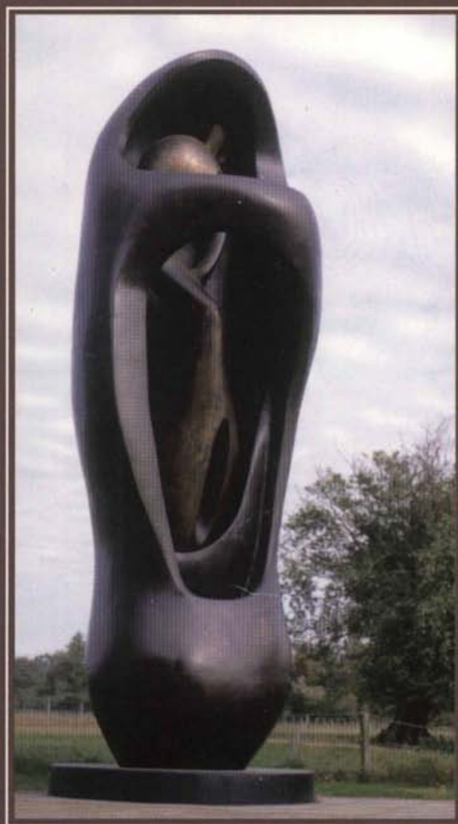
PSYCHOANALYTIC PSYCHOTHERAPY IN THE KLEINIAN TRADITION



Edited by

STANLEY RUSZCZYNSKI
and
SUE JOHNSON

KARNAC BOOKS

PSYCHOANALYTIC PSYCHOTHERAPY
IN THE
KLEINIAN TRADITION

Also edited by Sue Johnson & Stanley Ruszczynski
and published by Karnac Books:

PSYCHOANALYTIC PSYCHOTHERAPY IN THE INDEPENDENT TRADITION

PSYCHOANALYTIC PSYCHOTHERAPY
IN THE
KLEINIAN TRADITION

edited by
Stanley Ruszczynski & Sue Johnson

London
KARNAC BOOKS

The work illustrated on the front cover is reproduced by kind permission of the Henry Moore Foundation.

First published in 1999 by
H. Karnac (Books) Ltd,
118 Finchley Road,
London NW3 5HT

Copyright © 1999 by Stanley Ruszczynski and Sue Johnson

Arrangement and Introduction copyright © 1999 by Stanley Ruszczynski and Sue Johnson; ch. 1 copyright © 1999 by Philip Roys; ch. 2 copyright © 1999 by Susan Lipshitz-Phillips; ch. 3 copyright © 1999 by Jessica Sacret; ch 4 copyright © 1999 by Mary Adams; ch. 5 copyright © 1999 by Stanley Ruszczynski; ch. 6 copyright © 1999 by Noel Hess; ch. 7 copyright © 1999 by Jean Arundale; ch. 8 copyright © 1999 by Evelyn Katz

The rights of the editors and contributors to be identified as the authors of this work have been asserted in accordance with §§ 77 and 78 of the Copyright Design and Patents Act 1988.

All rights reserved. No part of this publication may be reproduced, stored in a retrieval system, or transmitted in any form or by any means, electronic, mechanical, photocopying, recording, or otherwise, without the prior permission of the publisher.

British Library Cataloguing in Publication Data

A C.I.P. record for this book is available from the British Library.

ISBN 978-1-85575-175-0

Edited, designed, and produced by Communication Crafts

Printed in Great Britain by Polestar Wheatons Ltd, Exeter

10 9 8 7 6 5 4 3 2 1

for Stella, Jamie, and Helen,
and Mike

ACKNOWLEDGEMENTS

We would like to sincerely thank all the authors for their chapters, often written in holiday time, or in precious free time, or between patients, teaching commitments, and other professional activities, whilst also trying to live life! We would also like to thank them for bearing with us both in our pressurizing of them and in our long silences as we tried to get on with the editing. We hope that they will be as pleased as we are with the end result.

We are very grateful to Cesare Sacerdoti and Graham Sleight and their team at Karnac Books for patiently waiting for this book and its sister volume, *Psychoanalytic Psychotherapy in the Independent Tradition,* published at the same time. Cesare Sacerdoti's sensitive but realistic understanding and forbearance of the shortcomings of psychotherapists trying to write, edit, and publish and his commitment to this project encouraged and sustained us. We are also indebted to Klara and Eric King for their skilful part in the production of these books.

We would like to thank those friends and colleagues who encouraged us and shared our excitement, and especially Faith Miles, who was particularly helpful in assisting us. We would like

to acknowledge the British Association of Psychotherapists, which trained us and which makes up an important part of our professional lives. We are especially grateful to our personal psychoanalysts and to those who supervised our clinical work during our training.

An earlier version of Philip Roys's chapter was published in *Reconstructing Infancy, Monograph No. 7, British Association of Psychotherapists,* 1996, under the title, "Reconstructing Infancy—A Kleinian View", and parts of it were published in the *Oxford Psychotherapy Society Bulletin, No. 26,* November, 1997.

On behalf of the contributors to this volume, we thank all of our patients, without whom this book could not have been written. We have made every effort to disguise clinical material so as to ensure anonymity and to use only that that is absolutely necessary for purposes of illustration. Through writing this book, the authors want to describe to colleagues their way of thinking about their clinical experiences. The purpose of this is to go on learning through developing theoretical understanding of, and therefore clinical work with, those people who come to our consulting-rooms.

CONTENTS

ACKNOWLEDGEMENTS vii

CONTRIBUTORS xi

Introduction 1
Stanley Ruszczynski & Sue Johnson

1 Recollection and historical reconstruction
Philip Roys 9

2 On the persistence of early loss and unresolved mourning
Susan Lipshitz-Phillips 39

3 Interrelationships between internal and external factors in early development: current Kleinian thinking and implications for technique
Jessica Sacret 55

4 "Turning a blind eye": misrepresentation and the denial of life events
Mary Adams 75

5 Tolerating emotional knowledge
Stanley Ruszczynski 93

6 Psychoanalytic psychotherapy for chronic depression
Noel Hess 117

7 Notes on a case of paedophilia
Jean Arundale 135

8 When is enough enough? The process of termination with an older patient
Evelyn Katz 153

REFERENCES AND BIBLIOGRAPHY 177

INDEX 189

CONTRIBUTORS

MARY ADAMS is an Associate Member of the British Association of Psychotherapists and has a full-time private practice of psychoanalytic psychotherapy. She is a member of the editorial board of the *Journal of the British Association of Psychotherapists*. She has published in psychotherapy journals.

JEAN ARUNDALE is a Full Member of and Training Therapist for the British Association of Psychotherapists and has a private practice of psychoanalytic psychotherapy. She is a Clinical Supervisor in the Psychology Department and at the York Clinic in Guy's Hospital, London, and teaches for the British Association of Psychotherapists and other psychotherapy trainings. She is the Editor of the *British Journal of Psychotherapy*.

NOEL HESS is a Full Member of the British Association of Psychotherapists and has a private practice of psychoanalytic psychotherapy. He works in the NHS as a Clinical Psychologist (Specialist in Psychoanalytic Psychotherapy) in the Department of Psychological Medicine and Psychotherapy, University College

Hospital, London. He is actively engaged in teaching for the British Association of Psychotherapists and other psychotherapy trainings. His publications and research interests include old age, depression, schizoid states, and the application of psychoanalytic thinking to theatre and film.

SUE JOHNSON is a Full Member of the British Association of Psychotherapists and has a full-time private practice of psychoanalytic psychotherapy and supervision. She had previously been employed part-time as a psychotherapist at the Brandon Centre for Counselling and Psychotherapy for Young People, London, where she worked with adolescents and their families. She teaches on a number of courses for the British Association of Psychotherapists.

EVELYN KATZ is a Full Member of the British Association of Psychotherapists and has a private practice of psychoanalytic psychotherapy and supervision. She works at the Student Counselling Service at King's College, University of London, providing psychotherapy for students and supervision to counsellors on placement. Previously she worked part-time as a psychotherapist at the Camden Psychotherapy Unit, London. She is involved in teaching for the British Association of Psychotherapists.

SUSAN LIPSHITZ-PHILLIPS is a Clinical Psychologist and an Adult Psychotherapist trained at the Tavistock Clinic. She is a Full Member of the British Association of Psychotherapists and has a private practice of psychoanalytic psychotherapy. She is actively engaged in postgraduate education within the British Association of Psychotherapists and is a Visiting Teacher at the Tavistock Clinic, London. Previously, she worked as a psychotherapist at the Camden Psychotherapy Unit, London, and has lectured on psychoanalytic theory at various universities and in South Africa. She has contributed to books and journals.

PHILIP ROYS is a Full Member of the British Association of Psychotherapists and has a private practice of psychoanalytic psychotherapy in Oxford. He is a member of the British Association of Psychotherapists' Psychoanalytic Training Committee. He

is Co-ordinator of the Isis Centre (Oxfordshire Mental Healthcare NHS Trust) in Oxford, which provides a community-based counselling and psychotherapy service and offers training and consultation to NHS and other professionals.

STANLEY RUSZCZYNSKI is a Full Member of the British Association of Psychotherapists and has a private practice of psychoanalytic psychotherapy. He is a Principal Adult Psychotherapist at the Portman Clinic (Tavistock and Portman NHS Trust), London. He is a founder Member of the Society of Psychoanalytic Marital Psychotherapists and for a number of years was a senior member of staff in the Tavistock Marital Studies Institute (Tavistock Centre), London, serving as Deputy Director and both Clinical and Training Co-ordinator. He is the editor of *Psychotherapy with Couples* (Karnac Books, 1993), co-editor (with James Fisher) of *Intrusiveness and Intimacy in the Couple* (Karnac Books, 1995), and the author of a number of book chapters and journal papers. He undertakes clinical teaching for the British Association of Psychotherapists.

PSYCHOANALYTIC PSYCHOTHERAPY
IN THE
KLEINIAN TRADITION

Introduction

Stanley Ruszczynski & Sue Johnson

For the purposes of this volume, what is meant by the "Kleinian tradition" is that clinical and theoretical orientation initiated by Melanie Klein, following on the work of Freud, but significantly developed by, in particular, Wilfred Bion, Herbert Rosenfeld, and Hanna Segal, and more recently by, amongst others, Betty Joseph, John Steiner, and Ronald Britton. The development of this line of thought is well summarized by Elizabeth Bott Spillius (1988, 1994), and its major theoretical and clinical concepts are comprehensively described by Robert Hinshelwood (1989, 1994).

The central theoretical concepts that inform the work of those practising in the Kleinian tradition are that of unconscious phantasy (Isaacs, 1948; Klein, 1958), the paranoid–schizoid and the depressive positions (Klein, 1935, 1946), projective identification (Klein, 1946)—especially as it has been developed by Bion and Rosenfeld to be understood as a form of communication (Bion, 1959; Rosenfeld, 1971)—the centrality of the oedipal situation (Britton, 1992b, 1998; Britton, Feldman, & O'Shaughnessy, 1989) and the theory of the container and the contained (Bion, 1962).

There are other important theoretical constructs (see Hinshelwood, 1989), but those mentioned here are probably the most influential for psychoanalytic psychotherapists who work in the Kleinian tradition.

It is relevant to note that these theoretical constructs bridge into clinical practice and are not only theoretically central but also help the clinician to think about the nature of the transference–countertransference relationship, the analysis of which is at the heart of contemporary psychoanalytic practice. Psychoanalysis has always grown from a fertile interaction between theory and clinical practice. Clinical experience comes to challenge the contemporary theoretical understanding and demands a development of that theoretical understanding so as to accommodate the emerging clinical experiences.

A vivid illustration of this theoretical and clinical interplay is the way in which Kleinian concepts—especially that of projective identification (Klein, 1946)—were used in the late 1940s and 1950s by clinicians such as Bion, Rosenfeld, and Segal to work psychoanalytically with borderline and psychotic patients, without significantly adapting their technique. As a result, there developed the need for yet further theoretical understanding of the psychotic parts of the personality. It soon became clear that this theoretical development was necessary for understanding not only the more severely disturbed patients, but also the more primitive aspects of those patients who would not be so considered.

More recently, clinical experience with narcissistic and borderline patients has led to the development of the concept of pathological organizations of the mind (Joseph, 1975, 1982; O'Shaughnessy, 1981; Rosenfeld, 1964; Segal, 1972). Steiner uses the evocative description of "psychic retreats" in his discussion of this complex and rigid psychic structure, developed by certain patients as a defence against both the fragmentation of the paranoid–schizoid position and the pain and mourning required by the move towards the depressive position (Steiner, 1993). Such psychic structures function defensively but also produce particular states of mind where, because the "bad" parts of the self are in the ascendancy over the "good" parts, considerable relief and pleasure is gained from pathological and perverse object relationships. This understanding of "negative narcissism" (Rosenfeld,

1971a) has proven to be extremely useful clinically with a broad range of patients who are often experienced as rigid, perverse, and difficult to treat. The concept has also been extremely useful in helping the understanding of very disturbed couples in psychoanalytic couple psychotherapy, who, on the basis of this rigid and pathological object-relating, established a near-impenetrable sado-masochistic relationship, which Mary Morgan has evocatively called a "gridlock" (Morgan, 1995). The theoretical value and clinical usefulness of this understanding of such pathological organizations of the mind is clearly demonstrated by the regularity with which many of the authors in this volume refer to it in their discussions.

