfully built on the work of Freud and extended our understanding of the different stages in the anal phase. Abraham allowed us to see that in the earlier anal stage, loss was reacted to directly, with somatic expulsion, not as an emotional experience. It was only in the later anal stage that the object is retained (albeit with a highly ambivalent attitude). From this perspective we might surmise that Andy had regressed to this earlier, less object-related state in these last three months.

In calmer moments, however, he acknowledged that he had gained insight from the therapy and that he now knew how damaged he was. In particular he seemed to be quite moved by my link with the way in which his father had suddenly and dramatically ended his relationship with his family. The idea that my patient was doing exactly the same thing with his psychotherapy made a lot of sense to him. He understood that in a way he wanted to leave me alone and destitute while he went off with his new lover/art. It did not make him change his decision, however. The understanding seemed to exist at a split-off level and could not be used for any protracted thinking. The only solution he could stand was to go his own separate way.

There is, however, a curious irony in this period of the treatment. In broad terms it has always been very hard to work in the transference with this patient. He was so focused on his body and its pain that pulling him into an exploration of a relationship seemed at times impossible. However, in this last phase of the work he did move away from the preoccupation with his body to much more clearly transference work. It can be no coincidence that in this last stage he was more focused on what he thought I was doing to him in the relationship than his bodily pain. The latter became much less of a priority for him. In one sense this has been the leitmotiv of the whole psychotherapy. As he moved from his body into a relationship he was faced with a terror that he did not know how to deal with. The unbearable feeling of his paranoid anxieties led to the inevitable expulsion of his psychotherapy.

An illustration of the extent of the persecution came in a session when he wondered whether I had actually manufactured this situation to 'kick start' him back into life. In his mind I had become a psychotherapist who could manipulate him unconsciously into taking the decision to leave his therapy. These elements of paranoia, although present often, crept in more clearly at moments like this. As I was struggling with the material retrospectively, it was this strong factor of paranoia that led me to think more clearly about the claustro-agoraphobic syndrome.

Although I remain worried about my patient and his apparent inability to metabolize any previous nurture that he may have had, he may have made some small steps towards health. He had moved to the edge of the psychic

pain of peering out from his 'black hole' of physical pain and inertia. The depressive position is still extremely far away but the thought of his own involvement in his condition has at least taken some root.

In the last week of the psychotherapy this patient handed me a piece of his art work. He wanted to ignore the giving of this gift and when I addressed it, he wanted to deal with it quickly. Typically, he bemoaned the fact that it was too simple, too small and the materials were slightly flawed. I brought attention to the manner in which he felt he had to demean this act, but that its importance lay in the fact that it had been produced and that this was a first. He had finally let something go and created something that was his.

This small piece of art, to my great surprise, beautifully conveys an enormous sadness. In the title and the construction of this work there is a reference to the pain of being cruelly enslaved to a harsh mistress (hostile object). It was as if he was aware at some level of how trapped he was in this space and his last and lasting communication to me lay within the art.

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 Journal of the British Association of Psychotherapists, 38, 118–128, 2000

The pre-formed transference: Its roots in Bion

MAURO ROSSETTI

ABSTRACT

The author looks at how the basis for Meltzer's concept, the 'pre-formed transference', is found in Bion's notion of 'preconception' and the clinical phenomenon of 'reversible perspective'. The pre-formed transference refers to patients' preconceived views of analysis and the fixed ideas with which they come into analysis. He discusses how, through reversible perspective, certain patients cling to their fixed perception in order to avoid engaging in a genuine transference relationship with the analyst. They do this by reversing the reality that the analyst presents, back to their own preconceived and often delusional view of things. This keeps them locked in an unchanging claustrum world of their own characterized by narcissism, omnipotence and pseudo-understanding. The author looks at Bion's linking preconception with the creation of 'myths', including the Oedipus myth. The development of insight is seen as dependent on the degree to which a patient is able to begin to tolerate dependence on the analyst and assimilate interpretations that bring about some change in his or her perspective. The paper ends with a clinical example.

Key words Bion, Meltzer, preconception, reversible perspective, pre-formed transference.

> It becomes clear that instead of this effortless attracting to the analytic setting all of the transference processes of the patient's life, it seems necessary to dismantle something that I've come to think of as the 'pre-formed transference' of the adult patient; the pre-formed transference, based on greater or lesser knowledge of or fantasies about the analytic method and the analytic experience, has to be taken down like an old shed at the bottom of the garden before anything new can be constructed. It can occur very quickly ... or it can take months or years to dismantle ... (Meltzer, 2000: 2)

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The 'pre-formed transference' described by Donald Meltzer may be clearly observed in our clinical practice. With the development of this concept you can find access to and modify situations that were once simply added to the list of those patients considered 'unanalysable'. In our work we have all encountered patients who believe that they are undergoing psychoanalysis or psychoanalytic therapy (and often the analyst or therapist believes it as well) but who are actually in a rather different kind of relationship. But what is this relationship? These are patients who can be gratifying for the therapist over a long period of time because they seem to understand interpretations and are continually providing 'deep' material that seems to fit the therapist's theoretical understanding. Often they will join in 'interpreting' their own behaviour, keeping their relationship with the therapist at an intellectual level. After the apparent external changes of the first year of therapy, the analytic relationship then becomes stagnant.

In this article I look at Meltzer's concept of the pre-formed transference, the conceptual origins of which are found in Bion's notion of 'preconception' and in the clinical phenomenon he described as 'reversible perspective'. Bion's concepts lay the foundation for Meltzer's studies on mental pain and on the development of thought (particularly his work on autism). In both the pre-formed transference and reversible perspective, the patient's goal is to maintain narcissistic omnipotence and avoid reality. If this continual acting-out succeeds, and it can be a subtle operation, a great deal of time may pass before the analyst becomes aware of what is happening, having fallen unwittingly into a trap, as it were. Not only does the patient not complain, he or she shows some 'expertise' in the analytic exercise and even seems to make progress.

Meltzer distinguishes a pre-formed transference from a genuine transference in which various degrees of infantile dependence are produced. In the former the patient tries to convince the analyst of the validity of his or her own view of things, denying the possibility of another point of view. The patient confuses the analytical relationship with a discussion or debate between two people. In this view the important thing is that one of the two convinces the other of the validity of his argument. Patient and analyst are equals in this battle to recognize unconscious mechanisms in the patient. Moreover, if they have different 'opinions', one will have to win out over the other or arrive at some 'chivalrous' concession. All of this prevents the emergence of new affects and thoughts.

When these patients realize that they are incapable of 'refuting' the analyst's ideas, they resort to misunderstanding, paraphrasing or pseudo-hallucinations as ways of 'deforming' the interpretations given by the analyst. Often such patients will convince themselves that the analyst wants to make them dependent and indispensable, especially when transference aspects are interpreted by the analyst.

One of Bion's points of departure is the simple observation that if you

touch the cheek of a nursing infant, he or she will turn his or her head and begin to suck. This is an action that no one has taught the infant. But Bion goes further when he states that simple actions are not the only ones that are innate, 'instinctive', due to 'conditioned reflex'. So, too, are more complex structures, which at the social level of communication become the bases for what we call 'myths' – what everyone 'knows'. It is this area that Bion pursues in his attempt to understand the origin of thought and the apparatus for thinking.

Preconception and the Oedipal myth

In *Elements of Psychoanalysis*, Bion tried to identify the elements which, combined in different ways like the letters in a written word, might sum up the entire psychoanalytic theory. From these elements he formed a grid which included 'preconception'. Bion describes preconception as 'a state of expectation. It is a state of mind adapted to receive a restricted range of phenomena' (1963: 23). He further asserts:

> The use made by Freud of the Oedipal myth has illuminated more than the nature of the sexual aspects of the human personality. Thanks to his discoveries it is possible while reviewing the myth to see that it contains elements that were not stressed in the early investigations because they were overshadowed by the sexual component of the drama. (Bion, 1963: 45)

Bion goes on to suggest a new understanding of the Oedipal myth:

> The riddle traditionally attributed to the Sphinx is an expression of man's curiosity turned upon himself. Self-consciousness or curiosity in the personality about the personality is an essential feature of the story: psychoanalytical investigation thus has origins of respectable antiquity. Curiosity has the same status in the myths of the Garden of Eden and the Tower of Babel: it is a sin. (Bion, 1963: 46)

We can now see how in Bion's analysis the Oedipus myth is not only part of the content of the mind but also part of the structure of the mind:

> The pronouncement of the oracle defines the theme of the story and can be regarded as a definition or a definitory hypothesis. It resembles a preconception or an algebraic calculus, in that it is an 'un-saturated statement' that is 'saturated' by the unfolding of the story; or an 'unknown', in the mathematical sense, that is 'satisfied' by the story. It is the statement of the theme of the story that is to unfold; the description of the criminal who is wanted. (1963: 48)

On this subject Sergio Molinari writes: 'Bion introduces the category of preconception which will be recognized as the quality that Kant attributes to an empty thought, which is that it can be thought but not known' (1982: 170). I think that the same thing might be said about unconscious fantasy (see

Melanie Klein, 1958 and Susan Isaacs, 1948). Bion says, 'I postulate an alpha element version of a private Oedipus myth which is the means, the preconception, by virtue of which an infant is able to establish contact with the parents as they exist in the world of reality' (1963: 93). The empty concept becomes full with its own particular meaning.