Following on the work of Freud, who referred to the "abnormal ego" and "psychotic part" of every normal person (Freud, 1937), psychoanalytic psychotherapists influenced in their thinking by Klein have been very interested in the relationship between different parts of the personality. Klein's concepts of the paranoid–schizoid position and the depressive position have been central to thinking not only about different parts of the mind but also about how an individual will throughout life—including in the analytic relationship—oscillate between more and less mature aspects of their personality. This is especially important in following the details of the transference relationship as it is enacted in the therapeutic encounter. This understanding, together with an understanding of the process of projective identification both as a defensively evacuative process and as a means of unconscious communication, make up the heart of clinical practice. The container–contained conceptualization offers an understanding of the means whereby the psychoanalytic psychotherapist can play his or her part in the psychotherapeutic relationship (Bion, 1962b).

The chapters contained in this volume all, in their different ways, address these core concepts, as well as raising a number of others.

In Chapter 1, "Recollections and Historical Reconstruction", Philip Roys outlines the Kleinian understanding of infantile development and shows how this informs clinical practice with the adult patient in intensive treatment. He refers to many of the concepts that are further elaborated by the writers of the subsequent chapters. Roys reminds us that Klein's delineation of the para-

noid–schizoid and depressive positions is a description of states of mind rather than of developmental stages, and he shows how the clinician may be able to observe and experience, in the transference–countertransference relationship, the way the patient constantly oscillates between these positions. Using detailed clinical material, Roys demonstrates how an analysis of the contemporary interaction between therapist and patient leads to the reconstruction, in the clinical encounter, of infantile anxieties and defences. He goes on to show how an understanding of these anxieties and defences leads to insight into the ways in which they inform the internal and external world of the patient.

In Chapter 2, "On the Persistence of Early Loss and Unresolved Mourning", Susan Lipshitz-Phillips takes up a similar theme by revisiting Freud's concept of the repetition compulsion (Freud, 1920g), especially in relation to the centrality of the experience of loss, in its many guises, and its influence on development. Lipshitz-Phillips shows how potent a force loss very often is, be it a loss such as that experienced on the birth of a sibling or the crippling premature loss of a mother. Using both clinical material and illustrations from literature she shows how various defensive arrangements can be made to ward off knowledge of the losses suffered. However, her argument is that in the transference relationship to the psychotherapist the residue of these unresolved losses will reappear and will need to be resolved so as to give the patient an opportunity to go on developing.

In these two chapters there is both implicit and explicit reference to the complex interaction between the internal world of the child and adult and the external reality within which they find themselves living their life.

In Chapter 3, "Interrelationships Between Internal and External Factors in Early Development: Current Kleinian Thinking and Implications for Technique", Jessica Sacret takes the reader to the heart of that which is often considered to be one of the central differences between psychoanalytic schools of thought: the place given to internal and external reality in the understanding of an individual's growth and development and current object relationships. She demonstrates how Kleinian thinking has developed, especially since Bion's seminal delineation of the containing function of the mother (Bion, 1962a, 1962b), to a clearer and more

detailed picture of the complex dynamic interrelationship between the internal world and external reality. Using the particular situation of trauma, both in its more dramatic form such as disasters and gross abuse and in its more subtle form such as failed maternal containment, Sacret shows that pathological organizations of the mind may be constructed to defend the patient against the psychic impact of external realities as well as against the ravages of internal fears and phantasies. An attempt to understand the inevitable and intricate interrelationship between the two is central to Sacret's chapter.

Klein and those who followed after her put an emphasis on the ways in which the internal world, with its expectations and projections, significantly influences the perception of the external world. However, though this emphasis influences both theoretical understanding and clinical practice, Klein herself, as well as those who followed her, clearly included the reality of the external world in their understanding of the development of the infant mind and object relations. Klein described how, "an inner world is . . . built up in the child's unconscious mind, corresponding to his actual experiences and the impressions he gains from people and the external world, and yet altered by his own phantasies and impulses. If it is a world of people predominantly at peace with each other and with the ego, inner harmony, security and integration ensue" (Klein, 1940, p. 345–346). She goes on to add that "unpleasant experiences and the lack of enjoyable ones, in the young child, especially lack of happy and close contact with loved people, increase ambivalence, diminish trust and hope and confirm anxieties about inner annihilation and external persecution" (Klein, 1940, p. 347). In summary, she writes, "from its inception analysis has always laid stress on the importance of the child's early experiences, but it seems to me that only since we know more about the nature and contents of its early anxieties, and the continuous interplay between its actual experiences and its phantasy-life, can we fully understand *why* the external factor is so important" (Klein, 1935, p. 285).

In Chapter 4, "Turning a Blind Eye: Misrepresentation and the Denial of Life Events", Mary Adams describes the developmental struggle involved in coming to terms with certain "facts of life", namely dependence, the differences between the sexes and be-

tween the generations, and the inevitability of time and death (Money-Kyrle, 1968). She shows how these facts can be dealt with either by coming to tolerate them and so facing reality and diminishing narcissistic and omnipotent phantasies, or by misrepresenting them, specifically by lying to oneself. Using clinical material, she shows how misrepresentation may produce a form of delusional escape from facing the facts of life but how crippling to emotional growth such a defensive construction is likely to be. This understanding of how such perverse states of mind can develop is central to informing clinical work with many different types of patients.

In Chapter 5, "Tolerating Emotional Knowledge", Stanley Ruszczynski discusses the process of containment and locates its development in the experience of the nature of the relationship to, and resolution of, the oedipal situation. He shows how coming to tolerate the truly triangular nature of the oedipal situation is essential in developing the capacity for containment. This requires the mourning of the loss of the phantasied sole possession of the mother or the father, and coming to tolerate the special link between the parents (Britton, 1989). He argues that containment requires both receptivity and reflection on the part of the psychoanalytic psychotherapist, capacities analogous to those that might be considered to be respectively the female and the male functions. It is when the two can be allowed to come together that there will most probably be an opportunity for understanding and hence development and growth. Britton has recently delineated this by differentiating between what he calls subjective and objective awareness of experience. He shows how either form of awareness, alone, will be partial and defensive, but that the capacity to tolerate both will lead to knowledge, both of the self and of the other (Britton, 1998).

The next two chapters address particular pathological conditions, some form of which is likely to be familiar to most clinicians in their daily practice, namely that of depression and perversion (in this case, paedophilia).

In Chapter 6, "Psychoanalytic Psychotherapy for Chronic Depression", Noel Hess addresses what he suggests is the most common complaint presented by patients, and he goes on to suggest that what patients refer to as "depression" is likely to cover a

variety of underlying pathologies with a spectrum of severities. His chapter is a detailed exploration of intensive psychoanalytic psychotherapy with a patient who presents with a chronic condition, where the depression has infiltrated the structure of the personality, rather than being a more acute presentation of a depressive episode in a previously reasonably well-functioning person. Touching on some of the ideas also discussed by Susan Lipshitz-Phillips in Chapter 2, Hess refers to the centrality of the experience of loss and the mourning required as part of its resolution. He shows how these are common to all forms of depression, whatever the degree of severity. He discusses both Freud's and Klein's seminal writings on melancholia and mourning (Freud, 1917e; Klein, 1935, 1940) and, following Klein, argues that mourning in adult life unconsciously reawakens infantile losses in relation to the primary maternal figure and all her functions. How this loss of the internal mother has been dealt with during the course of normal development will determine the process of mourning following a real external loss in adulthood.

In Chapter 7, "Notes on a Case of Paedophilia", Jean Arundale gives a vivid and detailed account of psychoanalytic psychotherapy with a severely disturbed patient who presented himself for treatment disturbed by the fact that he regularly entertained fantasies of sexual activity with underage males. The aggression at the heart of all perverse fantasy and activity became central to the therapeutic work with this patient, and Arundale clearly illustrates Stoller's, and others', understanding of sexual perversions being the "erotic form of hatred" (Stoller, 1976). As the clinical work developed with this patient, the despair and desolation often underlying such pathology began to emerge and become available for treatment.

In the final chapter, Chapter 8, "When Is Enough Enough? The Process of Termination with an Older Patient", Evelyn Katz discusses the process of termination, both in general—*all* psychotherapeutic treatments come to an end, be it planned or precipitate and premature—but specifically, in detail, termination with an older patient. She suggests that termination with this group of patients might have particular implications, and she reviews the literature on criteria for ending treatment as part of her discussion. She shows, however, that the capacity for more realistic and

therefore depressive functioning continues to be the aim of the psychotherapeutic treatment of all patients, whatever stage of life they might have reached.

All the chapters in this volume address the individual patient's struggle to come to know and tolerate some of the indisputable facts of life, including dependency, the double difference between the sexes and between the generations, the true nature of the triangle of the oedipal situation, the life-long oscillations between the paranoid–schizoid and the depressive states of mind, and the inevitability of loss. It is indisputable that there is often a range of internal forces organized in order that this knowledge be evaded, and it is, therefore, necessary for this internal saboteur to come to be known as well. This illustrates Bion's view that "knowledge" is the third factor of psychic life, alongside those of "love" and "hate". Freud had already alerted us to this in one of his final papers, "Analysis Terminable and Interminable", where he writes that, "we must not forget that the analytic relationship is based on a love of truth—that is, a recognition of reality—and that it precludes any kind of sham or deceit" (Freud, 1937c). This recognition of emotional reality, the gaining of knowledge and insight, has always been a central aim of the psychotherapeutic practice of psychoanalysis. The writers of the following chapters show how they go about promoting this in their daily clinical practice.

CHAPTER ONE

Recollection and historical reconstruction

Philip Roys

Writing in 1937, Freud commented that "the work of analysis aims at inducing the patient to give up the repressions . . . belonging to his early development and to replace them with reactions of a sort that would correspond to a psychically mature condition. With this purpose in view, he must be brought to recollect certain experiences and the affective impulses up called by them which he has for the time being forgotten" (Freud, 1937, pp. 257–258).

That such recollection is central to psychoanalytic psychotherapy there can be no dispute, but there are different points of view about what precisely might be recalled and how this should be achieved; in particular, historical reconstruction tends to be approached differently by contemporary Kleinians and those of other orientations.

In this chapter, I intend to explore contemporary Kleinian technique in psychoanalytic psychotherapy, with particular reference to the question of historical reconstruction. I shall suggest that it is possible to delineate a distinctively Kleinian approach to historical

reconstruction which follows from the Kleinian account of the development of mind and of its functioning.

Kleinian thought seems to have acquired the reputation of being difficult to understand. In part, this may result from the fact that much of its concern is with primitive experience that, by its very nature, is remote from adult experience and thought. But I think that, in addition to this, there may be something in the nature of the account that is provided—a dynamic, constantly moving picture—which can make it complex and troubling. I shall, therefore, begin by attempting to clarify some basic concepts, in the hope that this will facilitate clearer understanding of what follows.

Unconscious phantasy

A central concern of Kleinians is with the internal world. Melanie Klein "created a revolutionary addition to the model of the mind; namely, that we do not live in one world but in two—that we live in an internal world which is as real a place to live as the outside world" (Meltzer, 1981, p. 178).

Now, the important point here is not that as an outside observer it is possible to describe the contents of the mind of another objectively, but that we all have an awareness (albeit unconscious) of important things going on inside us.

At the deepest level of the mind, this awareness exists as unconscious phantasy. "An unconscious phantasy is a belief in the activity of concretely felt 'internal' objects" (Hinshelwood, 1989, p. 34). Hinshelwood provides a clear illustration: Take, for example, the infant who is hungry. His bodily sensations given by his physiology are also experienced subjectively and psychologically. The discomfort is attributed to the motivation of a malevolent object actually located in his tummy that intends to cause the discomfort of hunger. A *good* internal object is experienced when the infant is fed and feels the warm milk giving satisfying sensations in his tummy (Hinshelwood, 1989, pp. 34–35).

The concept of unconscious phantasy, then, "being the mental representation of instinctual impulses is the nearest psychological

phenomenon to the biological nature of the human being" (Hinshelwood, 1989, p. 34) and thus provides a link between biology and psychology. At the most primitive levels, unconscious phantasy is experienced by the individual in terms of objects that are felt to be concrete (as having a real existence inside or outside) and are believed to have good and bad motivations (towards the subject).

But there is much more to unconscious phantasy than the recognition of good and bad objects. "In the mental development of the infant... phantasy soon becomes also a means of defence against anxieties, a means of inhibiting and controlling instinctual urges and an expression of negative wishes as well" (Isaacs, 1952, p. 83).

Over time, this phantasy world of objects and of the relationships between them develops. "Growth and evolution of an individual are due not only to physiological growth and the maturation of the perceptual apparatus—memory, and so on—but also to accumulated experience and learning from reality. Learning from reality is, in turn, connected with the evolution and changes in phantasy life. Phantasies evolve. There is a constant struggle between the infant's omnipotent phantasies and the encounter of realities, good and bad" (Segal, 1991, p. 26).

In many ways, the concept of the internal world with its unconscious phantasy life and objects is rather mysterious and difficult to grasp. Everyday expressions such as being "gnawed by hunger" or having "butterflies in the tummy" may be suggestive of an internal world of live objects, but in themselves these expressions are probably not convincing.

The evidence for the existence of this world of phantasy came initially from Melanie Klein's play technique, in which the play of a child was regarded in the same way as the free associations of the adult in analysis—that is, as demonstrating the unconscious phantasies active in the patient's mind.

Klein says:

> Take, for instance, the case of Ruth who, as an infant, had gone hungry for some time because her mother had little milk to give her. At the age of four years and three months, when playing with the wash basin, she called the water tap a milk

> tap. She declared that the milk was running into mouths (the holes in the waste pipe), but that only a very little was flowing. This unsatisfied oral desire made its appearance in countless games and dramatizations and showed itself in her whole attitude. For instance, she asserted that she was poor, that she only had one coat and that she had very little to eat—none of these statements being in the least in accordance with reality. [Klein, 1926, pp. 135–136]

But it is a long way from the unconscious phantasy life of the infant to that of the adult. It is to the development of the individual and the interaction between internal and external worlds that I now wish to turn.

The concept of position

In contrast to Freud, Klein held that from birth the infant has a rudimentary ego that experiences anxiety and takes measures to deal with this. This primitive ego utilizes defence mechanisms and forms internal and external object relations.

In considering the question of the development of the infant, Melanie Klein eventually moved away from Freud's scheme of libidinal stages (oral, anal, genital, etc.) and utilized instead a model that, via the concept of "position", emphasized the fluctuations and the dynamic quality of psychic functioning and development. The term "position" refers to a particular constellation of impulses, anxieties, and defences. Melanie Klein described two positions: the paranoid–schizoid and the depressive. These refer to two types of anxieties and the characteristic defences and object relationships that the ego employs to deal with these.

In one sense, these two positions could be seen as phases of development, the paranoid–schizoid position occupying the first three to four months of the infant's life and gradually being superseded by the depressive position. But this would be very misleading, for the depressive position never completely replaces the paranoid–schizoid position. As Segal argues: "the integration achieved is never complete, and defences against the depressive conflict bring about regression to paranoid–schizoid phenomena,

so that the individual at all times may oscillate between the two" (Segal, 1964, p. ix).

In utilizing the concept of position, therefore, Klein was not just describing infantile development; she was outlining two characteristic groups of anxieties and defences that persist throughout life. There is "a continuous movement between the two positions ... so that neither dominates with any degree of completeness or permanence ... we observe periods of integration leading to the depressive position functioning or disintegration and fragmentation resulting in a paranoid–schizoid state" (Steiner, 1992, p. 48).

What, then, are the characteristics of these positions, which form such an important part of the Kleinian model of the mind?

The paranoid–schizoid position

The paranoid–schizoid position refers to a group of anxieties and defences associated with an immature ego preoccupied with the question of its own survival. The infant is assailed by anxieties from within and without, which are felt to threaten its very existence. These anxieties and defences are experienced in terms of concrete unconscious phantasies such as those described above.

The immature ego takes steps to rid itself of bad experiences and to maintain good experiences by splitting itself and its objects into two parts, good and bad. The bad experience is projected outwards. But although the infant may have succeeded in diminishing a bad and threatening *internal* experience, a price has been paid. It is now faced with a persecuting *external* object as well as with whatever is felt to remain of the bad internal experience. This is the prototype of the persecuting object relationship.

At the same time, in an effort to foster good experiences, good parts of the self are projected to create an ideal object relationship.

The separation of good from bad and the desperate attempt to hold on to the good and get rid of the bad is one of the characteristic features of paranoid–schizoid functioning. The central anxiety is paranoid—a fear of being attacked and overwhelmed by hostile internal and external forces. The primitive defences employed to deal with this (splitting, projective identification, and idealization)

aim to keep the bad as far away as possible from the good. But although moments of idealization may be created, the sense of persecution will be in the background, ready at any moment to return to centre stage.

The paranoid–schizoid position is, then, characterized by a desperate struggle for survival and the complex phantasy world that is elaborated as the infant deals with primitive anxieties.

The external world

So far, the focus has been on the phantasies that the infant has about its impulses and objects and of its relationships with them. But what of the real external world? Does this have any impact, or, as is sometimes suggested, does the external environment have little significance in Kleinian thinking?

While it is certainly the case that a major preoccupation is with the internal world, it would be misleading to conclude that the external world has no importance in Kleinian thought. Rather, it is suggested that there is an interaction between the two, with the state of the internal world affecting the perception of the external world, but with the real external world shaping the state of the internal world. Thus, phantasies, which are projected, can either be confirmed and reinforced by the external world, or the external world can lead to their modification. Cycles of projection and introjection can move in a negative or in a positive direction.

To take a simple illustration, let us return to the example of the hungry infant. In an attempt to deal with the bad object felt to be inside him, he will tend to project this outside. He will then be faced with a persecuting outside world.

This begins a process, the outcome of which will depend upon the strength of the infant's rage and the qualities of the real object (in this case, the breast) in terms of its capacity to satisfy his hunger. If the infant's rage is not too great and the mother responds sensitively and soon enough, the bad object felt to be attacking the infant will be modified by the good object that has been presented to him. His phantasy will be changed in a positive direction.

If, however, his rage and therefore his persecutory phantasies are very strong and/or his mother fails to respond in time, then the outside world will tend to confirm his internal phantasies. The perception of a bad and persecuting world will be perpetuated. The screaming, hungry infant who turns away when the breast is offered may be seen as having had his persecutory phantasies reinforced. He has been faced with a breast that is terrifying rather than a good object capable of satisfying his needs.

The illustration above enormously oversimplifies the phantasy life of the infant and his efforts to deal with internal anxieties, instinctual urges, and the frustrations of external reality. What I hope it does convey, however, is something of the complicated interaction between internal phantasy and the external world, of how phantasy colours the perception of reality, and of how reality can lead either to its modification or to its reinforcement and confirmation.

The depressive position

How, then, does the infant move forward from the paranoid–schizoid position? The key issue is whether good experiences have sufficiently outweighed bad experiences. Under favourable internal and external conditions, at the age of about four to five months, the infant will gradually become convinced of the resilience of his good object and his libidinal impulses in the face of his bad object and his destructive impulses. There will therefore be less need to project bad parts outside, and the external world will therefore be less dangerous and persecuting. With a more benign internal and external environment, the need to split and project diminishes, resulting in a push towards integration.

The infant is now at the frontier of the depressive position, in which he comes to recognize that the same object that is capable of meeting his needs and wishes can also frustrate them and that he can feel both love and hate towards it. "This is not simply an enlargement of awareness and knowledge, but the disruption of the existing psychic world of the infant. What had previously been

separate worlds of timeless bliss in one ideal universe of experience, and terror and persecution in another alternative universe, now turn out to be one world. And they come, these contrasting experiences, from one source . . ." (Britton, 1992b, pp. 38–39).

In the depressive position, there is a shift from concern about the survival of the self to include concern for the internal and external good object. Feelings of guilt and of genuine concern for the object (and not merely for the gratification that it gives), if tolerable and tolerated, lead to a hope that all might not be lost after all, that some repair or reparation might be possible. "This is based on the sense of an internal world in which some goodness survives, whatever paroxysm of bad feelings sweep across it" (Hinshelwood, 1989, p. 148).

The working-through of the depressive position represents a major developmental milestone. If the painful "sense of distinction between self and object and between the real and the ideal object" (Britton, 1992b, p. 40) can be borne, the infant gradually enters a psychic universe in which he is able to accept reality (which can be painful and frustrating) and engage in symbolic thinking.

But the intense conflict engendered in the depressive position may be too much to bear. In this case, the experiences that cannot be faced will be avoided. Briefly, there are two main groups of defences that might be called upon—paranoid and manic. The use of paranoid defences involves a retreat from the threshold of the depressive position back to the paranoid–schizoid position. The reinstitution of splitting and projective identification and other primitive defences ensures that good and bad are separated, omnipotent control is maintained, and depressive reality and its associated anxiety and conflicts are thereby avoided.

Manic defences are a particular group of primitive defences distinguished by their aim of denying depressive anxiety and guilt. "In this state the source of conflict is that the ego is unwilling and unable to renounce its good internal objects and yet endeavours to escape from the perils of dependence on them as well as from its bad objects and id" (Klein, 1935, p. 227). Segal argues that "the manic relation is characterized by a triad of feelings . . . control, triumph and contempt" (Segal, 1964, p. 83).

With the advent of the depressive position, there is the possibility of love and goodness becoming integrated with and prevailing over hate and badness. There is a question, however, of whether this love and goodness will survive the knowledge of the Oedipus situation. Britton suggests that "just as in the depressive position the idea of permanent possession has to be given up, so in confronting the parental relationship the idea of one's sole possession of the desired parent has to be relinquished" (Britton, 1992b, p. 40).

For some, however, relinquishing the idea of being the special one proves impossible, and "life, instead of being lived, can become the vehicle for the reinstatement of . . . defensive illusions, and the relationships of the external world are used only as stage props for an insistent internal drama whose function is to deny the psychic reality of the depressive position and the real Oedipus situation" (Britton, 1992, p. 45).

Kleinian technique

What, then, are the implications of the above point of view for therapeutic technique?

Specifically, it is the view of unconscious phantasy, and of how this infuses the transference, which informs Kleinian technique and tends to distinguish it from other approaches. Hinshelwood, for example, suggests that the transference " . . . is not . . . merely a repetition of old attitudes, events and traumas from the past, it is an externalization of unconscious phantasy 'here-and-now'" (Hinshelwood, 1989, p. 15).

According to this view, the "experiences and the affective impulses" (Freud, 1937d, p. 258), which have been forgotten and must be recalled, are not just patterns of relating to key figures or important incidents from the past, but the internal world of the patient as manifested in his *total* attitude to the therapist and the therapeutic situation.

Other approaches tend to view the transference and the therapeutic task differently. Ponsi comments: "In the classical concep-

tion, since the analyst assumed that an event was being repeated, he focused his attention as reconstruction of the infantile history, with a view to freeing the patient thereby from the restrictions of the repetition compulsion" (Ponsi, 1997, p. 243).

A succinct illustration is given by Freud:

> One lays before the subject of the analysis a piece of his early history that he has forgotten, in some such way as this: "Up to your *N*th year you regarded yourself as the sole and unlimited possessor of your mother, then came another baby and brought you grave disillusionment. Your mother left you for some time, and even after she reappeared she was never again devoted to you exclusively. Your feelings towards your mother became ambivalent, your father gained a new importance for you" . . . and so on. [Freud, 1937d, p. 261]

There have been many developments in psychoanalytic theory and technique since 1937, but to the extent that the transference is still conceived of as the repetition of *events*, this leads to an emphasis on the patient being freed from the repetition compulsion by means of historical reconstruction. Thus, a contemporary Freudian, Sharon Raeburn, comments that "reconstructions are still an important part of psychoanalytic therapy, because repressed early experiences are highly emotionally charged and are repeated in actions" (Raeburn, 1996, p. 6).

The Kleinian view is somewhat different:

> unconscious phantasy, the cause of the transference is not something that occasionally irrupts into the patient's relation with the analyst and then interferes with his reason and Cupertino. It is the fertile matrix from which his actual motives spring and which determine his apparently rational behaviour—no less than his silence and negation and openly defiant resistance. The therapeutic task of extending the patient's knowledge about himself, about his unconscious impulses and defences against anxiety and pain, makes it necessary to bring his unconscious phantasies to consciousness. [Heimann, 1956, p. 113]

According to the Kleinian view, therefore, it is the task of the therapist to explicate the unconscious phantasies that the patient brings to the consulting-room. It is the refusal of the therapist to fit

in with these unconscious phantasies that is a key factor in promoting change. By his interpretations, the therapist explicates the patient's underlying unconscious phantasies; if effective, these interpretations will reduce the patient's distortions of the therapist, which result from his unconscious phantasies. This creates the possibility of the internalization of new object relationships in a changed internal world.

Fairbairn eloquently summarizes this view:

> Psychoanalytic treatment resolves itself into a struggle on the part of the patient to press-gang his relationship with the analyst into the closed system of the inner world through the agency of the transference and a determination on the part of the analyst to effect a breach in this closed system.... [Fairbairn, 1958, p. 385]

Projective identification

The concept of projective identification describes the process whereby the patient tries to "press-gang" (Fairbairn, 1958, p. 385) his relationship with the therapist to fit in with his unconscious phantasies. The concept refers to the process by which parts of the self are, in phantasy, split off and projected into another object. The "projector", in phantasy, thereby changes the object, which now contains the projected part. There are a number of possible motives for so doing—for example, to control the object, to avoid separation, to evacuate a bad quality.

A question of some interest and controversy has been the extent to which this process is merely a phantasy in the mind of the projector and the extent to which the recipient of the projection can be changed to conform to the projector's unconscious phantasy. Bion, for example, suggested that projective identification, as well as operating as a mechanism of defence, could also serve as a mode of communication. The infant might not only rid himself of unbearable experiences but might also create the possibility that the mother might come to understand these unconsciously. The infant could behave in such a way as "to arouse in the mother feelings of which the infant wishes to be rid" (Bion, 1967, p. 114).

In his model of the container and the contained, Bion (1962a, 1962b) outlined how, under favourable circumstances, the mother would recognize and be able to contain the infant's unmanageable experience. He talked of maternal reverie:

> This is her capacity with love to think about her infant—to pay attention, to try to understand.... Her thinking transforms the infant's feelings into a known and tolerated experience. If the infant is not too persecuted or too envious, he will introject and identify with a mother who is able to think, and he will introject his own now modified feelings. [O'Shaughnessy, 1988, p. 179]

According to this view, there is a continuous cycle of projection followed by introjection during which unbearable feelings are projected into the mother and returned by her to the infant in a more manageable form. Eventually, the infant not only takes in the now modified but formerly unbearable feelings, but also begins to establish an internal object capable of undertaking the functions of modifying frustration and of thinking.