Thought begins with the coupling of preconception and frustration, if this 'no-breast' frustration can be tolerated and not resented. If, on the other hand, the absence is not tolerated, one sinks into psychosis and self-destruction. The present-bad-persecutor breast can only be evacuated. Likewise with the preconception of the Oedipus myth,

> if, through envy, greed, sadism or other cause one cannot tolerate the parental relationship and attacks it destructively ... the Oedipal preconception itself is destroyed. As a result, the infant loses the apparatus essential for gaining a conception of the parental relationship and consequently for resolution of Oedipal problems: it does not fail to solve those problems – it never reaches them. (Bion, 1963: 93)

Reversible perspective: transforming a dynamic situation into a static one

From preconception one passes to reversible perspective, which is used, as we will see in what follows, to make sure that preconception never coincides with the experiences that might be close to it.

On the subject of reversible perspective, Etchegoyen asserts that it acts – together with acting-out and negative therapeutic reaction – as an impediment to insight: 'Insight is always painful, but it forces us to change our opinion of ourselves'. Reality, moreover, forces us to keep track of absences, of what doesn't exist or exists no longer. 'According to the common-sense view of mental development, it consists of the heightening of the capacity to grasp reality and the diminishing of the obstructing force of illusions' (Etchegoyen, 1991: 688). But this process doesn't develop in the patients in question; rather their illusions must prevail over reality.

Reversible perspective is the opposite of the capacity to change one's perspective of things and oneself. At this point the ability to know, K, becomes –K. In turn, the complementary oscillation between the depressive and paranoid-schizoid position (Ps<–>D) and the relation between container and contained becomes negative. Thus the psychotic side of the personality prevails and the dominant sentiment is envy: 'The psychotic personality employs envy fundamentally in the development of objectival relations, set against the neurotic side which employs the libido' (Etchegoyen, 1991: 755). However, this real and true disability is not easily perceived during a session. We have a clue to its existence when little by little with the passage of time an analysis that seemed to unfold easily proves in fact to be an analysis in which nothing whatever is modified in the patient. Bion says that the image presented is curiously difficult to define. It is also difficult for the patient to

say precisely why he or she wants to undergo analysis. 'There is evidence that the patient is prey to extremely painful emotional experiences,' he says, citing the reversal of perspective as an indication of this.

> If they take place in the session the patient invariably has a facile explanation of what is taking place. The explanation is often couched in terms that successfully disguise the real nature of the experience. These explanations are manipulated in such a way as to invite interpretation expressed in the terms that the patient has learned to expect from the analyst. (Bion, 1963: 52)

'In every interpretation there is a significant presupposition; for example, that the analyst is the analyst: this presupposition can be tacitly denied by the patient' (Bion, 1963: 54). In reversible perspective, the contrast between analyst and patient is not explicit and the reversible perspective makes it possible for the patient to avoid a conflict with the analyst. It is as though the patient recognized the fact of having two parents, but denied the existence of the parental couple with all its psychological implications. The problem is that the patient after months or years of experience in analysis has obtained an ample knowledge of the theories of the analyst, but has no insight. The development of insight is dependent on the degree to which the patient has been able to assimilate the interpretation bringing about some change in his or her own perspective (Bion, 1963: 56). There is, however, a great difference between this and what we call normally manifesting resistance in the transference relationship: the patient will cling to the ambiguity in his or her analyst's choice of words or intonation in order to give the interpretation a twist that the analyst never intended. Observing the difference is difficult, since a patient who uses reversible perspective also adopts other forms of misunderstanding, concealing the most serious aspects of his or her illness. Bion concludes that the capacity of the patient to learn but not use analytical theories stems from making preconceptions not correspond to the realizations that are close to them. 'The unsaturated element remains unsaturated' (Bion, 1963: 58).

In summary, then, it is not necessary for the patient to be in disagreement with the analyst. He or she merely avoids the conflict by reversible perspective. It is a way of functioning that exists even outside of analysis. All information that comes from the outside is made to confirm the patient's point of view because it is seen through this reversing filter. This underlines Meltzer's observation about the way such patients live in projective identification with their objects.

In my notes after a session with a patient who showed the characteristics I am describing, I wrote:

> Mario talks continuously, from the time he comes in until the end of the session, and he doesn't want to be interrupted. Sometimes he leaves me a little space towards the end, but only so that I'll respond to all that he's said during the same session or to respond to a question of his. If I don't respond he observes that I am 'having trouble'

> and if my interpretation simply describes this manoeuvre, then I am 'complaining' because he has put me in a tight spot.

I am describing how reversible perspective serves to transform a dynamic situation into a static one. But when, as a result of the analyst's interpretations, this cannot be sustained, the patient will resort to misunderstandings and even hallucinations. For example, during certain sessions, when the patient quoted above heard a (voiceless) noise outside the consulting room, he would stop immediately and ask: 'Excuse me?' or 'What did you say?'

Etchegoyen suggests that, in the end, reversible perspective challenges the analytical contract because the patient continuously refers back in his own mind to his own perception of the analytic contract. None of this is explicit because it takes place unconsciously: 'Let us remember that in general it is the borderline states that employ reversible perspective, and not the overt psychosis where delusion is evident' (1991: 764). There exists also a connection with narcissism: 'The difficulty of accepting the existence of the other is equivalent to the inability to accept a reality other than that of our dreams' (1991: 769). In reversible perspective the object exists only to confirm one's own convictions led by one's own dreams. Feelings of hate, envy and jealousy dominate, and there exists no reparatory behaviour, as one might find in a genuine capacity for role-play, for example. In such role-play one does not deny the difference between subject and object or the experience of placing oneself in the place of another.

The pre-formed transference: an illusory control of reality

Meltzer points out that in the pre-formed transference the patient tries to avoid a true transference in order to continue to exercise an omnipotent control over the situation (Meltzer, 1992). But it is an illusory control. At most the patient may manipulate the analyst and that way believe he or she can manipulate reality itself. But to control reality at all the patient would have to be fully engaged in it. Here the patient is engaged in a mere 'as if' way of operating. It is, as Meltzer describes, a 'survival technique' and not a true and real transference. In these cases, he explains, the patient 'shows in therapy the survival techniques of the claustrophobic world in which he lives' (Meltzer, 1992: 103). It is important to recognize the patient's state of incarceration, the unliveable situation of 'a child who got lost'. Making contact with this child who lives inside the patient is indispensable.

Interpretations talking about different parts of the personality in the early stages of analysis with such patients prove useless. We are in the presence of a psychotic mechanism. What is required, according to Meltzer, is a slow and patient process of dismantling the underlying misunderstandings, session after session.

A clinical case

Mariana is a 52-year-old woman whom I see twice a week. Making notes after her early sessions proved difficult as the sequence of themes or thoughts elaborated became hazy. I will describe a few sessions that I did succeed in transcribing in the first year. In this material I hope to show the way she steered away from what was said during the sessions and the dynamic significance of 'misunderstandings'.

In these sessions Mariana brought thoughts and themes for us to address, wanting to find a particular meaning in everything she said. Often she began by taking me back to things I had said the previous session, asking me to clarify the meaning of what I was trying to tell her. She thought perhaps I wanted to say this or that. But in fact what she really wanted was to dictate what I should say. It was her way of controlling the session and my thoughts in an attempt to prevent me from thinking freely. On the other hand, the things that she proposed seemed to chime well with what she imagined goes on normally in an analytical session. I often felt that I needed to tread carefully with her as though she could not bear to discover a different reality.

She did not associate in any recognizable sense but instead filled the sessions with her own theories about herself or her own reworking of my interpretations or observations, making them into definitive statements: 'You told me that I shouldn't talk about my husband, that I should talk about myself instead.' In truth, what I had said was that the only way she talked about herself was by talking about her husband and her relationship with him. In addition silences were not tolerated. She often used the phrase: 'I want to understand why this is happening to me, and I'd like you to tell me something to point me in that direction, in order to understand.' At these moments I would point out her difficulty in thinking freely and how she could not tolerate my doing so. Whenever she referred to our sessions she hesitated before giving them a name and in the end said 'meetings' or 'appointments' or 'interviews' or simply 'here'.

I observed that she had a textual memory of my phrases which Meltzer suggests is characteristic of the patient who tends to 'paraphrase' (Meltzer, personal communication). However, they became altered in the larger scope of the discussion and used to confirm her own theories. For example, when I suggested that she inhabits the life of her mother and feels ill-equipped to live any other way, during the following session she insisted that I had said that she should live her own life and not live in the shadow of other people.

However, Mariana slowly began to see how she used these manoeuvres as a defence against becoming dependent. For example, she began one session saying that she had to have some cysts removed, but was afraid of a major operation and 'losing a part of herself'. Then she compared being on the couch in the preceding session with her relationship with the dentist: unable to 'have a discussion' with him when lying down. When I suggested that lying down on

the couch left her feeling in danger of losing parts of herself or having parts of herself taken away by me, she agreed, conveying a need to keep all the different parts in line and co-ordinated with one another. She described her ideal as being like those people who are sure of themselves with no need of outside assistance. Her grandmother, she said, lived to be more than 90 without ever needing anything. She didn't even have a purse, only a few loose coins to give to beggars who knocked on her door.

I pointed out the tension between her wish for an internal fullness, possessing all those things necessary for living independently, and her wish to have fewer things, like no purse (female genitals) and no longing for a man who would undermine her self-sufficiency. It suggested that having to keep these contradictory wishes in place and at the same time apart required her to remain constantly vigilant.

In the following session Mariana began by saying that she had read about something called the 'Ideal Ego' and that it was helpful in understanding the difference between shyness and shame. She added that she must definitely overcome shame, but that as it is something fundamentally human she should accept it. Today she wanted to lie down on the couch because of this new understanding. She had to let herself go. She had 'decided' that she would feel secure. In the end, however, she could not do it. She added that, when she was little, whenever someone came to the door she would run away and hide. I suggested that her frequent use of the words 'possibly' and 'maybe' might be a way of running away and hiding. I pointed out that she spoke to me as though she were watching herself as an outside observer, not as herself. She then tried to talk about something else, saying that she hid in the garden behind a bush and came out only when the visitors were leaving, to say goodbye to them. I suggested that perhaps today the book was the bush, and that she wanted to hide behind it while trying to talk about her sense of shame. Somewhat embarrassed and tearful, she began talking about her failures, her wasted career, the child she aborted and the baby she never had.

Towards the end of the session, in the minutes that she often filled with empty rhetoric, she remembered a dream.

> She dreamed that she promised her mother she would straighten the laundry at their house but that it was full of stuff, she wasn't able to straighten it all out, and that there was rotten food and a horrible stench. She also talked about a woman who is a patient in a 'day hospital'. Once this woman started to clean the kitchen furiously because she was angry with Mariana and with a hospital worker; with Mariana because she had not called her at home that week, and with the hospital worker because she was pregnant and did not take care of her as she used to.

There was not enough time to take up these feelings about her work with me, the laundry room and the need to confront the things that she feels are disordered, dirty or foul-smelling in herself. Given the way she previously would take my words as an indication of 'how one should be', thinking with her about the dream would require time.

Shortly thereafter she brought another dream, this time early in the session.

> In the dream she was with her mother at their beach house, which they were preparing for the summer. There were two closets where they put old clothes [I think of her two weekly sessions]. There was a blouse of her mother's that Mariana wanted for herself. 'Should I tell my mother or not?' In a corner there was a silent friend. She tells her mother that she could go on vacation with one of her friends.

She herself made various interpretations concentrating on the blouse. Why the blouse? It was not a complete garment. She said she wants to go 'all the way'. I tried to interest her in 'telling or not telling', but she paid no attention and continued her own attempt to interpret the situation of her mother's blouse. When I came back to her 'telling or not telling', she talked about her relationship with her sister which was full of anger and rivalry. The 'not telling' is also linked to her relationship with both her mother and with me and with the fear that the truth can hurt. She must 'comprehend' she said. I suggested this 'comprehending' seemed to be a way of turning attention away from the question of telling her mother, and thus telling me and most importantly herself, about the truth of her envious feelings. 'Should she tell everybody everything about herself?' she asked.

My pointing out the link between the 'not telling' her mother, and the 'not telling' with me seemed to make no impact. She insisted on seeing the dream her way. Showing no sign of tension or aggression, she would simply take what I said and adapt it to suit her own initial idea. Meanwhile, she looked to me constantly as though asking for confirmation of her own 'interpretations'. The session ended, leaving me feeling that she did not understand what I was trying to say, but also how difficult it was to say it clearly.

The following session Mariana began by saying that it is true she is obstinate and insistent in conversation. She felt that she has little time and wanted to resolve things in a hurry, but afterwards she did think about what I said. I said I thought my interpretations and descriptions were like the blouse of her mother's that she secretly envied. It was difficult to tell me how much she envied them. Instead she tried to maintain she had plenty of her own interpretations.

Mariana tried to draw me into competing with her, believing we were locked in a contest of intelligence but for the moment she had to submit. Although she felt she learned things from me, her view was that she was 'overcoming trials' that I presented her with. When she was 'capable' of overcoming all of them, she would be 'strong and decided' like me, like her sister and like her 90-year-old grandmother. She had to 'deserve' this knowledge I have inside and that I withhold from her, and she struggled to ignore any envy. Envy might have made her angry but she never got angry with me, merely resigned to the frustrations that she experienced during the sessions.

My interventions, descriptions and interpretations left her disoriented and

afraid of a trap, another trial that I would put her through. She became disoriented because there were moments when reality entered and I was no longer the pre-constructed analyst she engaged with in 'dialogue' outside of the sessions. In those periods I think I became the 'silent friend in the corner' of the dream. Little by little, I was able to challenge her convictions and introduce fragments of truth and reality. For a brief period she began displacing the conflict with me on to her body. She proposed getting an operation, something that she had 'needed to do for a long time'. I think it seemed her only way of avoiding issues of old age, the children she never had – the laundry room in her dream with all its melancholy contents. Given the radical nature of this somatizing defence, that is to say 'the operation', I am led to believe that Mariana was beginning to experience profound depressive feelings along with a hope for some 'operation' that might deal with them.

Conclusion

I often wondered whether Mariana would ever be able to participate in a real analytical situation and move from 'confrontation', 'learning what to do' and 'how it should be' to a truly experienced transference with me. She tried to convince rather than seduce me. But this wanting to convince me calmly and with consistency was a way of trying to get inside me and remain in a claustrum world. At first sight, there seemed to be nothing psychotic. Nevertheless, for a long while the entire relationship with me was based on misunderstanding. In this way she could avoid engaging in a real transference with me and avoid having to confront reality. Her own convictions about the state of the world, what for her represented an analytical relationship, what she wanted from herself, and 'who' she wanted to be, were all hidden by a false spirit of surrender and a false humility.

What she could not express were her emotions. When I suggested that she needed me to care for her, recognize her and provide for her like a girl who sometimes feels orphaned, she accepted intellectually what I said, but for a long time there was no modification in the relationship that she established with me or with herself.

Only gradually, after almost two years of analysis, was she able to use the couch, and to allow herself to begin to free associate and feel things emotionally.

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Journal of the British Association of Psychotherapists, **38**, 129–135, 2000 © Whurr Publishers Ltd

Notes on the back of my programme: Jonathan Miller's ENO *La Traviata*

JAMES V. FISHER

The haunting overture that opens Verdi's opera *La Traviata* is unbearably poignant, anticipating feelings for which we are not yet quite ready. It begins softly, the proleptic instrumental motif from that final act with its agonizing death scene giving it an edge of painful expectancy. In the notes to the music in his *ENO Opera Guide to* La Traviata, Denis Arnold points to the heartbreak conveyed by the broken motif with dynamic markings accenting the weak beats (Arnold, 1981). The overture then moves to the sounds of Violetta's cry of love from the middle of the second act, itself a transformation of the music of Alfredo's impassioned appeal to her in the first act, a theme recurring throughout the opera. The overture ends as it moves into the lively, almost frantic waltz sounds of the party in which we will meet the courtesan Violetta and Alfredo who loves her. The effect is to warn us that this is no ordinary party, but rather a meeting of lover and beloved, haunted by grief and loss.

The opera has had a powerful effect on me, particularly recently after having seen Jonathan Miller's ENO production, then seeing Richard Eyre's Royal Opera production, and then returning to see the Miller production a second time. In these brief 'notes on the back of my programme' I want to share some of my reflections on this opera, with particular reference to Miller's production. My aim is to share some observations both about aspects of the opera and about the thoughts and feelings it evoked in me – observations, one might say, in a psychoanalytic mode, a mode of noticing feelingly and imaginatively with an eye to linking emotional experiences. We often describe something like a performance of *La Traviata* as 'meaningful', and I am assuming here that when we talk about the 'meaning' of something we are drawing attention ultimately to our emotional experience in reference to it. Asking what something means takes us into the world of emotions, whether that something is sung or spoken on the stage or in the consulting room.

My assumption is that significant emotional experience, especially of something like *La Traviata*, is actually a simultaneous experience of multiple meanings, multiple stories. Frequently, and this is part of what gives it its emo-

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tional depth, these meanings and emotions are not only multiple but conflicting as well. We experience this ambiguity and complexity in everyday things we find meaningful. And we experience this ambiguity and complexity in a heightened way in what we recognize as art – indeed, perhaps this heightened ambiguity and complexity of emotions is part of why we see it as art.

Consider how the Miller production invited the audience to experience some of the associations haunting Verdi's adaptation of the novel of Alexandre Dumas the Younger, a novel about a courtesan with whom a respectable young man falls hopelessly in love. The scene opens with the chorus enjoying a party already under way, costumed in a set reminiscent of the Second Empire (the actual period of the first performance). It is interesting that Verdi wanted his opera staged in 'modern' dress (1850s) but was forced to set it in 1700. Then we notice that Violetta – no mistaking Rosa Mannion's voice – is the only woman in a trouser suit. True, it was only for Act One. But why? Does everything a director does need to have or convey a meaning? This 'fallen woman', this 'woman led astray' as '*traviata*' literally means, why is she not wearing a wonderfully glorious ball gown like all the other women? Is she meant to be 'modern', bringing to mind Miller's provocative gangster *Rigoletto*, or is there a hint of gender ambiguity? Does Miller mean to say something through the costume? I make a note to myself: *ambiguity*.

Both times I saw the Miller version of *La Traviata* I found myself counting the chairs around that huge round table – not easy since some were occupied, others not. I made it 18 on both counts. But there must have been almost that many more members of the chorus standing around filling the hall with songs and chatter. What were they going to do while the 18 were eating? And why am I even noticing this irrelevant aspect of the staging? Still I can't stop myself worrying about those left out, excluded. Will there be a second sitting of dinner? Now this diversion is so silly that I forget it until afterwards when I add to my mental notes: *exclusion*.