What happens under favourable circumstances between infant and mother may happen in psychoanalytic psychotherapy if the therapist is able to bear the patient's projective identification, recognize it, and return it to the patient in a way that he can bear.

Countertransference

The question of the impact of the patient on the therapist has, of course, been of long-standing interest and debate. Heimann, in her classic paper "On Countertransference" (Heimann, 1950), is generally credited with opening a debate about the complexities of making use of the therapist's feelings to provide information about the patient. The central idea is that by means of projective identification the patient evokes in the therapist feelings that, if scrutinized, can contribute to the therapist's understanding. A key concern has been the extent to which feelings that belong to the therapist can be distinguished from those projected by the patient.

Recently there has been increasing interest in the way in which the therapist can be affected by the patient, not only in terms of

"thoughts and feelings", but also in "propensities towards action" (Feldman, 1997, p. 227).

Betty Joseph, for example, stresses how patients make use of primitive defence mechanisms to avoid pain and conflict, and how, in therapy, they involve the therapist in their defensive armoury. She writes: "defences like projective identification, splitting, omnipotent denial are not just thought; they are in phantasy linked to the transference" (Joseph, 1983, p. 142). Joseph is here emphasizing that psychoanalytic psychotherapy is not just an intellectual activity or experience: given the primitive anxieties and defences involved, there is a pressure (often very subtle) to *act* and to induce the therapist to behave in ways that correspond with the patient's unconscious phantasy.

Such pressure may or may not be successful (in terms of getting the therapist to behave in certain ways), but even if the therapist's behaviour is not affected, his behaviour can still be given meaning that conforms to the unconscious phantasy of the patient. Such enactments or pressures to enact, if scrutinized, can provide valuable information. Tuckett comments: "enactment makes it possible to know in representable and communicable ways about deep unconscious identifications and primitive levels of functioning which could otherwise only be guessed at or discussed at the intellectual level" (Tuckett, 1995, quoted in Feldman, 1997, p. 228).

Psychic equilibrium

The Kleinian interest in primitive levels of experience in the anxieties and defences of the paranoid–schizoid position has led to a recognition that, although "our patients come to us, we and they hope to gain understanding. . . . In fact, many are against understanding" (Joseph, 1983, pp. 139–140). Patients repeat infantile defences in "the attempt to draw the analyst into behaviour that will evade painful emotional confrontations by attempting to maintain and restore an age-old system of psychic balance" (Spillius, 1988, p. 14).

Underlying this point of view is the contention that the capacity and willingness to face reality and the pain and conflict to

which this gives rise is a feature of the depressive position. It is only when (either in a hypothetical general sense or at a particular moment in a session) a patient is operating firmly within the depressive position that he is capable of thought and willing to think.

Thus, although patients may present as wanting change and understanding, unless they are emotionally capable of this, they are likely to use their therapy—and, in particular, their relationship with their therapist—to avoid understanding and the psychic pain that results from it. Entering psychotherapy may, therefore, have more to do with an unconscious wish to preserve the psychic status quo, perhaps by reinforcing threatened defences, than with a wish to achieve real insight and change.

A number of Kleinian thinkers have considered how a tightly organized system of defences may be created on the border between the paranoid–schizoid and the depressive positions in a struggle to preserve a psychic equilibrium in the face of paranoid and depressive anxieties (Riviere, 1936; Sohn, 1985; Steiner, 1987, 1992, 1993).

Given the concern with such issues, it is not surprising that detailed scrutiny of the immediate present of the session has come to play a central part in the technique of many Kleinian psychoanalytic psychotherapists.

Historical reconstruction in Kleinian psychotherapy

What, then, of the historical past? What place does historical reconstruction have in Kleinian psychotherapy?

In one sense it can be argued that its place is central. To the extent that it is the patient's archaic internal world that is present in the unconscious phantasies, that are enacted in the transference, Kleinian psychotherapy can be characterized as being concerned with the reconstruction of this primitive world.

The "experiences and affective impulses . . . which he has for the time being forgotten" (Freud, 1937d, pp. 257–258) and which "he must be brought to recollect" (ibid., p. 257) are held to be the unconscious phantasies that the patient projects into the transfer-

ence. The therapist carefully explicates this archaic world in the hope that the patient might be freed from its tyranny.

This, of course, begs an important question: to what extent does the unconscious phantasy of the adult reflect the internal world of the same adult in infancy or childhood? This is a complicated question. It is likely that parts of our internal world and some of our internal phantasies have a very long history indeed and may correspond to the anxieties and defences prevalent at a very early age. As we develop, however, it is axiomatic that our internal world changes, so that it is almost inconceivable that the internal world of an adult corresponds, in any overall sense, with the internal world of the same adult when a child.

The question of the historical validity of reconstruction of the internal world in psychoanalytic psychotherapy is one of considerable interest and importance. But it may be of more immediate interest to academic psychologists than to Kleinian psychotherapists. The key issue is that patients bring us their *current* anxieties, conflicts, and characteristic ways of dealing with these. They ask for our help in finding more satisfactory ways of dealing with the relationship between their inner and outer worlds. According to the Kleinian view, change and development proceed, not so much from accurate understanding of the historical past, as from the modification of underlying anxieties and defences via the understanding and interpretations of the therapist. In this sense, the historical validity of the internal world reconstructed in the psychotherapy may not be such an important issue.

But what of the patient's external past? What place do attempts to gain a clear, more accurate understanding of this have in Kleinian psychotherapy?

It may be fair to suggest that the interest in very early experience tends, paradoxically perhaps, to direct the attention of Kleinian practitioners away from the historical past. There are two key reasons for this.

1. The concern with primitive and often non-verbal communication gives rise to an interest in the acting-in in the session, in its immediate detail and the moment-by-moment changes between patient and therapist. Attention is directed not only to verbal content, but also to subtle changes in atmosphere and the ways in which non-verbal activity may provide evidence of the enactment

of primitive unconscious phantasies. Clearly, such an interest in the present tends to deflect attention away from the exploration of the historical past.

2. There is the recognition that it is only when a patient is operating (in a hypothetical general sense at a particular moment in a session) within the depressive position that he is capable of and truly willing to think. At all other points on the continuum between the paranoid–schizoid and the depressive positions, the patient is to a greater or lesser extent struggling to avoid painful reality.

Thus, patients may not wish for increased understanding as much as for the restoration or achievement of a manageable psychic equilibrium. To the extent that the patient is preoccupied with such issues, then history and its reconstruction may be used, not to genuinely promote increased understanding, but to deflect attention away from the explication of the present. Such exploration might threaten to disturb the patient's equilibrium rather than promote it.

Under such circumstances, a reaching for history may promote a false, if relatively safe, pseudo-understanding. The defensive possibilities in historical reconstruction are, therefore, of considerable concern.

But this need not always be the case, and there are times when genuine explication and understanding may be possible. It is at such times, when depressive-position functioning is to the fore, that historical reconstruction may be genuinely illuminating rather than primarily defensive.

Such illumination and understanding, if genuine, will be emotionally lively and suffused with depressive concern. It will not simply be an intellectual and defensive manoeuvre.

Historical reconstruction of this kind involves the recovery of lost objects and relationships. The attacks and distortions promulgated by the patient are diminished, and a more truthful picture of the past emerges. This process is likely to be painful; not only will the patient face the damage and distortions he has inflicted, but he will also have to face the limitations of his objects and their inability to create a perfect world. There will be mourning for a lost world, which, because it is lost, is impossible to repair. The atmosphere will be one of concern rather than of blame.

As Heimann eloquently suggests:

> There are moments in the analysis when the patient recovers his lost original objects. He then dwells on memories of incidents and feelings, speaks with deep and genuine concern about them, works out what a certain episode means to him and must have meant to his mother or father, how he misunderstood them or they misunderstood him at the time, whilst he now realizes that he falsely attributed to them motives of indifference and hostility. In these thoughts and feelings there is sadness, remorse and quiet love, not paranoid hatred or self-pity. [Heimann, 1956, p. 120]

The extent to which it is possible to recover early memories in this way may, of course, be limited, and from a Kleinian point of view such historical construction may not be essential for change and development to take place. Nevertheless, a recovery of the historical past—and, perhaps more crucially, the reworking of emotional attitudes towards key figures and incidents from the past—may contribute to the development of a more benign and resilient internal world. Freed from some of the distortions and grievances from the past, the patient may evolve an internal world that is a resource that is better able to sustain him through the vicissitudes of everyday life.

Clinical example

I would like now to turn to a clinical example to illustrate some of the concepts and issues discussed above.

Mr A

This material concerns a 38-year-old solicitor, the only child of a mother with a manic-depressive illness and a rather remote father. He worked in a law centre and led a very restricted life, with no close relationships. I would like to begin with one of our early sessions.

Mr A arrived on time, took off his coat, and lay on the couch. After some silence, he said, "There's something that's bothering me, this difference between phantasy and reality". There

was a silence. I wondered what he was talking about and what I could possibly say. He went on, "At the men's group last night one of the members was told by another that he was mothering him. I didn't know what they were talking about—I'm confused about what was happening—this difference between phantasy and reality."

In the subsequent silence, I was puzzled. Perhaps the patient is presenting an obvious dilemma that I just do not understand? I should surely be able to understand. Then I had a slight sense he might be putting me on the spot or intimidating me.

"It was okay last week", he said, " but I don't know any more." Another silence followed. His reference to last week reminded me that we had recently explored his difficulty at not being the therapist with me. And so I said that we had considered a similar issue here last week, about his attempting to sidestep his true position with me, which we had understood as linked with his anxiety about being a child in relation to a parent. I asked whether he might have felt clearer about these things last week, but that this was no longer so.

"Yes, but if I can think I didn't want to and wasn't trying to be a parent when I was a child, then I can be a child, which is what I want to be."

It required some thought on my part to make sense of this complicated construction, which I found quite intimidating.

Eventually, I found a way through and commented that this seemed like quite magical thinking. I had in mind here the omnipotence of his thinking, characteristic of paranoid–schizoid functioning; he thinks something and this (in phantasy) then happens. He agreed with my comment and fell into silence.

I was not convinced, in the light of our previous work and his attitude in the session, that he wanted to be a child, so I went on to say that I wondered if it really were the case that he wanted to be a child. Perhaps this was something that he found difficult and painful.

Mr A immediately responded, "Well, yes, when I let my parents take care of me they were always patronizing. I didn't like it." I said that I wondered if this might be true here. He doesn't like being a patient, although a part of him may want my help. I said I noticed that he began the session by referring to a group in which he plays a leading part. Perhaps he is telling me that he is my equal and not my patient or child. He interrupted me, "Well, yes, I feel like I'm a fraud. I don't feel like a leader." He fell silent. The tone of this comment was dead and somehow not fully convincing.

He went on to talk in a very detached way and at some length about the circumstances of his birth. Amongst other things, he talked about how his parents had only recently met when his mother became pregnant and of how he was born in a nursing home, which had recently been turned into a casino.

I found myself feeling rather confused and not really following what he was saying until he said, "I don't know if this is relevant, but my parents were thinking I was going to be a girl and hadn't thought of a boy's name when I was born". Somehow, as he made this comment, he seemed to come alive.

I had a sense that he was letting me know that something central to his view of himself could be denied by others. I said therefore that I wondered whether he also felt angry and upset when I had challenged his attempts to be my equal, as if I was almost denying his gender in a humiliating way. "Yes, it does feel the same in a way. I feel completely stuck." Silence.

I was left feeling unsure whether or not he agreed with me. His "yes" was said with little enthusiasm and qualified by "in a way". Also, it was not just he who felt stuck, but it was as if he were making me feel stuck by digging in his heels and bringing his work to a halt. He went on, "It makes me feel I must sort it out myself". I felt wounded, as if he were angrily pushing me away.

After a silence, I said that this was just the point. When I acted as a therapist, he experienced this as a terrible wounding attack on his view of himself as a potent leader. It could feel as if

I were punishing him for being a fraud. So he mustn't expose himself to this and must sort out his difficulties himself.

Although this was greeted with silence and deadness, I felt relieved. At least I'd been able to make sense of something and could not, therefore, be that stupid or useless. Although far from satisfied and not convinced I had made contact with, or helped, him (if anything, I had an uneasy sense I may have hurt him), I felt as if I had survived a kind of test.

As the therapy progressed, it became increasingly clear how difficult Mr A found it to be involved with someone who might not be useless. A close male work colleague was leaving, and this coincided with the news that the colleague had inherited a large sum of money. This emerged as the Easter break was approaching.

Mr A announced that he was applying for a rather prestigious job and was planning an exotic holiday. Eventually, I interpreted that he was attempting to give himself the comforting phantasy that he was leaving me, but this did not alter the reality that he was losing his colleague and also losing me for the Easter break.

His response was uncharacteristically reflective and moving. "I'm stunned, what I get up to, you're right . . . it doesn't make any difference, it hides the fact that he decided to leave first. I feel, well, a bit silly really."

But the reflective and accepting atmosphere soon disappeared, and the following session began with references to Mr A's envy of people who "didn't need" psychotherapy. He went on to tell me that he had felt "stupid" in the previous session. "It was like learning two times two equals four. Simple. I want to get there first." We understood how much he hated it and how small he felt when I understood something he did not. For me to make any intelligent comment felt awful to him, yet he was also aware that he needed the help and understanding that I could give him.