Ambiguity and exclusion – hints of an Oedipal story. Already this erotic 'fallen woman' seems to carry something of the erotic mother for me, the gender ambiguity transposed unconsciously, musically, into the potential confusion of the generations. Alfredo's courting of this '*traviata*' to my mind has overtones of a little boy's dream of capturing the erotic mother from the adult world which seems to him so promiscuous. For the little boy, mother's involvement with father can be experienced as infidelity, the first betrayal – in Janet Adelman's phrase 'insofar as she is not merely his, she is promiscuously other' (Adelman, 1985: 134). Although this is foreshadowed in the woman being identified as a courtesan, in *La Traviata* the separation and betrayal is yet to come. In a sense it is *the* issue of the opera.

With this theme echoing in my mind, the apparently idyllic Act Two seemed to portray the longed-for happy ending to the shared mother–son fantasy of evading the Oedipal prohibition. The generational boundary can be crossed. Here in a country house outside Paris it is as if we were offered a

picture of Oedipus and Jocasta *before* his persistent 'seeking to know' spoiled the idyll. But spoiled it is, all too soon, as Alfredo discovers unwelcome information from the maid Annina. It seems that the lovers live together in bliss through Violetta's tainted wealth. Furthermore, she is having to sell all her possessions to sustain it. In the play of Dumas *fils* it is clear that the courtesan's wealth comes from her continuing to give herself to her rich protector in Paris. It is as if the little boy (in Alfredo) suddenly realizes that all his happiness is dependent on the earnings of a 'prostitute', echoing one 'betrayed' son's version of the parental relationship.

Alfredo's declaration that he will now look after 'his' woman himself hints at the omnipotent outrage of the little boy when his dependence is exposed. Meanwhile in the opera Alfredo's father arrives to confront '*la traviata*' with the impossibility of the liaison. On what basis is it impossible? Is Giorgio Germont, Alfredo's father, merely the spokesman for conventional morality, the implacability of social structure which means that Violetta's liaison with his son is ruining his daughter's chance of marriage? Is that what we hear when the father sings to Violetta in the duet in Act Two '*Pura siccome un angelo*' ('I have a daughter sent from God')?

As an argument from conventional morality, I must say, it seems remarkably out of its depth in the context of the breathtaking beauty of that duet of Violetta and Alfredo's father Germont – Rosa Mannion and Christopher Robertson drawing us into emotion beyond mere conflict with social mores. But if the father represents the reality of the divide between the generations *and* the awareness of the passionate, erotic love of the mother for her son – well that thought both evokes and is evoked by the beauty of that duet: 'Do not now deceive yourself/By trusting in delusion:/Say you will be, for my sake (*siate di mia famigilia*, 'our' family?)/An angel of consolation'. Violetta seems to respond to this plea for the next generation, for the gentle daughter (*giovine*), pure and lovely. Father is now full of pity for her and the anguish that breaks her heart – her suffering in giving up Alfredo. The love that transcends the generations along with the pain of its impossibility is acknowledged.

The programme notes I have read seem uniformly to agree with Weaver (1996) in hearing Germont *père* as the voice of a rigid bourgeois morality. But I heard in those duets in Act Two the voice of the father intervening on behalf of the reality of the unbridgeable divide between the generations. He appeals to Violetta to give up the liaison on behalf of the two children. He appeals to Alfredo his son to give up the liaison on behalf of the father and the sister. And behind his appeal is 'the voice of God' whose 'voice inspires a father's words'. Is this the bourgeoisie calling on the authority of religion to demand compliance, or the invocation of the voice of a father who seeks to sustain the difference between the generations in the face of the powerful erotic link which would erase that difference? And, moreover, I think to myself, where is the mother in this appeal? Why does the father not appeal *on her behalf*? Even were she dead, the power of her absent voice on behalf of her

children would only be the stronger. Unless, of course, the appeal is *to her*.

Interestingly, Weaver (1996) notes that Felice Varesi, the baritone who first performed the role of the father Germont, objected that Verdi had not given him interesting enough music to sing. Weaver's observation is that 'If anything, *La Traviata* is an opera of duets, not of arias'. It is almost as if musically Verdi poses for the opera's audience the dilemma of the need for the third perspective. Listen to the words of the play of Dumas *fils* as the father speaks to Marguerite (Violetta): 'Your relationship is not the fruit of two spirits, nor the union of two innocent natures; it is a passion of the most earthly and human kind, born of the caprice of one of you and the fantasy of the other'. Both in the play and in the opera, the father appeals to the picture when they both have grown old: 'Who can say that the first wrinkle on your brow will not tear the veil from his eyes, and that his dream will not fade with your youth?'

But what of Violetta? If we hear echoing beneath the voice of the 'woman led astray' the cry of the mother facing separation from the child she so passionately loves, we also hear the pain of the woman dying of a consumptive illness. The pain of separation is felt to be the pain of death. Having been happy together for three months in the country, a passionate idyllic intimacy which could be rivalled only by those early months of mother and her baby, death/weaning/separation are inevitably on the horizon. Miller (1996) describes tuberculosis (a clinical version of the romantic consumptive illness of which Violetta is presumably dying) as having symbolic significance, citing Susan Sontag's *Illness as Metaphor*. In addition to symbolizing the dangers of life in the 'big city' (the adult world), Miller suggests that:

> It also symbolises, in some strange way, the just deserts of a dissolute life. It's more blameless than syphilis, and it has a romantic, hectic quality. In men it's associated with the notion of inspiration, delicacy, sensibility – the poet ruined by tuberculosis. But in women it represents a just desert mingled with a certain wistful beauty.

Simultaneously it is the penalty of Violetta's depravity and the symbol of her innocence. Might we say it is the child's, and the mother's (in a particular state of mind), view of intolerable mental pain, the pain that attends separation, the recognition of difference, development?

I can only commend to you the intense beauty of that first scene of Act Two, particularly the duet I have already mentioned and the duets between Alfredo and Violetta and between Germont *père* and Alfredo his son. 'How I hung my head in shame/when you left without a word,' sings the father to his son, 'God led me here to bring you home.' Of course it is the story of a distraught bourgeois father seeking to prise his son free from the arms of a dying Parisian courtesan. That is the form of the story Verdi adapted from Dumas *fils*. But to my ears it resonated with another story, universal in its emotional power as was that of the itinerant who became King of Thebes and went to bed with the woman who was also his mother.

But what of the son? Is this separation, and the pain of it, primarily the responsibility of the mother/courtesan? It is true that Violetta's pain seems equated with her death, consumed by the anguish of giving up what could not be. The power of *La Traviata* for me is that it gives centre stage to a dimension of the Oedipal drama that Freud largely ignored. Freud even wrote of the mother–son relationship: 'This is altogether the most perfect, the most free from ambivalence of all human relationships' (Freud, 1933: 168). That is not what I hear in Violetta's anguished sacrifice for the sake of the virginal daughter nor what I hear in Jocasta's anguished cries in *Oedipus the King*. Note that for Violetta the picture seems to shift to the father–daughter relationship as her giving up of Alfredo the son evokes the painful memory of her wish to be considered by Germont as a daughter (which he finally acknowledges in Act Three) – and not the father's partner in what would be the little girl's version of another violation of the generational boundary. Every mother is also a daughter whose weaning relationship with her child evokes the never-forgotten 'weaning' from her father as well as her mother as she gives up any fantasy that this child is her father's child.

In the second scene in Act Two Alfredo acts out his omnipotent outrage at the 'betrayal' of Violetta, this woman who 'threw him over', by throwing at her the money which will 'repay the debt' he owes from being a 'selfish coward, kept by her'. Germont the father responds firmly: 'you're not my son,' he sings. This is not the way the son becomes an adult, despising the woman who loved him and kept him, treating her with contempt for her refusal to acquiesce finally in this fantasy of the breaching of the generational divide. The father knows the love this woman bears for his son, not only in the passionate embraces of their months of exclusive intimacy, but even more in her capacity to give him up so that he may have a life of his own. At the end of the final scene Violetta paints a picture of the virgin, pure and simple, whom Alfredo will make his wife, offering a portrait of herself as 'an angel in heaven praying for her and him'. No loving mother could sing more passionately of her sacrifice.

The final act of the production evokes the emotional denouement with particular intensity. Critics have noted Jonathan Miller's 'medical' version in which Violetta tries again and again to rise from her deathbed, but cannot. Is that a realistic picture of her consumptive illness (her tuberculosis)? Perhaps. But I also felt the 'impotence' of the faithful mother unable finally to yield to her agonized erotic longing for her son, a yielding that would destroy him. Momentary manic flights in the ecstatic duet between Violetta and Alfredo the son remind us of their idyllic intimacy. In the words of Peter Conrad, 'Alfredo claims to derive his life from her' as he sings to her that she is 'breath and light' (*sospiro e luce*) to him, she is his 'breath and pulse' (*mio sospiro e palpito*) (Conrad, 1989: 155). But attended now by *two* lovers, father and son, she has to acknowledge that it is too late for such fantasies of the erotic union of mother and son – it cannot be. It is what Freud called in his final publication

'the painful impossibility': 'The boy's mother has understood quite well that his sexual excitation [when he shows her his male organ] relates to herself. Sooner or later she reflects that it is not right to allow it to continue' (Freud, 1940: 189).

What Dumas *fils* and particularly Verdi add to this story is the intensity of the mental pain that separation, weaning, growth and development entail. Here the son gives up his fantasy, perhaps only when the woman/lover/mother suffers first the painful finality of its impossibility. This happens not in fear, but in the context of love – Violetta's sacrificial love as well as the father Germont's love for Violetta and his son and daughter. Violetta is now accepted as a daughter and, as she dies, father and son embrace – not a picture of the fear of the castrating father. Conrad in his discussion of Zeffirelli's 1982 film of *La Traviata* also hears these Oedipal echoes in the final scene:

> Cradling her in his arms, Domingo's Alfredo is now the forgiving father Germont had claimed to be in the second scene, when he told Violetta that God spoke through her; then he lays his head on her chest, like a son imploring a mother's pardon, and she collapses into the arms of the almighty patriarch Germont. (Conrad, 1989: 304)

I think we are here in the realm of the ineffable, that if *La Traviata* were literally a story about a mother's passion for her son and the dilemma of the transgression of the boundary between the generations, *it would not work*. A symbol must participate in the most ordinary elements of everyday life, otherwise we would not begin to understand it. And yet it takes us to another realm or level, as do our dreams. It is a mystery. It is a continuous challenge for us to talk about what gives meaning to our existence without translating it, in our all-too-pedestrian, prosaic way, into the trivial, whether in our consulting rooms or in our discussions of the creations of our artists.

Just in case this view of the 'traviata' of Verdi and Dumas *fils* as the erotic mother seems all-too-improbable, consider this little anecdote from the notes of April FitzLyon on Dumas *fils* and his dramatic version of his novel in the ENO guide to *La Traviata*:

> At the end of the first performance of his play Dumas's friends asked him if he was going on to a party to celebrate his success. He replied that he was not, as he was *spending the evening with a lady*; he then went on to have a quiet supper *with his mother*. This anecdote contains the key to Dumas's life and work, and particularly to his relationship with Marie Duplessis [the real life courtesan who was the model for Marguerite/Violetta]; for he was illegitimate, and the difficulties both he and his mother had had as a result marked him profoundly. (*ENO Opera Guide*, 33, my emphasis)

There is so much more to be said about this opera as Verdi musically brings us, I believe, to new depths in our understanding of the Oedipal drama at the core of our experience.

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 Journal of the British Association of Psychotherapists, 38, 136–150, 2000

Books Reviewed

Psychoanalytic Psychotherapy in the Independent Tradition

Edited by Sue Johnson and Stanley Ruszczynski
London, Karnac Books, 1999, pp. 197, pbk £17.95

Psychoanalytic Psychotherapy in the Kleinian Tradition

Edited by Stanley Ruszczynski and Sue Johnson
London, Karnac Books, 1999, pp. 188, pbk £17.95

These two books, each consisting of eight chapters, have been written by experienced members of the Psychoanalytic Psychotherapy Section of the British Association of Psychotherapists. The chapters consist of carefully selected material illustrating the way that each author uses particular aspects of psychoanalytical theory to understand the relationship between therapist and patient.

Both books have a good, clear introduction by the editors, summarizing the content of each chapter. The editors are well suited to the task of presenting a cross-section of contemporary approaches to analytic work, as they are colleagues and friends who trained together while developing their different approaches – Sue Johnson in the Independent tradition, and Stanley Ruszczynski in the Kleinian tradition.

To start with the first book, in keeping with the Independent tradition, there is a sense of the constant questioning of orthodoxy. This is driven, I would assume, by two sources. The first of these is the personality of the therapist. It cannot be merely an accident that a therapist chooses to develop in one school rather than another. The second comes from the nature of the difficulties encountered in the consulting room with particular sorts of patients.

The interests of the authors of *Psychoanalytic Psychotherapy in the Independent Tradition* are diverse. They range from the issue of disclosure of information of aspects of the therapist's life to the limits of what may be achieved by psychotherapy. The authors draw on a wide range of psychoanalytic ideas to form the basis for their own particular way of working with their

patients. In contrast, the feel of the Kleinian volume is much more of a body of therapists working within a generally agreed orthodoxy, nearly all referring to the ideas of the same small group of authors.

Reading *Psychoanalytic Psychotherapy in the Independent Tradition* is rather like a visit to a gallery of modern art. You can never be quite sure what you will find there. Some work is familiar; other work seems strange and new. Some work may not stand the test of time whereas other examples may come to be accepted as quite normal. The undercurrent of restless questioning of the Independent authors leads to one of two outcomes. First, a modification of 'classical' technique, or second, a reinvestigation of theory and a consequent rethinking by the psychotherapist of his or her position in the counter-transference, without a change of technique.

I want to emphasize the difference between these two results because it is an important one. Sue Johnson has two chapters and each of them could be said to represent these different results. For that reason I have paid a good deal of attention to her contributions. In the volume's opening chapter she takes Winnicott's idea of the false-self as a starting point from which to question the orthodoxy of the therapist always maintaining the classical, neutral position of the 'blank screen'. She writes of how, when she began as a therapist, she clung for security to what she came to regard as a rigid framework. She describes her work for more than 10 years with an adopted patient who had experienced a mother who had never told her the truth when it mattered. Johnson describes beautifully the detailed ramifications of some incidents from the treatment.

In the first incident Johnson returned from her usual early morning walk with her husband to find her patient waiting outside in her car. The patient had never arrived so early. The therapist felt ashamed to be out in her grubby clothes and, sticking to what she felt was psychoanalytic decorum, she ignored the patient. Johnson later interpreted that the patient was angry about being ignored but came to think that her interpretation had been defensive. The patient had known that she, the therapist, had seen her. Later she told the patient that she had seen her, but had felt embarrassed. Johnson says that this signalled a change in the therapy. From the patient's point of view the therapist had at first behaved falsely by becoming the untruthful, false-self mother.

Much later there is another incident. Johnson discusses the way that she confirmed her patient's idea that the reason her therapist needed time off work was because the therapist's mother had just died. The author discusses the complex consequences of the patient's feelings about having this fact confirmed: whether or not it is a burden for the patient or ultimately if it might have been what was required of the therapist at a crucial moment. Johnson explicitly does *not* advocate a technique of random self-disclosure but says that while maintaining anonymity '99.9% of the time' there are 'those moments [in which] it has been demanded of me that I be my true self – my real self – and not an enigmatic therapist' (p. 26). She had come to believe that her growing confidence in her ability to trust her own judgement might allow her

to avoid retraumatizing the patient by behaving like the patient's internalized mother.

The reader will be left in no doubt of the extent to which the therapy helped this patient. However, there are inevitable questions. If the therapist, having made the defensive interpretation, had remained neutral, might it have then been possible to maintain neutrality and interpret the extent of the patient's confusion, anxiety and rage (rather than anger) caused by the therapist ignoring her? Would this have been traumatic?

In her second chapter Johnson uses Winnicott's distinction between 'object-relating' and 'object-usage' to illuminate the difficulties of working with a profoundly damaged and disturbed young woman. Johnson explains that in Winnicott's terminology, 'object-relating' is an earlier 'pre-integration' state than 'object-usage', which depends on a degree of psychic integration. (These terms of Winnicott's are confusing because we have grown used to thinking of 'object-related' as something quite developed.) Johnson describes how she uses these concepts to monitor and understand her counter-transference and the appropriateness or otherwise of her interpretations. If the patient is in an 'object-relating' state, he or she may be aggressive but has *no destructive aim*. The patient is therefore unable to take ownership of the consequences of his or her aggression. Interpretations that do not take account of this are likely to be experienced by the patient as a bewildering, traumatic attack. The therapist, who may feel hurt and may be made to hate the patient, may be provoked into just such an attack. The therapist has to learn from experience to hold on to this hatred. The patient can then see that the therapist does not mistake aggression for destructiveness. The move to a more integrated state of object-usage can then take place in which the patient is able to try to safely destroy, in fantasy, a non-retaliatory therapist.

I found this second chapter of Johnson's a convincing example of the therapist reinvestigating a piece of theory in connection with her clinical work, which leads to a change, not in technique, but in the way that the therapist thinks about the patient's material. (It is the same, important issue investigated by Berkowitz, using a different theory, in her later chapter in the same volume.)

Joscelyn Richards finds the psychoanalytic theory of the 'splitting of the ego' inadequate as an interpretive tool to deal with patients whose psychotic selves seek constantly to undermine good therapeutic work. She uses the theories of Klein, Bion, Rosenfeld and Sinason as a basis for the development of the idea of the 'internal cohabitee' as a term applicable to the universal existence of a psychotic self in each one of us. This has led her to a way of interpreting that objectifies this aspect of the patient. For example, when the patient is in the grip of a manic self, the therapist says: 'I wonder if she speaks fast because she can't bear you to pause and take your time in recognising the impossibility of her changing' (p. 46).

I think I would put Richards' approach somewhere between the two categories of change of technique and alteration in the way the therapist regards

the patient's material. The approach certainly seems quite radical and controversial. It gives rise to important questions, such as how much of a departure is it from familiar psychoanalytic thinking and practice? If it is a radical departure does it extend psychoanalytic technique or does it make an appropriate demarcation between psychotherapy and psychoanalysis, or is such a demarcation meaningless? How much does it really allow the patient to reintroject split-off aspects of the self? Would it be possible to question the psychoanalytic theories of psychosis and extend them without needing such a change? There is an implication in Richards' opening remarks about the theories of Rosenfeld, and so on, that they may not be all that effective if something else is missing. What Richards says to the patient obviously makes the patient feel that she is in the presence of a sympathetic, thoughtful and containing person. Could it be this, rather than the altered approach, that helped?