* * *

I think that this material demonstrates how patients make use of primitive defence mechanisms to avoid pain and conflict and that in therapy they involve the therapist in their defensive armoury. At both the level of the content of his material and at the level of what was being enacted in the transference and countertransference, the patient was preoccupied with avoiding the recognition of his dependence and the painful feelings that this evoked.

We can get a fuller picture of Mr A's defensive structure and of the unconscious phantasies that underlie it when we consider the countertransference.

Two countertransference feelings were particularly notable: (1) the feeling that I had to struggle to understand the generally dead material that Mr A brought and to bring him to life; and (2) a feeling that I was involved in a kind of contest in which I sometimes felt I had lost and at other times I had survived and won. When losing, I felt rather intimidated by the patient, and when feeling pleased with myself, I was sometimes aware of a feeling that I might have hurt him. I think this material can be understood as a drama with unconscious origins. In this unconscious phantasy, I think Mr A identified with a deadening but triumphant maternal object and used projective identification to evoke in me feelings that he could not bear himself and which he feared might overwhelm him. I was the one who was to feel and think about his feelings—for example, feeling hurt and rejected and stupid, or rather superior and triumphant. I struggled to bring these feelings alive, while he identified with his depressed and remote mother and frequently triumphed over me in my failure. On the occasions when something did make sense or came alive, it was almost as if the situation were reversed. My uneasy sense that I may have hurt him, and my vague sense of superiority may indicate that I became the triumphing, contemptuous mother, looking down on him.

Now I think there are many things that might be commented on in this clinical material. What I would like to emphasize, however, are five key features.

(1) The patient enacts an unconscious phantasy in the transference and attempts to draw me in to participate and play a part in this drama. I struggle to bring him to life, while in his identification with his depressed mother he rather contemptuously looks

down on me. At times the roles seem to reverse, and in the phantasy I become something like the remote, contemptuous mother and he the one who struggles to bring me alive.

(2) It is by paying close attention, not only to what he says (the content of his material), but also to his impact on me (the countertransference) that this becomes clear. The feeling that I was struggling to bring him alive, the sense of competition, and the associated alternation between feelings of triumph and humiliation were gradually registered and reflected upon.

As a result of this reflection on the transference as a total situation (Joseph, 1985), it was gradually possible to reconstruct the unconscious phantasy that Mr A had projected into his relationship with me. The correspondence between this unconscious phantasy and the unconscious phantasies of the patient's past is, of course, not clear. The relationship between the unconscious phantasy and the patient's objective historical experience is also unknown. At this stage, such questions are not of primary interest. Rather, the focus is on the immediate situation of the transference and countertransference, and the anxieties and defences that are being enacted in the consulting-room.

(3) I think the material illustrates how the patient can use talk about his history either defensively—to deflect attention from a problematic immediate situation—or to promote communication and increased understanding. When Mr A talked in a detached way about the circumstances of his birth, this seemed confusing, and I was unable to make use of it. It might be argued that I had simply failed to understand the significance of the content. I think, however, that if the countertransference is explored, then an alternative explanation can be given. I believe that initially, when he talked of his history in a rather dead way, the patient was trying to get away from me—possibly as a result of my previous comment. After some time, however, his anxiety abated, and he moved a little closer to depressive position functioning. This enabled him to open up communication—with the comment, "I'm stunned"—which enabled understanding to develop.

(4) Further reflection on what is happening permits the conclusion that the patient is struggling to deal with depressive anxieties and illustrates the consequent back-and-forth movement between the paranoid–schizoid and the depressive positions. Much of the

content is about the conflicts and struggles that ensue when Mr A begins to recognize his need for others, especially his therapist. This is both talked about and enacted with the therapist. For example, in the early sessions he makes use of projective identification to evoke in me unwanted feelings of insignificance and humiliation. Later, we can see the crisis provoked by the Easter break and the good fortune of his friend. He cannot bear the evidence of separateness, need, and dependency that this expresses, and he again makes use of projective identification, so that, in phantasy, I am the needy one being left and he is the one who is doing the leaving. The retreat back towards the paranoid–schizoid position is followed by a movement forward towards the depressive position, when he recognizes his need for me and allows me to help him see how difficult he finds this. Later still he moves back towards the paranoid–schizoid position as he talks about feeling "stupid" and wanting "to get there first". There is, therefore, a constant movement back and forth as the patient struggles with his depressive anxieties.

Finally, I hope it is clear that although invited to play a part in the patient's unconscious phantasy and although to some degree he may unconsciously do so, it is the therapist's capacity to reflect on the part allotted to him that is so important in promoting change. Instead of simply enacting the phantasy, if the therapist can also recognize something of what is happening, think about it, and give it back to the patient via an interpretation in a digested and manageable form, some change may be possible. Thus, I tried not to enter into competition with Mr A over which of us was the therapist but, rather, attempted to make sense of what was going on between us and gradually to try to tell him something about my observations and thoughts. Of course, however careful, sensitive, and skilled the therapist, it is likely that whatever he says—or does—will be drawn into the patient's phantasy. Indeed, it can be argued (e.g. Carpy, 1989, p. 292) that some degree of enactment is both inevitable and necessary before any thought and reflection is possible. Thus, after initially accepting my interpretations about how he was dealing with the Easter break, Mr A began to complain that my comments made him feel small, and he expressed a wish "to get there first". The phantasy of competition is re-instituted as my interpretation is incorporated into the drama. The

task of the therapist is to recognize and refuse to respond to the (often very subtle) pressure to participate in such enactments, so that over time the phantasies become less pervasive, as other possibilities emerge.

A later session

I now turn to a later session that will, I hope illustrate both further movement and how, rather than serving a defensive function, historical reconstruction can promote increased understanding and development.

> Mr A came in and seemed slightly angry. After he had settled on the couch, I told him the dates of a forthcoming week's holiday break. His response seemed rather cold—he just said "yes". He went on to say, "I know this may sound rather mercenary, but will you be charging me for that week?"
>
> I said I would not be charging him and had to interrupt him to continue to say that his comment was surprising—I had not ever previously charged him for sessions during a break that I had taken.
>
> Mr A agreed with this and went on to say that on the previous day "something happened which made me wonder whether you might charge me". He went on to tell me in some detail that a parent had complained about him in a letter sent to the head of his firm. He had been involved in defending the complainant's son in a criminal case, and the son had received a custodial sentence. The letter of complaint had accused him of being cold, arrogant, and uncaring and had said that he should not be employed to defend people.
>
> Mr A talked about the lack of interest and support from his colleagues. One had offered to help him write a reply to the complaint, but none seemed emotionally available to him.
>
> I found myself feeling considerable sympathy for him, but as we had recently spent several sessions exploring how sharp and contemptuous he could be, I was also struck by the con-

tent of the complaint. I therefore acknowledged how hurt and vulnerable he felt, commented on his sense that he had not had real support, and suggested that he might feel this because of his own unease at how sharp he could be.

He half agreed with me but went on to clarify that he was not so concerned about the technical aspect of the complaint. He was more concerned about the part that concerned his behaviour when he had seen the mother and son in the Court cells after her child had been sentenced. The mother had accused the patient of being unsympathetic to her and cruel to her son. The patient was very clear that he had not behaved in this way, yet he felt exposed and vulnerable.

Mr A then went on to say that the whole incident reminded him of his relationship with his mother.

He spoke angrily about how his mother (particularly during her manic episodes) would often accuse him of not caring about her and of being cold and dismissive. This made him feel very angry, because this was just how she was towards him. When she was manic, she was cruel, and when she was depressed, she was selfish. "No wonder I've got problems and need psychotherapy", he said.

After talking about this for a few minutes, he became less angry and gradually became sad. Eventually, he said that the point was that really he wanted his mother to be with him as she was when she was "well". When she was high or depressed, it was as if she had become someone else. He cried as he went on to talk about his mother in a moving way, of her troubled childhood, of how frightened she could be before she went into mental hospital, of how ashamed she was of her illness and of her sometimes rather clumsy efforts to help him. She had hurt him, but perhaps he had hurt her too. She was not the best mother in the world, but she couldn't really help this, and it was difficult for all the family.

Referring to his response to my telling him about the break, Mr A said, "I knew you wouldn't charge me really, but, you see, when you talked about the break, I hated it. I can't stand the

idea of you having a holiday with your family. It's not fair, but it's better if you're awful."

We were able to understand that when he felt hurt and excluded, a familiar drama ensued. I became a dismissive figure, not interested in him and prone to exploit him. Such a version of me protected him from his awareness of wanting me and of missing me. In this drama he became identified with a cruel and arrogant maternal object locked in battle with a hostile world. This had a long history, and he was reminded of what had happened with his mother. There had, however, been a price to pay for relief from feelings of exclusion and loss; he was left isolated in a world that was against him. His initial reaction to the news of the break was to respond in this familiar way.

The accusation of the complainant that Mr A had been arrogant and cruel, while objectively untrue, did reflect an unconscious truth and was, therefore, disturbing to him. Although he had not done the things of which he had been accused (of behaving in a dismissive and cruel way), his reaction to the complaint was to feel as if it was true (he felt uneasy, exposed and vulnerable). I think that the reason for this may have been that unconsciously he had felt on the side of the excluding authorities, looking down, perhaps with contempt, on the delinquent boy and his mother. The complaint thus served as a vehicle for the enactment of an unconscious phantasy in which objects were attacked in order to deal with loss and exclusion. In this phantasy, the patient was sometimes in the role of the "excluder" (as in Court) and sometimes in the role of the excluded (as with the break).

It now seemed as if it was possible for Mr A to begin to acknowledge and bear to know how he felt when he was left. This was true both in his relationship with his mother and in his work with me. He could also recognize what he did to protect himself from such painful feelings. The capacity to recognize what he felt, how, in the service of defence, he attacked his objects, and how his perceptions of important relationships,

therefore, became distorted enabled other possibilities to emerge.

In his relationship with his mother, he could now feel concern for her and about how he had treated her. While acknowledging her difficulties and limitations, these were talked of with regret, rather than as justifying a grievance. This enabled him to recover something good and potentially strengthening in his relationship with her.

Similarly, in his view of me and of the unwelcome break, Mr A was able to tolerate his feelings of loss and exclusion and recognize his attempts to avoid these. No longer distorted by his attacks, I was available as relatively benign and helpful.

I think this session, in contrast to the earlier work, demonstrates how the patient's defensive structure has become less rigid and how he is now able to confront some of the pain he had previously been unable to contemplate. Although the nature of his difficulties and the content of his unconscious fantasies remain broadly the same as when he entered therapy, his capacity to explore these and to take in and use what I say has increased. I think this indicates a move towards the depressive position in which thinking and exploration are now a possibility.

It is also notable that in the countertransference I felt sympathy and not intimidation. I was able to think, and when I had something to say I did not experience relief or triumph but a satisfying feeling of contact. I think this provides further evidence of how the enactment between us of his unconscious fantasies of triumph and humiliation has reduced and has been replaced by an increased capacity for thought and exploration.

This movement towards depressive position functioning seems to extend to the patient's use of his history. Although initially Mr A seemed to use the reference to his mother to evade lively but painful contact and to justify a grievance ("no wonder I've got problems and need psychotherapy"), eventually he became more thoughtful and was able to acknowledge feelings of exclusion, loss, and concern.

This opened up the possibility of a relationship less infused with contempt and cruelty and involving greater love and concern. While not denying a historical reality that was far from ideal (and at times probably cruel and frustrating), the patient's link with his past now has the potential to carry a different and more hopeful meaning.

Conclusion

In this chapter I have outlined the Kleinian understanding of infant development and shown how it informs work with adult patients. I have suggested that while the Kleinian concept of position can indicate a developmental stage, it is more properly seen as a particular constellation of anxieties and defences, which, to some degree, persist throughout life. Although there is movement in normal development away from the paranoid–schizoid position towards the depressive position, this is never final and absolute. In ourselves and in our work with patients, we can observe the constant shifting between these positions. The anxiety about survival is never completely overcome, and the anxiety about separateness, dependency, and guilt is never fully worked through.

It appears something of a paradox that while Klein was a pioneer in investigating the mind of the infant, current Kleinian practice gives priority to investigating the here-and-now of the consulting-room rather than attempting to reconstruct the historical past. This apparent paradox becomes less of an issue, however, when it is appreciated that it is the contemporary manifestations of these very early states of mind, these primitive, unconscious phantasies, that are of interest to Kleinians.

I have shown how the patient's world of unconscious phantasy is explicated via detailed scrutiny of the transference and countertransference. A key feature of Kleinian psychotherapy is that, just as the mother promotes the growth and development of her infant by her capacity to understand and contain the infant's unbearable anxieties, so the therapist aims to capture and hold onto the patient's anxieties in the consulting-room. The central concern is

with the immediate quality of the session. *It is the experiencing of the live interaction* WITH *the therapist, rather than an intellectual explanation* FROM *the therapist, that leads to the reconstruction of infantile anxieties and defences.* The anxieties may be experienced in a lively way, and it is therefore crucial that the therapist has the capacity to contain and digest these rather than simply to enact the object relationships with which they are associated. They can then be returned to the patient via an interpretation in a more manageable form.

Reconstruction for contemporary Kleinians is primarily, therefore, a painstaking attempt to understand the archaic world of unconscious phantasy as manifested in the present. Historical reconstruction of the patient's external world does not generally occupy centre stage.