Ruth Berkowitz's contribution is firmly within the second category of a reinvestigation of theory. She describes how she is forced by her work with her patients to think anew about trauma. She takes a new look at Balint's proposition about the three phases that constitute trauma. She then uses these as a starting point to explore the possible relationship between these stages and the way that a patient re-creates and re-experiences them in the treatment. She explores the way that the patient may unconsciously set up a situation in which, via repetition-compulsion, the therapist may be forced to unwittingly re-create the third stage of trauma (denial by the perpetrator). It seems to me that in using and extending Balint's idea Berkowitz has produced, in her chapter, an important and original contribution to psychoanalytic thinking.

Anne Tyndale (who does not advocate a change of technique) looks at the idea that here-and-now transference interpretations are the only mutative factor in therapy. She proposes that they may sometimes be used by the therapist as a way of managing his or her own anxiety, and as a means of controlling the patient. Her ideas about the use of interpretations with a historical link may be compared with Philip Roys' thoughts about this in his chapter in the Kleinian volume. Tyndale also discusses the pitfalls of the fashion for 'therapist-based interpretations', which may be heard by the patient as a confession of actual, possibly negative, feelings towards the patient.

The other authors in the 'Independent' volume cover important and interesting topics and I do not mean, by not discussing them at length, to imply that they are any less worth reading than the ones I have already mentioned. Judy Cooper discusses the limitations of the therapeutic endeavour, particularly in the case of patients with early damage. Viqui Rosenberg asks; why is it that the erotic transference has been written about so infrequently? Her thought-provoking answer is that it is 'because it always implies a counter-transferential ordeal'. She investigates aspects of this ordeal and arrives at some interesting conclusions. Anna Witham takes as her subject the relationship between dreams, day-dreams, transitory (or 'in between') states and unconscious fantasy and asks; where in the mind do these states occur? She

explores the way that patients may make use of these states of mind creatively or defensively.

The common concerns of the Kleinian therapists are: the recovery and repair of the lost (split-off) internal objects of infancy; the reintrojection of lost parts of the psyche; the need to attend to the manifestations of these lost object-relationships in the transference and counter-transference; the importance of the knowledge or denial of the facts of life and death. The Kleinian chapters therefore have an overall coherence. There is not the sense of the questioning of orthodoxy of the 'Independent' volume. Instead there is a sense of the careful and slow re-enforcement of the Kleinian heritage. At best this contributes to an elegant, convincing, containing and illuminating structure. Occasionally, though, there is a bit of a sense of the dutiful buffing up of the Kleinian reliquary.

The opening chapter of *Psychoanalytic Psychotherapy in the Kleinian Tradition* by Philip Roys sets an authoritative tone. He gives a lucid summary of the main concerns of Kleinian practice before turning to his main subject – the place of historical reconstruction in the Kleinian approach. I was convinced by his clear and clinically useful argument that reconstructive interpretations are helpful only when the patient is in the depressive position. He places, at the centre of Kleinian therapy, the understanding of archaic unconscious fantasy and anxiety and the way these are dramatized in the present. He pays particular attention to the way that the therapist's counter-transference will give clues as to whether or not the patient is using references to the past as an escape from present anxieties or as a genuine attempt to understand his history. I will not be surprised if this chapter becomes a valuable, widely used teaching text.

Susan Lipshitz-Philips effectively follows Roys' theme in that she describes the way that early loss has been dealt with by her patients. She emphasizes that knowledge alone of the facts of those losses will not help. Rather it is the way that the patient repeats in the transference the unconscious anxieties and object relationships which will allow the rebuilding of emotional links that have hitherto been missing (lost, split-off or projected). Like Ruszczynski, in a later chapter, Lipshitz-Philips emphasizes that it is the rebuilding of emotional knowledge, not intellectual knowledge, that is crucial to the good analytic work. Lipshitz-Philips includes a thought-provoking, insightful study of Thomas Hardy's *The Well-Beloved* seen from the viewpoint of the subject's restless search for a replacement for an early, lost, idealized maternal object.

Jessica Sacret tackles the criticism that the Kleinian approach pays little or no attention to the way that the external world impinges on and determines intrapsychic development. She gives the historical reasons why this criticism has been made as being due to the emphasis placed by Klein and her immediate followers on the presence and significance from birth of unconscious fantasy and destructiveness. She shows how there has been a gradual change in that many subsequent followers of Klein (particularly Bion) have taken into

account the effects of external events – traumatic and non-traumatic. Sacret nevertheless argues that what remains central to the Kleinian method is the interpretation of the way that the patient's fantasies are projected on to actual external events, which are then used as receptacles for these fantasies. Like Roys she makes the point that it is the interplay between traumatic events and the patient's internal world that is crucial to the structuring of the infant mind. Sacret (again like Roys) emphasizes the importance of projective identification and its containment through counter-transference as a way of understanding the nature of this interplay.

There is a noticeable similarity between Sacret's thinking in her chapter and that of Berkowitz in the 'Independent' volume. In keeping with the renewed psychoanalytic interest in trauma, both authors, with their different viewpoints, focus on its effects on the developing mind and on the importance of the therapist being able to process and contain projections in the counter-transference so as to avoid retraumatization through disbelief.

Again, too briefly to do them justice, I will mention the other contributions to this volume. Mary Adams uses her work with a particular patient to illustrate the way that a patient may defend himself or herself against knowledge of the facts of life and death, through the denial of reality. This theme of acceptance of the facts of life is also the one pursued by Stanley Ruszczynski. He gives a satisfying, clear account of the way that Kleinian thinkers have developed Freud's ideas about the importance of the child's curiosity about itself in relation to its parents, into a crucially important set of ideas about the wish to know, and defences against what might be known. He shows how he welds the ideas of the main Kleinian authors into a whole. Ruszczynski then uses this to understand the impact of his patients' projections on him as they fight either to deny or to accept the 'emotional knowledge' of Oedipal, generational reality and the 'triangular space' of child–mother–father.

Noel Hess' subject is the internal world of patients whose personalities and lives have been dominated by depression. Like Judy Cooper in the 'Independent' volume, he is realistic about the limitations of psychoanalytic psychotherapy. He says that psychoanalytic work with the sort of patient he describes will be effective only if the therapist is able to help the patient find the 'inner foundations of love, hope and goodness that may appear to have been lost, fragmented or destroyed' (p. 134). Hess places great emphasis on the essential work of mourning for and repairing the damage done to the lost objects of infancy.

Jean Arundale writes about a paedophiliac. Her understanding is that her patient uses the perverse sexual act to regulate his self-esteem and to avoid psychic disintegration. The boys he uses sexually represent his idealized child self. She places at the centre of this work an understanding of aggression, which arises from unresolved omnipotence (as a defence against castration anxiety). Arundale does not exclusively use Kleinian ideas. She builds on the work of Stoller, Glasser and McDougall as well as that of Freud and Klein, and

the comments she makes to her patient reflect this. Her chapter would not have looked out of place in the 'Independent' volume.

Evelyn Katz takes the termination of therapy as her topic. She says that 'If we accept that, unlike medicine, psychoanalysis does not provide a "cure" for illness, how are we to know when the work is done?' (p. 154). She looks at various answers to this question, from Freud's ideas about the aim of psychoanalysis being to help the patient reach a state in which he may work and love, to Steiner's thoughts about the patient needing to reintroject split-off and projected aspects of the self.

It seemed clear to me that the same patient would have a very different experience with each of the seven authors of the 'Independent' volume. In contrast I was struck by the thought of how similar, even allowing for individual differences of personality, the experience of a patient might be with each of the eight Kleinian therapists. (I do not intend to imply this is a bad thing.)

These two books represent a landmark. Both books succeed in their task. Indeed the editors have served well both the British Association of Psychotherapists and the history of psychoanalytic psychotherapy. I think both volumes deserve to be widely read, discussed and compared. I think they are likely to become a benchmark against which any subsequent, similar collections will be measured.

SIMON ARCHER

Jungian Thought in the Modern World

Edited by Elphis Christopher and Hester Solomon
London, Free Association Books, 1999, pp. 277, pbk £16.95

This impressive and important book places Jung's theories appropriately into the present and even the future culture of ideas, understanding and beliefs.

The well-chosen cover shows a remarkable photograph taken in the High Energy Laboratory of CERN in Geneva, Switzerland. When the Atom Smasher bombards an atomic nucleus with high-energy particles, the analysis of the resulting spray of debris allows observers to determine the architecture of the objects under consideration. The experimental results suggest that it is more useful to hurl small particles at the object that one wants to explore, rather than the equivalent of rocks; with small particles one can build a more sophisticated picture of the object under examination. Large rocks could actually break and obliterate it.

Given so many similar, or parallel, ideas and attitudes between Jung and modern physicists, it is not surprising that Jung hoped that physics and

psychology would come one day closer together and be recognized as giving alternative descriptions of the same reality. This hope may have led to Jung's collaboration with the quantum physicist Pauli, and may been furthered by their collaboration.