Whether it is for a brief moment or for a more substantial period, however, when depressive-position functioning is to the fore, historical reconstruction can be genuinely illuminating and may both reflect and help to promote psychic change. For contemporary Kleinian practitioners, the central issue and concern is, therefore, not so much historical reconstruction itself, but how this is approached and the use to which it is put.

CHAPTER TWO

On the persistence of early loss and unresolved mourning

Susan Lipshitz-Phillips

In this chapter, I discuss the impact of early loss and the ways in which the personality can be constructed to keep in touch with, to commemorate, or, on the other hand, to deny such experiences, using both clinical and literary examples.

Psychoanalytic theory of psychic reality shows that reaching adulthood does not necessarily coincide with reaching maturity. Individuals remain constrained by, and live in, their past in various ways. As Freud (1920g) described it, the powerful force of the repetition compulsion refuses to allow later experiences to modify earlier, often disappointing ones. He recognized, in *Beyond the Pleasure Principle,* that the individual felt obliged to "repeat the repressed material as a contemporary experience instead of, as the physician would prefer to see, remembering it as something belonging to the past" (Freud, 1920g, p. 18). And he understood that the compulsion to repeat painful experiences was an attempt to keep them alive, perhaps to control them, and could be used psychoanalytically as a communication. When a traumatic experience breaks through the protection that the mind usually employs, the person deals with the breach in order to continue functioning, by

resorting to their usual defences. This is particularly likely when they suffer loss and bereavement.

Freud (1920g) and Klein (1940) saw that repetition and denial were a rejection of memories for their patients and could therefore become the vehicle for the possibilities of psychic change. Klein (1940) developed her ideas that mourning involved dealing with anxieties and a sense of persecution as well as pining for the lost object, and furthermore she discussed a sense of triumph over the object as part of the manic defence against its loss. She said that mourning reactivated infantile patterns and was a transitory state of illness. Unless the anxieties could be metabolized and worked through, a static situation of unresolved mourning could result. Hence, adulthood has to be seen as delimited by the past, and mental life is shaped both by dominant phantasies and by environmental events.

Clinically we see this when we "read" a patient's account of his or her own history and note the re-creation of family constellations and the precision with which age-related events are reproduced. Freud's writings on love and choice of love object (1910h, 1911c, 1918b) recognize the power of the Oedipus complex in our choice of partner and the repetition from one generation to the next of unresolved unconscious feelings. Similarly, in writing about culture, Freud described how groups of people cohere on the basis of unconscious needs but can be split or get into conflict if their hostility is not held down by the group leader or a collective ethos (Freud, 1921c), such as that provided, for example, by religion.

My interest here is in how a variety of experiences of loss, ranging from the crippling early loss of a mother to the loss of place provoked by siblings' arrival can persist into adult life. I give some clinical examples and then refer to the literary description of some of these themes, as offered by Thomas Hardy in his novel, *The Well Beloved.*

Mrs E

My first patient, Mrs E, came for consultation complaining of increasingly frequent and debilitating panic attacks. She was of the same age as her mother had been when she was born, and

with the break-up of her marriage Mrs E wondered whether she would ever have children. Recently she had been prevailed upon to accommodate her twin sisters; the arrival of the first coincided with the emergence of her overt symptoms, which had worsened with the arrival of the second. Mrs E was agoraphobic on the roads and felt hemmed in and severely depressed at home. She was aware that when her sisters were born she had been sent away from home, and she knew she always found them irritating. She could not, however, see any link between the past and her present sense of being crowded out until it was put to her that she was thrown back to her childhood. This seemed quickly to reduce the intensity of her symptoms. It soon emerged that as a small child Mrs E had become precociously self-sufficient in order to protect her parents from her jealousy of them as a couple and as parents to her troublesome sisters. However, her sense of losing her mother's attention preceded their birth, as her mother had been depressed in the patient's first year, pining for her father, who was often absent. As a child she had been unable to face this loss before the twins' arrival had inflicted a sudden long separation from her mother.

This old situation had been doubly revived, and the splitting she had operated by keeping her distance literally and psychically from the family was now impossible to sustain. Mrs E's resentment and hostility were in conflict with her sense of duty, and she had retreated more and more into a debilitating illness, for fear of the impact of thinking or saying what she felt. The discovery that I could bear to discuss her hatred, for example, seemed to enable her to distinguish the terrible, destructive infantile phantasies of the past and present from a real attack on the existence of her objects and to reduce her need to attack her own functioning instead. I think that the persistence of these unresolved feelings had left Mrs E vulnerable; she had only partial relationships, was often badly treated, and her underlying anxieties kept her on the move, fuelling her need to travel constantly and making her very elusive.

It is noticeable that these are quite consciously known events. Freud wrote: "Forgetting impressions, scenes or experiences nearly always reduces itself to shutting them off. When a patient talks about these 'forgotten' things he seldom fails to add, 'As a matter of fact I've always known it, only I've never thought of it'" (Freud, 1914, p. 148). So we have come to see them as neither fear nor phantasy but often-repressed reflections of an important failure in the individual's world that they were not helped to metabolize at the time, leaving therefore extensive damage. The disaster need not necessarily be a big one, but the disappointment may still feel massive. Evidently, conscious knowledge is no protection from the shock of memories returning to disturb the system, and this can be provoked by the recreation of old circumstances, as in the case of Mrs E. In her adult life they created the conditions for reworking the past or for a breakdown.

Mrs G

In this next clinical example there is an illustration of the return of a dismissed bit of family history that affected my patient's difficulties in a postpartum illness and plagued her in her struggle to mother her own child. Of the many losses suffered by her family, it seemed that the death of a child in a family boating tragedy stayed in Mrs G's mind. With the birth of her own baby, this disaster went through the protective barrier of memory and phantasy and became overwhelmingly real and part of Mrs G's intensely anxious state. She was constantly preoccupied with her baby's survival and watching over her eating and sleeping kept the patient incessantly vigilant, both day and night. It seemed that nothing could reassure her, and she was tormented by highly coloured and dramatic scenarios of disaster. At one session she reported a dream including these elements: *She was following a figure up some stairs, afraid to fall as there was no rail, and saw a tiny, thin baby left exposed at the bottom, with tribal people dancing around it in some sort of ritual. She bathed the baby, but it made a mess, so she rejected it. Then she was in an underground place like a catacomb or temple, which was flooded with water, and there was a wreck eerily visible through the half-light.*

> Her associations suggested that the dream referred to the sea and the boating accident, with the wreck in the water and an awareness of a submerged temple or burial place. She saw herself inside as having a mother who allowed such an accident to occur and felt unsure she could be a good-enough mother to her own baby. In fearing that she had inherited the mantle of these neglectful parents, she tried to be beyond reproach and to outdo or even triumph over them—hence her extreme vigilance and persecutory state. In going away up the stairs and rejecting the messy baby, she was leaving it again, as if history unconsciously could only repeat itself. There is also the sense that she became omnipotent and lost any feeling of getting help from a capable aspect of the parental figures or from her therapist. At times, in the grip of this state, she was almost impossible to reach, but in the course of intensive therapy it became possible gradually to differentiate the historical from the present situations. This relieved the anxiety, and, as time went on, her daughter's survival also helped, but Mrs G continued to be vulnerable to depression and psychotic thinking.

This example raises the question of how far conscious knowledge can help in the modification of the past and therefore intervene in repetitions.

I think that there are developmental determinants in the sense that Klein (1957) discussed when in her theory of the mind she spoke of the fluctuating balance between persecutory and depressive anxieties. This is partly a given and partly reflects the ability or failure of the individual to deal with life experiences. The environment, and particularly the extent to which it offers containment, will affect how loss is borne, whether a constructive reparative process occurs, and whether a good internal object can be re-established. The mind seems to need intellectual as well as emotional knowledge for learning from experience to occur. The severity and type of loss will affect and delimit the extent of possible psychic change. Many writers—Erikson (1959), for example—assume that there is a move from activity to contemplation in the course of ageing. However, as these examples show, it

is not a necessary concomitant of ageing that mature (in the sense of depressive position) functioning is achieved.

What is tolerated in our culture as adolescent exploration—for example, in having crushes and partial relationships—will be seen as a repetition if it persists unchanged into later life. Often an individual comes for therapy at the point when they realize intellectually that their behaviour is unchanged over time, but they feel powerless to alter it alone. Jaques' (1965) view on adulthood is helpful because he links maturity and having feelings of concern, guilt, and loss with recognizing the inevitability of death. This, he says, brings the mind under the dominance of the reality principle. Advancing chronological age—particularly after mid-life—makes this less easy to deny and can even lead to a greater creativity. Denial can be very persuasive, and we become attached to the familiar world of our repetitions with their enticing offer of a timeless, unchanging universe. The pain of being caught up in repetition can, on the other hand, motivate the desire to avoid it and promote change. Jaques describes adulthood as a state where "infantile depression is being worked through but with mature insight into death and destructive impulses to be taken into account" (Jaques, 1965, p. 505). He suggests that recognizing death as "real" is an important discriminator of maturity and challenges the universal unconscious belief in eternal life. What is possible for any individual depends on whether love or hate predominates in their mental life; the refusal to accept the facts of life only leads to the reinforcement of manic defences and can lead to a total retreat from psychic reality (Steiner, 1993).

This seems to help to understand the preceding examples: splitting processes severed emotional and intellectual knowledge. Through working in the transference, especially around breaks, there is an opportunity to reconstruct the links and bring them alive. As Joseph (1985) has described it, the total transference atmosphere of assumptions and inevitabilities that the patient tries to reconstitute with the therapist is a clue to the old relationships that they inhabit and part of the process of repetition. She stresses the importance of "seeing transference as a living relationship in which there is constant movement and change" and that "everything of importance in the patient's psychic organization based on

his early and habitual ways of functioning, his phantasies, impulses, defences and conflicts, will be lived out in some ways in the transference" (Joseph, 1985, p. 454). This complex view enables us to see why intellectual knowledge of loss or abuse, say, is no protection against the intrusion of the damaged infantile level of psychic functioning into later life. And unless the details of the repetition can be traced via work in the transference and countertransference, the damage can quietly persist and perhaps become visible to the patient only as a sudden tantrum, psychotic episode, or destructive attack wreaking havoc in their lives. It also seems that in some cases the splitting processes create a stasis and paralyse growth in a persistent way.

Jaques (1965) sees the ability to manage such destructiveness as being linked with the capacity for creativity. Just as the extent and type of splitting varies depending on whether the patient is operating in a paranoid–schizoid or depressive mode, so will the type of creativity be affected. Sometimes the unconscious investment in maintaining the status quo can be so powerful that it paralyses life entirely, but more often it subtly structures and inhibits the quality of life the patient is permitted and deadens their internal world. In the Thomas Hardy novel I refer to, there is an example of how the hero's ability as an artist—and indeed the subject of his sculptures—is related to his state of mind. But before proceeding to that, I think it is important to consider what contribution environmental failure can make to these processes.

Melanie Klein (1940) described the intricacies of projective identificatory processes operating between a mother and her infant. Depending on the "fit" between mother and infant, they form the basis of early experience and influence how bearable primitive anxieties are for any particular baby. The extent to which the mother can modify her baby's anxieties will affect whether the child is left to put together an agglomeration of partial experiences, using omnipotent phantasies, rather than creating solid internal objects. In extremis, the child is left in a private world of communication (Bion, 1957).

Klein also allowed for the contribution made by the baby's own endowment—especially of envy (Klein, 1957, p. 176)—in the difficulty of modifying primitive anxieties and primitive thought.

In describing how the child's inner world is built up, Klein (1940) refers to the processes of internalization and the constant interaction in the child's experience between an "internal" and an "external" mother, one being the "double" of the other. This "double" "at once undergoes alterations in the child's mind through the process of internalization; that is to say, her image is influenced by his phantasies and by internal stimuli and internal experiences of all kinds". She goes on to say that "external situations" that follow the same route from the earliest days also "become 'doubles' of real situations and again are altered for the same reasons" (Klein, 1940, p. 346). It is therefore not difficult to extrapolate from this that particularly powerful external events can strain the defensive apparatus: the loss of the real mother, as in my next case example, means the loss of the irreplaceable object. Klein (1940, p. 353) says: "the actual loss of a loved person is, in my view, greatly increased by the mourner's unconscious phantasies of having lost his internal 'good' objects as well. He then feels that his internal 'bad' objects predominate and his inner world is in danger of disruption." She goes on to discuss how unpleasant or traumatic experiences will increase the likelihood that trust and hope will diminish and that anxieties about inner annihilation and external persecution will increase. This balance affects whether the depressive position can be established more securely or whether the paranoid–schizoid dominates. Resorting to repetition is more likely when there is less trust in "good" objects and their capacity to survive. The repetition would seem to be acting almost like a predisposition to recreate the familiar circumstances internally as well as emerging in a pattern of relationships as both memorial and communication, as discussed earlier.

The strength of resolution of these issues in treatment depends on working them through so that instead of cutting off from loss, using splitting and denial as defences, the patient is able to overcome their resistances. A "good" internal object rather than an ideal one can also now be instated. Freud (1914g, p. 155) wrote: "One must allow the patient time to become more conversant with this resistance with which he has now become acquainted, to *work through* it, to overcome it, by continuing, in defiance of it, the analytic work according to the fundamental rule of analysis."

Mr D

This final case seems to illustrate some of these themes. Mr D came for therapy in dire distress, as he tearfully explained that his family was breaking up, and he felt that nothing could be done. He wondered, however, whether I could effect a rescue. My understanding of this seemed to elicit the information that his mother had died in childbirth and he had not had a stable foster home for some time. He proceeded to describe how he had done quite well in life, formed relationships and had worked, using an independent self who was created to transcend most obstacles. He had learnt survival techniques and also looked after others, constantly reversing his early feelings of vulnerability. But lately he had become worried by his frantic panic when he felt misunderstood, and he was also finding it increasingly difficult to be away from home and family.

As the therapy progressed, it became clearer how Mr D's survival had been based on rejecting the meaning of his mother's death, although he was aware of it as a biographical fact. This he could do as long as he felt little about anyone's comings or goings: his, my own, or his family's. The illusion, fostered in his past, was maintained that none of it mattered—he could not miss what he had never known. As the worst had already happened to him, what was there to be anxious about? However, as he aged and his own son was leaving home, Mr D was faced again with his undigested, unmourned loss. His sense of a gap, of something missing, was revived, and his solution of being parented himself while parenting his son was no longer viable as a container for the projection of his own neediness. It also gradually emerged how Mr D had used a secret relationship to his dead mother—unconsciously the ideal, perfect object—to help him to face disappointments in life. She had apparently kept him going, but also kept him separated from his real, available objects and what they offered him. This left him lonely.

Jaques (1965) points out that if death has no meaning, then neither does life, so that any creative efforts the individual makes are felt

as alien and external. So Mr D found that his external creation of a new father/mother/son family was not sufficient to blot out his own past. Unless he could mourn the loss of his manic defensive solution, he would be unable to develop. Recognizing that the therapy, rather like the foster care, was not the same thing as growing up in his own family seemed to be vital. It meant that I was neither omnipotent nor confused about these differences, and it finally allowed space for his mother's existence and her loss to be faced and mourned. His survival in the future would now be seen against this background and that of his own ageing and death. The way Mr D had arrived in treatment seemed to be comprehensible, after some years of therapy, as carrying these old problems with him; he needed attention to the earliest traumatic and confused situation of his life in order to develop.

Thomas Hardy's *The Well Beloved*

Thomas Hardy's 1897 novel, *The Well Beloved*, offers a powerful literary example of the themes I have been discussing. Although Hardy wrote two alternative endings to his novel, the resolution they offer is the same. *The Well Beloved* can lay claim to exploring the same terrain as Proust's *A la Recherche du Temps Perdu*. Both recognize the importance of memories and the way repetition of personal history affects the possibilities of loving and creativity.

Hardy's story is a phantasy, with little pretence at realism or credibility. It follows the story of Jocelyn Pierston's life and his fascination with three generations of women from one family. Jocelyn, a sculptor, was born on the rocky Isle of Slingers whose quarries supplied stone for buildings in London and for his own works of art. He had not known his mother, who died early in his life, and his relation to his father is distant. The story begins with his return from travels abroad to see his father. He knew from boyhood—Hardy tells the reader—that he was subject to transient involvement with a "love" that located itself in one woman after another, migrating endlessly. This time it took up its abode in the body of his neighbour and distant kin, Avice Caro, whom he met on his return to the island. Under this spell, he quickly asked her to marry him, but when she refused to consummate their love before marriage, as required by ancient custom, he lost interest.

On his journey back to London he met Marcia Bencomb and fell in love with her, but she soon left him.

In his loss, Jocelyn was able to work successfully at his sculpture, dedicated himself to the study of female beauty, and was rewarded by becoming a Royal Academician. However, he was constantly plagued by his well-beloved:

> Essentially she was perhaps of no tangible substance a spirit, a dream, a frenzy, a conception, an aroma, an epitomized sex, a light of the eye, a parting of the lips. God only knew what she really was; Jocelyn Pierston did not. She was indescribable. Never much considering that she was a subjective phenomenon vivified by the weird influences of his descent and birthplace, the discovery of her ghostliness, of her independence of physical laws and failings had occasionally given him a sense of fear. He never knew where she would be, whither she would lead him. [Hardy, 1897, p. 34]

He discovered that his plaster-and-stone images of his phantasies tapped into public taste and brought him popular acclaim.

His friend, Summers, observed that one day he would meet his match in a woman whose own well-beloved would flit about like Jocelyn's. He advised Jocelyn not to marry and warned him that as he grew older, the situation would become untenable. This is of interest to us, for here there seems to be a presentiment that with increasing age this problem of love would have to be faced in new ways.

Twenty years passed, and now aged 40, Jocelyn returned to the island, where he learned of Avice's death. Filled with memories of her, he was astonished to see her double, young and unchanged, incarnated in a local girl. He learnt that this girl was no vision, but Avice's daughter, and he pursued her. He moved back to the island, but found that she was afraid of his attentions, and she finally confessed that she, too, had trouble with a migrating image of her beloved. It roved from man to man as his did from woman to woman. Undaunted, Jocelyn decided to try at least to look after her, and took her back to London with him. Later he discovered that she was secretly already married and was pregnant, so he brought about reconciliation between this Avice the second and her husband Isaac.

For twenty more years Jocelyn worked and travelled and knew nothing further of the couple's life, until by chance he heard that Marcia had gone back to the island. Simultaneously, he received a letter from Avice the second, saying that she was now widowed and would like to see him. Now aged 60, Jocelyn again returned to the island to find her child, now 20, the latest incarnation of his original love, Avice. Jocelyn felt driven to court this third Avice, although the disparity in their ages was shocking to both. Their marriage was encouraged by the girl's mother—Avice the second. The young girl was discovered in time to have a lover of her own age, who was in fact Marcia's stepson, and these two eloped. Avice the second then died, and after all these shocking events Jocelyn fell ill. He recovered to find that Marcia had nursed him back to life. In the twilight of the sick-room, Jocelyn saw her as miraculously young and unchanged. She told him that this was an illusion of makeup and bravely offered to reveal herself to him without artifice.

> The cruel morning rays—as with Jocelyn under Avice's scrutiny—showed in their full bareness, unenriched by addition, undisguised by the arts of colour and shade, the thin remains of what had once been Marcia's majestic bloom. She stood the image and subscription of Age—an old woman, pale and shrivelled, her forehead ploughed, her cheek hollow, her hair as white as snow. [Hardy, 1897, p. 201]

In seeing her so, Jocelyn was relieved to acknowledge his own ageing, so long denied; gratefully and without regret he saw the departure of his plaguing phantasies. With them went his interest in art and in beauty, and he gave up his studio, feeling that a curse had been removed from his life. He and Marcia, to the delight of the islanders, settled into a close relationship. They reconciled Avice the third with her husband, and Jocelyn devoted himself to good works on the island. The endless romantic cycle was broken by their acceptance of the reality of time, age, and death. The curse of Aphrodite was broken, and Jocelyn found true love when he joined in the reality of being human and therefore subject to the laws of time.

* * *

Werman and Jacobs (1983) discussed *The Well Beloved* as an example of infatuation, "a painful, repetitive and finally absurd ritual" (p. 448) that Jocelyn is compelled to enact until the end of his life. They list the characteristics of infatuation in the story; the lover having an intense, irrational, dreamlike experience of an idealized object. They point to the fundamental ambivalence and how, as flaws in the beloved inevitably become visible through closer acquaintance, so disappointment follows. Werman and Jacobs (1983) go on to give biographical details to link Hardy's personal experience with his fiction. For example, they wonder how he could have written such a story if it were not for his own difficult experience of marriage, his youthful closeness to a much older woman, and his several love affairs.

While it might be interesting to pursue this line and wonder about the function Hardy's fiction served for its author in healing his past and present, I want instead to briefly discuss this notion of infatuation, so vividly described in *The Well Beloved.* Werman and Jacobs (1983) refer to Kernberg (1974) as saying that "people who become infatuated are incapable of establishing object relation; infatuation is a repetition compulsion whose origins are in developmental failures" (p. 448). Certainly Hardy's hero, Jocelyn Pierston, seems unable to process loss or face depressive anxieties until the last phase of his life. The mother earth of the island and the perfect feminine principle embodied in *The Well Beloved* were entwined and seem to represent a powerful maternal imago. Given that Jocelyn did not know his mother, there is a feeling that he is intensely searching for some real embodiment of her in order to evade his loss. Unconsciously, his lost mother is the model of an ideal woman, and his difficulty in seeing her as a whole is epitomized by the description of the partial features (voice, aroma, and lips) that captivate him in turn. This seems to depict the operation of the infantile mind, experiencing only fragmented aspects of the mother at first, as described by Klein. Without a real person who might become coherent through reality-testing, Jocelyn is left with a series of part objects that momentarily appear to cohere and create a passing facsimile of perfection. His experience is like "falling in love", but he is constantly faced with the absence of a real model for his affections as the fascination wears off. His experi-

ences with three generations of Avice Caro dramatize this inability to get away from his early loss and his imprisonment in the repetition compulsion.

Hardy remarks that Jocelyn Pierston does not produce great art. This seems to represent awareness that sublimation is only partially successful as a solution to his psychic difficulties, as well as preventing him from really loving. Once Jocelyn accepts the reality of ageing, he loses interest in his art, as if its source were pathological. He also turns to repairing the island that his father's quarrying has ruined, as if to repair the mother earth. His first concern is said to be to restore clean drinking water to the local people—surely a significant symbolic gesture of reparation.

* * *

In the case material and in the portrayal of the struggles of Jocelyn in Hardy's novel, the overshadowing presence of early loss is visible. The persistent effects of catastrophic loss, particularly in delaying the recovery of what Klein (1940, p. 362) thought of as harmony in the inner world, is evident as the world is stripped of its goodness, leaving the infantile mind in the grip of terror that it will not be able to survive. At such times it seems that all friendly figures have deserted him. In the relatively ordinary developmental experiences of the series of losses proceeding from the first absence of the breast, the child builds up stamina and has the memory of surviving to draw on. When there has been an unacceptable loss, there is a really lost, damaged object inside, reinforcing the belief in fragility and a reminder that survival is not guaranteed.

In conclusion, I return to Klein's (1940, p. 344) paper on mourning, where she says, "In my view there is a close connection between the testing of reality in normal mourning and early processes of the mind. My contention is that the child goes through states of mind comparable to the mourning of the adult, or rather that this early mourning is revived whenever grief is experienced in later life. The most important of the methods by which the child overcomes his states of mourning is, in my view, the testing of reality." The clinical material and fictional account outlined here

reflect some of the different defensive arrangements that can be made to defer or refuse to face the reality of loss. The reactivation of old grief in later life can be the undoing of these old, apparently acceptable compromises between knowledge and feeling and show up the costs of maintaining these structures.

The first patient, Mrs E, developed a somatic solution, and her experiences of panic led her to worry that she was going to black out, lose consciousness, or die. She had medical investigations to reassure herself that she was not physically ill, only to find that she had cleared the way for worrying about her mental state. It seemed almost preferable to lose her mind or to have to go to bed and retreat from the world than to face exploring the contents of her mind—especially the hatred of her siblings and the sense of loss of her mother's attention.

Mrs G, on the other hand, suffered from alternating manic and depressive states. She often retreated into a world in which she omnipotently controlled things and expelled badness into the outside world. Unfortunately, it returned to plague her in the form of persecuting anxiety that her baby would not survive, and she felt that she had to watch over the badness to try to keep her safe. Hence her identification with a bad mother inside operated to spoil any good qualities either she or her objects had. She felt that the only safe place for the baby had been inside her, and ever since their separation at birth she felt that the world was untrustworthy. The additional fact that members of the family had died young seemed to be further evidence of the dangers; thus the cycle of mistrust persisted.

In Mr D's case, an apparently much more functional solution had been possible as he had created a new family to provide him with what had been missing in his own infancy, and this external reparation seemed to help him survive quite well. However, predicated as it was on the denial of the fact of his mother's death, it was fragile, and his infantile rage, loss, and distress kept reappearing to remind him of it.

Perhaps one could characterize Jocelyn Pierston's solution, in Hardy's story, as one of obsessional repetition; while he did not retreat from life and unbearable reality into psychosis, he certainly is described as maintaining massive denial of natural processes.

The consequences were that he could not form a partnership nor have a family, nor could he enjoy his work. He suffered from the pursuit by his well-beloved phantom until he could finally face the fact that all three of the Caro women were lost to him. This was the beginning of his recovery.

The child wants to grow up and have all the perceived advantages of maturity and power. However, as I hope I have illustrated, this appears on closer acquaintance to be a complex and erratic progress, since the unconscious forces of repetition are ranged against us. As psychotherapists trying to think about and intervene in such processes, we do well to be vigilant to their appearance in the transference.

CHAPTER THREE

Interrelationships between internal and external factors in early development: current Kleinian thinking and implications for technique

Jessica Sacret

In this chapter I want to explore, in a necessarily somewhat schematic way, some of the issues implicit in current theoretical developments in the Kleinian literature and to elaborate some of their implications. More specifically, I want to focus on the relationship between internal and external influences in psychic development, insofar as these are highlighted in the discussion of issues underlying the understanding and treatment of patients whose therapy seems to present particular difficulties by virtue of the predominance in the personality of what has come to be known widely in the literature as a "pathological organization" of the personality (Spillius, 1988). For example, Joseph (1975) has described "patients who are difficult to reach"; Steiner (1993) uses the notion of the "psychic retreat"; and Rosenfeld (1971) has elaborated the concept of "destructive narcissism". Others in the Kleinian tradition have also written on the subject of this now well-documented albeit diverse phenomenon.