The authors in this collection of papers have aimed to present and bring to light those qualities that are implicit in Jung's work, and need to be shown as central to it. And they have shown how close Jung's researches and his thinking are to some of the central ideas of modem post quantum mechanics. Indeed, on first examination, they seem to be complementary to the latest developments in super-string theory, which promises to bridge the uneasy and puzzling gap between the relativistic universe of Einstein and the probabilistic world conjured up by Schroedinger's quantum mechanics. If it all turns out to be a question of harmony, vibration and resonance (and not just in four dimensions but in a mind-boggling 11 dimensions), then, in this respect, Jung and Pauli, with their concept of synchronicity, were, and still are, truly far ahead of their time.

It seems to me to have been a valuable decision to have made Warren Coleman's 'Models of the Self' the first chapter of the book, because it is an excellent guide to those ideas of Jung that support the conviction that he is indeed a 'modern' if not a 'postmodern' thinker. As Coleman shows, Jung's works really place him in the 21st century. It was Jung who first proposed to Freud that all those who wanted to become psychoanalysts should themselves undergo a personal analysis. This seems to suggest that, like quantum physicists, he also had recognized the potential and powerful effect that the observer can have on the observed. After all, the analyst responds to the patient in terms of his own perceptions: but these may have been distorted by personal and unconscious complexes.

In his article, Coleman emphasizes that when Jung describes and talks about psychic structures and contents, he considers them primarily as 'processes'. Thus he eschews attempts to reify them or to represent them as objects, as parts, as particles, as objects that have definite and permanent qualities, characteristics or boundaries. Such a conception of psychic structures and functions is essentially dynamic; it inevitably involves an expectancy of randomness. It also leads to a re-evaluation of the experience of 'not knowing'. For 'not knowing' is potentially realistic because it inches one forward towards one's acquaintance with reality and with truth, which can never be static or permanent. Professor John Casti, a physicist and mathematician, suggests that science's most distinguishing characteristic is that it is always tentative; that any theory represents 'our best guess at the moment as to how the world operates'. But these guesses are continually revised in the light of new observable evidence: 'Theories are created to be replaced.' Such a realization makes a person available to doubt, and so it stimulates the capacity to accept uncertainty and to tolerate and to seek out

open, rather than closed, systems. In fact, Jung himself had expressed some suspicion of theorizing, sensing perhaps the danger that narcissism and fear of uncertainty might lead people to resist change – the new, the unfamiliar.

I want to mention here especially those authors, and their papers, that seem to be relevant to the points that I have made so far. In fact, they have stimulated my thinking and understanding and I hope that this will be the effect also on future readers. This book may also help to explain the great interest and preoccupation with Jung to a wider contemporary public.

One of the points in this volume that may astonish many people is made by Michael Simpson, who was a zoologist before he trained as a Jungian analyst. He notes in his chapter 'Creative Life in a Scientific World' that: 'Some parapsychologists and physicists are working actively on possible meeting points between parapsychology and quantum mechanics.'

Helen Morgan discusses directly the relationship of analytical psychology and the new physics, in particular quantum theory. She describes this clearly and carefully and then relates it to psyche, to mind: 'Ever since the observer began to be a factor in the behaviour of quantum reality, the nature of consciousness has been seen as an appropriate and necessary subject of enquiry for scientists' (p. 120).

Both John Clay, discussing literature, the arts and creativity, and Dale Mathers, writing about spirit, spirituality and religion, highlight the fact that men and women experience an archetypal, compulsive need to find meaning and purpose, and they recognize that symbols function to transform the ordinary, the everyday, into the meaningful.

Hester Solomon's paper 'The Ethical Self' is most thought-provoking. She deals with the important theme of ethics, a subject not sufficiently discussed in the literature, although it is intensely relevant to therapy and therapists. This is in fact beginning to be recognized, as became evident at a recent conference of the Jungian Anglo-French-Belgian group. In the paper Solomon aims to explore the origins of the ethical attitude which she sees in the interaction and interdependence of nature and nurture, of inborn ethical thinking and behaviour – in and through the self – and through the processes of socialization – that is, relationship with other beings. In other words, the ethical attitude is multi-determined, the result of the impact of both innate and environmental influences. This is a rich chapter, drawing on analytical and developmental theories. But Solomon also emphasizes the importance of Jung's concept of the shadow and reminds us that the concept of the shadow is indeed central to Jung's understanding of the self as an ethical entity (p. 199).

This book will go a long way to establish the potency of Jungian ideas in the modern – indeed the post, postmodern – world.

ROSEMARY GORDON

Child-Focused Practice, A Collaborative Systemic Approach

By Jim Wilson
London, Karnac Books, 1998, pp. 150, pbk £14.95

Jim Wilson is an experienced and well-respected family therapist based at the Family Institute in Cardiff. This book arises from his concern that:

> family therapy theories have considered children as objects rather than as subjects of their own concerns. Children are referred to variously as 'parentified child', 'scapegoat', 'mediator', or 'go-between', defined according to a conceptual framework in terms of their role or function within the family and the frame of reference of the therapist. (p. xviii)

His premise therefore is that:

> it is both possible and therapeutically useful to create ways of talking *with* (as well as about) children which challenge some methods of family therapy yet remain consistent with developments in systemic and related theories. 'Talk' here includes both spoken as well as non-verbal, action-oriented, and age-appropriate ways of communicating with children ... and adolescents. (p. xix; emphasis in original)

Wilson's experience and playfulness certainly come through in this book. One really gets a sense of what it must be like to be a child in a room with him. Although there are some references to theory which he sets out in the first chapter on 'A Framework for Child-Centred Practice', the strength of the book is in its practically based discussion of techniques and ideas about communication. There are useful chapters on 'The Child in the Therapeutic Context: Convening and Consulting with the Significant People'; the importance of 'The First Encounter'; and 'Child-focused Questioning'. An interesting section on 'Playful Dramas for Serious Problems' examines Wilson's ideas of 'playful mind-reading' – where the therapist speaks up for the child in order to facilitate communication with parents; 'mini-sculpting', which has been developed from the technique of 'sculpting' but which uses symbols rather than the people themselves to represent family members and other significant people in children's lives; and 'therapeutic rituals' where 'celebrations' or 'rites of passage' are encouraged in families to assist in moving children on developmentally when they have become stuck. Wilson devotes a whole chapter to his ideas on 'Forms of Writing'; there is a trouble-shooting section on 'Preoccupying Questions'; a summary of the first findings of a research project at the Family Therapy Institute, which invites the views of parents and children on treatment; and an 'Appendix' where Wilson outlines a number of training exercises to familiarize practitioners with the ideas in the book.

Throughout, one is struck by the writer's insistence on attending to the 'competence and resourcefulness' of both the child and his or her family.

Conflict between parents and children is dealt with sensitively, placing the emphasis on improving communication rather than taking sides.

I understand that Wilson is an eloquent and dynamic speaker on child-focused work, encouraging childcare workers from different fields first to think about the need to involve younger children in discussion, and second to develop the confidence to be creative and experiment. One family therapist colleague has described to me how Wilson stimulates practitioners to 'find the child inside and allow that inner voice to come through'. I imagine that all readers of this book will concur that the writer effectively succeeds in his aims to give weight to the voice of the child in the context of family therapy, and to convince workers that it is not 'really a heresy to see children on their own as a family therapist'.

So what might child psychotherapists usefully learn from Wilson's ideas?

In the Editors' Foreword, David Campbell and Ros Draper suggest that 'the book seems to combine techniques of child psychotherapy with those of family therapy – two approaches which too rarely discover common ground!' I was struck by the exclamation mark here. It is perhaps fair to say that in some multi-disciplinary settings the two approaches have had the tendency to compete as rivalrous parents for the attention of their 'offspring' patients/clients. I was keen to consider ideas from Wilson's family therapy perspective: and particularly interested to see whether his book might draw on the kind of thinking which child psychotherapists can bring to the subject of communication with children.

I think the book gets closest to this thinking in the acknowledgement of Winnicott's contribution, which Wilson characterizes as the 'playful domain'. The subchapter which deals with the use of metaphor – 'as-if' communication – effectively discusses how the practitioner can tackle potentially conflictual issues symbolically, and thus in a less anxiety-provoking way for the child. Wilson's example of a game of conkers to enable two brothers to explore their aggressive relationship is a poignant exposition of distance regulation between siblings. His idea of using letters to allow a child (or especially an adolescent who may be even more inhibited about communicating worries) 'to become an observer of his own thoughts' is another creative application of metaphor – and one I have certainly used myself with an anxious patient.

At other moments also Wilson touches on areas which a child psychotherapist may recognize – for example, he suggests that 'the therapist's reaction may be significantly different from the feared response anticipated by a child', something which I have found useful to think about as 'pre-transference'. A further example is when Wilson describes how 'the therapist practitioner is partly observing and also contributing from the "inside", listening to himself reflect on the overall picture of the child-family-therapy system'. At such moments I find myself wondering if Wilson knows about the concept of counter-transference, and whether this is something he wants others to know about without being able or wishing to say where it comes from – that in fact, it is something very useful that those child psychotherapists do know about.

Through reading this book I have realized that there is a difference

between a 'child-focused' approach which aims to consider children as subjects, not objects, and a psychodynamic one which gives weight to the notion of *internal* object-relations. Nevertheless, I am left wondering whether Wilson's suggestion that, in child-focused practice, the relationship with the therapist is not 'the main medium for healing', underplays the importance of what child psychotherapists might call 'the therapeutic alliance' which the writer has so effectively constructed in the examples he gives.

This brings me to a concern I have about the book – which I found both enjoyable and edifying – from the point of view of a child psychotherapist. In the introduction Wilson quotes from a participant at a family therapy conference who asked, 'How can we justify doing individual work with children in a mental health service in which child psychotherapists see this as their territory?'

I have to confess to a rather defensive response to this remark. I began to wonder whether child psychotherapists *are* territorial about such work, or whether that is just how we are perceived, or whether it is perhaps not such a bad thing if we are perceived in this way. I thought about my own practice in a multidisciplinary team where I believe distinctions *are* made between whether a child needs individual work, for example with an art therapist, or psychoanalytic psychotherapy. I considered the value that colleagues from other disciplines place on the thinking of child psychotherapists when they ask for supervision of their work with individuals or groups of children.

I wonder whether my defensiveness is connected to the trend, increasingly present in child and adolescent mental health teams, towards 'evidence-based practice' and away from psychoanalytically grounded treatments. In this climate it is of crucial importance that child psychotherapists do continue to find ways of engaging generously with family therapy and other colleagues about what we can offer each other and our patients, without losing sight of our unique contributions.

JULIA MIKARDO

Cruelty, Violence, and Murder: Understanding the Criminal Mind

By Arthur Hyatt-Williams
London, Karnac Books, 1998, pp. 350, pbk £22.95

Hyatt-Williams' book is the culmination of 20 years of psychoanalytic work at Wormwood Scrubs prison, where he treated both ordinary criminals and murderers serving life sentences. In his work he applies the discoveries of Melanie Klein and Wilfred Bion's model of thought development to offer a special understanding to the dynamics involved in the potential murderer.

The book is a well-knitted collection of papers, which Dr Hyatt-Williams prepared during the course of his work over the years. For those readers who are not acquainted with the author, Hyatt-Williams is a senior psychoanalyst,

past Chairman of the Adolescent Department of the Tavistock Clinic and Director of the London Clinic of Psychoanalysis. An analysand of Melanie Klein and Hanna Segal, the author teaches extensively in this country and abroad both on criminality and on the work of Bion. The papers in this book are selected and edited by Paul Williams to show the development of the main theme of Hyatt-Williams' research, namely the evolution of what he terms the 'death constellation' and its derivatives.

His book is divided into five parts. Part I involves the definition of the death constellation and its various facets. Part II deals with aggression, brutalization, cruelty and latent murderousness. Part III discusses assessment and treatment issues and the micro-environment surrounding criminality. Part IV deals with severe offenders, criminal chronicity and chronic deviance, and Part V studies death forces in adolescence and in illness, including an interesting analysis of Shakespeare's *Othello* to illustrate the interplay of the various manifestations of the death constellation.

Hyatt-Williams' central thesis is based on the premise of the existence of unmetabolized destructive forces leading towards the establishment of a death constellation in the psyche of the criminal. This is linked primarily to a failure of the psyche to evolve from the paranoid schizoid to the depressive position. The prelude to action comes from a state of part-object relationship. The author's main tenet in his understanding of aggression is that when psychic pain becomes unbearable, no reality testing can take place and the main effort by the psyche is to get rid of accretion of stimuli. This is accomplished either through immediate gratification or by getting rid of the need through destructive means.

Hyatt-Williams proceeds to set the theoretical basis in his work with criminals, namely, the mechanism of splitting off; the installation of a narcissistic organization; the inability to test reality and essentially the failure of the process of mourning. The mental apparatus of the criminal functions at a quasi-parasitic level and is unable to develop proper object relations. The author also lays down the foundations of the psychological forces that the analyst has to work with when dealing with these types of patients. Essential to this is the need to monitor the counter-transference.

He asks the question, why do some people attack and others do not? What mitigates the need for revenge and repetition of traumas in some, whereas others develop compassion and reparation? Hyatt-Williams answers these questions by considering the existence of a split-off encapsulated death constellation in potential criminality. When the latter is triggered it leads towards an illusory feeling of well-being. The intra-psychic configuration of the potential perpetrator, which he calls the 'blueprint of murder', can be therapeutically worked through and thus decrease the risk of a murder being committed.

Murderousness, according to Hyatt-Williams, is an evacuation of an indigestible fear of death. The potential murderer lacks a capacity to work through a murderous state of mind in fantasy life because of a lack of capacity to symbolize. Hyatt-Williams applies Bion's theories to show how the murderous

patient has a lack of an internal projective-identification-accepting object, and as a result the patient functions only at a two-dimensional level.

In describing the dynamics involved in latent murderousness. Hyatt-Williams reminds us that aggression has both a positive developmental function of survival, and a negative function which is egotistical and predatorish in nature. He shows the process of breakdown in the mind of the criminal. In times of crisis the mental apparatus gradually regresses from a state of depressive anxiety to persecutory anxiety resulting eventually in concrete thinking. The mind of the potentially violent individual harbours an undigested set of traumas which have been split off and encapsulated. This remains as an intra-psychic enclave that is potentially liable to fester well into the future. The aggravation of an explosive situation leads towards escalating violence because of difficulty in distinguishing between internal and external reality. A delusion takes place in which, through projective identification, the object is blamed for the pain experienced. The criminal then attempts to physically get rid of the enemy.

Risk of acting out depends on three variables. The first is the level of death constellation in the psyche of the individual, the second is the capacity of the individual to detoxicate and therefore diffuse the death constellation and the third is the level of pressure on the individual by the outside reality. The wider the polarization in the splitting at an early level for the baby, the more difficult will be the task of bringing the split objects together and working through the depressive position. The death constellation remains explosive unless the crimes committed in mind have been brought to awareness and thought about. The potential murderer lacks a good internal object, which can 'name' the toxicity involved. A central aspect of the therapeutic change is to help the patient develop an internal container that can mentalize and therefore detoxify the murderous unconscious fantasy. In hardened criminals, the situation becomes much more difficult because there is an actual crime that needs to be expiated and mourned.

Hyatt-Williams gives vivid examples of what he terms 'manic cruelty', where the main aim is to control or master the threatening situation through denial, triumph, splitting and omnipotence. Debrutalization or humanization requires a painful tolerance of the self's brutal tendencies, and to be able to bear guilt.

It is very common for psychosomatic symptoms to appear at this stage of treatment, signalling that the mental apparatus is not ready yet to negotiate the conflicts experienced internally. The apparition of somatization is usually indicative of progress in the mental life of the psychopathic character.

In an interesting clinical presentation of a family in therapy, Hyatt-Williams examines the micro-environment in which violence festers, that is, the family. He highlights the interplay between projective identification and manic defence and shows how a family acts as a system aimed at avoiding depression through omnipotence and scapegoating. One member of the family, in this case the son, is set up to be the agent of the family's aggressiveness,

both as its recipient and as its vehicle. The son functions on a masochistic level by deriving pleasure from the attention he gets from the family.

Hyatt-Williams devotes the final chapters of the book to investigating other areas in psychosocial life, such as adolescence, life-threatening illnesses and power structures, demonstrating paths that the death constellation can take, other than criminality. The author enumerates the factors that are instrumental in creating a personality where play and reality are confused and in which the death constellation prevails. Underlying an intolerance of frustration is a lack of a projective identification containment caregiver, and, more importantly, a caregiver that projects into the child his or her own persecutory and delusional ideas. In adolescence the death constellation can lead, for example, towards promiscuity, nihilism and drug addiction.

Touching on psychosomatics, the author demonstrates with clinical examples the close connection between guilt-ridden states of mind and the occurrence of illnesses. Hyatt-Williams clearly shows how, when the individual is unable to digest his own guilt and is deprived unconsciously of a proper container for his emotions, he projects the unresolved conflict into his own body, sometimes resulting in grave illness.

The book concludes with a chapter entitled 'Restoring the Balance'. Hyatt-Williams reminds us that the affect of the death instinct has no representation at first and only through the mother's reverie can it be retrieved mentally. The author puts forward the central argument that when death as a thought cannot be tolerated by the psyche, it has to be projected and subsequently concretely gotten rid of into someone else.

I found the book well written, clear, profound and humanistic. In this book, Hyatt-Williams makes an original contribution to the understanding of the dynamics involved in deviance, murderousness and addiction. In effect, the concept of the death constellation, based on undigested death instinctual forces and their derivatives, is an invaluable insight into understanding the workings of the death instinct.

Although at times seemingly repetitive, this reader found the book very instructive, not just from a theoretical point of view, but also for the many insights concerning early life and its consequences in the development of personality. It is suggested that the presentations are read carefully because each contribution, although sometimes simply stated, is the outcome of years of investigation and conceptualization.

I would recommend this book to experienced clinicians, trainees and social scientists. The author, in my view, stands together with Herbert Rosenfeld, Donald Meltzer and Hanna Segal in terms of his contribution to the application of the discoveries of Melanie Klein and Wilfred Bion to understanding severe pathology. This book ought to be regarded as a seminal work in the psychoanalysis of psychopathy. A highly recommended addition to our psychoanalytic library.

RICARDO STRAMER

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James HM (1960) Premature ego development: some observations upon disturbances in the first three months of life. *Int J Psychoanal* 41: 288–95.
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VOL 38, NO. 2, 2000
ISSN: 0954 0350

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