The notion of the "pathological organization" is of a complex system of defences "characterized by extremely unyielding de-

fences and which function to help the patient to avoid anxiety by avoiding contact [I would say, intimate contact] with other people and with reality" (Steiner, 1993, p. 2). The idea also encompasses widely differing phenomena encountered in the consulting-room: withdrawal, stuckness, or deadness on the one hand, or destructive and self-destructive behaviour on the other. Joseph (1989b) describes the ways in which patients can appear to be making progress, but this is never maintained. Thinking about patients who could be described in such terms, and in perusing the literature, I found it helpful to disentangle my thoughts about seminal Kleinian concepts such as "the death instinct", "envy", and "destructiveness", and how these notions link with the aetiology of the pathology in question.

In my clinical work I have found that many—although not all—of the patients who seemed to have the most difficulty in allowing change, or who seemed to be unable or unwilling to make use of the therapy, were also those patients who presented histories of traumatic experiences, whether sexual, physical, or emotional, including traumatic neglect or loss. This made me think carefully about the relative influences of intra- and extra-psychic forces and their interplay in the difficulties displayed by my patients. It also made me consider more fully the implications for technique of understanding the pathological organization in terms of its aspect as defensive against trauma originating from the environment.

The emphasis of Kleinian thought has developed from its early, perhaps somewhat exclusive focus on the intra-psychic world of phantasy, where phantasy is thought to be the primary factor in psychic development, to a more fully interpersonal view, via Bion's work (1962a, 1962b) on containment, which gave a crucial role to the mother's capacity for reverie. Recently, we have seen the publication of a volume of papers from writers influenced by Klein on the issue of trauma—that is, the impact of external, albeit extreme, events on the psyche (Garland, 1998). In that volume, Bell points out that the relationship between the internal world and external events is often discussed as if they were opposing categories. However, from a psychoanalytic point of view, he says, we are interested in "how, in the interplay of projection

and introjection, external experiences are represented, internalised and dealt with" (Bell, 1998, p. 168). In reading the early Kleinian literature, one can gain the impression that the role of external factors in development is negligible or non-existent; that pathology is always and exclusively the result of innate destructiveness, linked with the death instinct; and that the related concept of constitutional envy is entirely responsible for the existence of a weak ego linked with the inability to internalize the good breast.

Although this characterization is presumably somewhat of a caricature of what Kleinians actually believed, this is often the impression given and the view held of Kleinians by other psychoanalytic schools. As Spillius points out, "Both Klein and her followers have often been accused of overemphasizing the negative" (Spillius, 1988, p. 7). It seems that when Klein first formulated her theories, the part played by aggression and innate destructiveness, which she linked to the death instinct, was emphasized both by herself and by other analysts just because she gave more weight to them as factors in the formation of pathology than did Freud (see Hinshelwood, 1989, who gives the history). A consequence of this, allied to her equally controversial view that unconscious phantasy is present from birth (Klein, 1958), meant that the early Kleinian literature seemed to reflect a view that the aggressive and destructive phantasy of the child was not only dominant but overwhelmingly pre-eminent in the causation of its pathology. Any potential influence of the environment, in the shape of maternal and familial failure, was not emphasized.

An eminent example of this is Segal's (1964) seminal work, *Introduction to the Work of Melanie Klein,* where the discussion is carried on almost exclusively in terms of the child's phantasies, projections, and introjections, and no mention is made of any reciprocal impact the maternal figure might have on the child's defences and psychic development. However, since Bion (1962a, 1962b) has made the basis of psychic health the relationship between container and contained, a focus has developed whereby maternal and environmental failure are sometimes offered as relevant to the understanding of pathology. In the body of current Kleinian thinking, thus, there has been a movement towards a greater recognition and acknowledgement of the contribution

played by the mother and the parental couple, an inevitable movement following the general acceptance of the theory of containment, which is discussed below.

Klein became aware, by the 1950s, of the sorts of criticisms outlined above, that she ignored influences of external reality, and she was at pains to spell out her position. Envy, she wrote, is to some extent constitutional, though varying individually in strength and interacting from the beginning with external circumstances.

> Furthermore, whether or not the child is adequately fed and mothered, whether the mother fully enjoys the care of the child or is anxious and has psychological difficulties over feeding—all these factors influence the infant's capacity to accept milk with enjoyment and to internalise the good breast. [Klein, 1957, p. 179]

Spillius emphasizes the point, and to my mind makes the characterization of envy truly object-relational. She writes that:

> The expression of envy, and indeed of love and hate in general, occur and develop in relationships with objects, so that one can never meet the constitutional component unmodified by experience. Nor can one tell, from the perspective of the consulting-room, how much of a patient's envy is constitutional, how much has developed because of his experiences with objects, or how much is the result of the process of interaction between the two. What one can tell from the way he behaves in the consulting-room is what his envy is like in his internal world now, how severe it is, how it expresses itself in reaction to his analyst, and what defences he uses. [Spillius, 1993, p. 1201]

Spillius is acknowledging that it is impossible to prove or disprove the existence of the death instinct. Clinicians working in the Kleinian tradition do not find it difficult to believe that something intrinsically destructive might be at work, linked with the operation of the death instinct, whilst the non-Kleinian may see it in more purely defensive terms. Experienced clinicians working in the field disagree on the issue. (For example, see Rosenfeld, 1971a, on destructive narcissism, in reply to Kernberg's, 1967, attempt at a rebuttal.)

However, as Steiner suggests, "It is not necessary to resolve controversial issues about the death instinct to recognise that there is often something very deadly and self-destructive in the individual's make-up which threatens his integrity unless it is adequately contained" (Steiner, 1993, p. 4).

He thus acknowledges that we do not have to believe in the death instinct to recognize destructiveness and envy in a patient. To my mind, what is important is how we think of the interplay between internal and external influences in the operation of what appears to be destructive or self-destructive behaviour.

Klein always placed more importance on the death instinct than did Freud, because her work with small children revealed the extent of their aggressive phantasies and consequent fear of retaliation. She believed that the powerfully harsh superego she encountered must be an early manifestation of the death instinct, of which, like Freud, she said that a portion is directed outwards and becomes, for her, linked with the notion of envy, whilst the portion remaining within becomes directed towards the ego. This internally directed death instinct, in post-Kleinian conceptualization, becomes the basis for destructiveness and self-destructiveness and for the formation of the pathological organization. Thus in Klein's view, we are born with disintegrative tendencies due to the operation of the death instinct with its characteristic mode of operation of attacks on linking.

Segal (1993) gives a helpful clarification of the psychological impact of the life and death instincts. She points out that pain and anxiety come from the urge to live; pain and conflict are an inevitable aspect in living. Death, on the other hand, is the absence of conflict and is the desire for oblivion. The experience of need, the drive that connects us to others, can be dealt with in two alternative ways. The life-oriented way manifests itself in the drive to satisfy needs, which leads to object-seeking and love. The death-instinct-driven way is to annihilate the need, or the perception of need, or to attack the ego that perceives the need.

Early writings on sabotaging phenomena emphasize the dominance of "bad" over "good" parts of the self (Meltzer, 1973; Rosenfeld, 1971a). Others focus on the operation of the destructive superego (Brenman, 1985; O'Shaughnessy, 1997). Sohn (1985) and

Rey (1979, 1994) have also written in this area; and Joseph (1989b) has made a unique contribution. A developing line of thought has been to think in terms of a fixed constellation of defences, accounting for the power and persistence of the resistance to change. This notion was elucidated by O'Shaughnessy (1981), who described a psychic system conceived of as a defensive organization operating in a systematic way, as opposed to the previous general idea of defences acting in a comparatively piecemeal way. A paper by Segal (1972) describes a delusional system developed as a defence against annihilation. A crucial aspect of such a structure is that it is organized around omnipotent phantasies and defences.

Spillius summarizes the current Kleinian thinking:

> There are two main strands of thought in the idea of the pathological organization. The first is the dominance of the bad self over the rest of the personality; many authors point out a perverse, addictive element in this bondage, indicating that it involves sado-masochism, not just aggressiveness. The second strand is the idea of development of a structured pattern of impulses, anxieties and defences that root the personality somewhere in between the paranoid–schizoid and depressive positions. This pattern allows the individual to maintain a balance, precarious but strongly defended, in which he is defended against the chaos of the paranoid–schizoid position, that is, he does not become frankly psychotic, and yet he does not progress to a point where he can confront and try to work through the problems of the depressive position with their intrinsic pain. There may be shifting around, and at times an appearance of growth, but an organization of this kind is really profoundly resistant to change. . . . There is considerable variation in the psychopathology of pathological organizations, but the analyses of these individuals tend to get stuck, either to be very long, only partially successful, or sometimes interminable. [Spillius, 1988, pp. 195–196]

Whilst Joseph (1982) expresses a common view in her belief that the pathological organization is both a defence against, and the expression of, the death instinct and leaves it at that, Rosenfeld (1978, 1986) cites deprivation by the external object, both in the past and the present, as a factor.

Steiner has particularly elaborated the notion of the pathological organization, which he prefers to call a "psychic retreat". He suggests that such an organization "serves to bind, to neutralize and to control primitive destructiveness whatever its source, and is a universal feature of the defensive make-up of all individuals" (Steiner, 1993, p. 4). I note here that Steiner is careful to state that although he thinks primitive destructiveness is universal, he refers to it as defensive and is wanting to make it clear that he is not assuming the existence of innate destructiveness implying a belief in the death instinct. He also cites trauma and neglect as causative in the formation of the pathological organization.

I have accentuated the developing tendency for failures in parenting function to be mentioned in descriptions of pathology, because it appears to me that the view we hold on this issue has important implications for technique. Bion says that

> . . . on some occasions the destructive attacks on the link between patient and environment, or between different aspects of the patient's personality have their origin in the patient, in others, in the mother. [Bion, 1959, p. 106]

Britton, too, puts it that, "on the one hand there was the patient's inborn disposition to excessive destructiveness, hatred and envy; on the other there [is] the environment which denies to the patient the use of the mechanisms of splitting and projective identification" (Britton, 1992a, p. 109–110).

Bion's notion of containment involves the mother's capacity to accept and modify, through reverie, the baby's projections of terror, rage, and envy, and of proto-mental and beta elements that are unmanageable to the infant's psyche. An inability to accept and contain projections on the part of the mother can result in an experience of nameless dread for the infant and a sense that his communications are stripped of meaning. Hence, although there may be an innate disposition towards destructiveness, a crucial factor in the infant's development is the mother's capacity to contain and modify that destructiveness. In the view of Hyatt Williams (1998, and personal communication), the death instinct has to be modified by the containing mother if severe pathology is to be avoided. Britton suggests that a vital contribution to the

mother's containing function is the father's capacity to contain the mother in her relationship with the baby.

According to Britton, Bion suggested that "if this relationship between mother and infant goes badly wrong, instead of a helpful superego, an 'ego-destructive superego' develops . . . when containment goes wrong in some people, it produces a part of themselves opposed to themselves . . ." (Britton, 1992a, p. 107).

This would be the state of affairs that leads to the development of the ego-destructive superego, and the elaboration of this structure in terms of internal objects that attack the ego can result in a pathological formation. In the same paper, Britton goes on to make the interesting point that he has noticed that patients whose problems stem from parental difficulties in containment are often very responsive to analytic work, in distinction from patients whose more severe pathology, he believes, implies an innate component.

A very problematic consequence of inadequate containment is when any change is felt by a patient to be a step on an inevitable descent into chaos and the terrors of fragmentation. There has to be some sense of psychic continuity for there to be the possibility of change. Otherwise it will be experienced as "catastrophic" (Bion, 1967). The underlying anxiety of someone in an uncontained state of mind is described in graphic terms by Britton as resulting in the phantasy of incarceration or disintegration, the only alternatives being a deathly container or exposure in a shattered world, as Rey (1979) describes it. Britton points out that the movement between the paranoid–schizoid and depressive positions is not just an oscillation backwards and forwards between the two, but represents the process of learning and change throughout life; that we are always having to deal, if we can, with the terror of letting go of certainties in order to allow the possibilities of change, new thinking, and the potentiality of new situations to occur, a process that can go on indefinitely.

Although the term "trauma" is in general use throughout the non-Kleinian literature, Baranger, Baranger, and Mom (1988) point out that Klein uses the term "trauma" hardly at all. Hinshelwood (1989), in his *Dictionary of Kleinian Thought*, omits it completely. Baranger et al. suggest that in Klein, the concept of trauma is absorbed into the general anxiety situation of the paranoid–schizoid position and that it "shifted somewhat . . . towards

the term 'anxiety situation' . . . which only partly covers the Freudian concept of the traumatic situation" (Baranger et al., 1988, p. 121).

However, this way of thinking has changed, as indicated by the publication of the book *Understanding Trauma* (Garland, 1998), which contains many papers by analysts of the Kleinian tradition. Bell, in his discussion of "External Injury and the Internal World" describes the traumatic situation as "the breaking through (often described as a breakdown) of unmanageable anxiety and mental pain; a breakthrough which is brought about by a combination of internal and external factors" (Bell, 1998, p. 167). Some major life events, loss, profound life changes, or catastrophic events like the sinking of a boat or a train crash are obvious sources of trauma. In the present period of sensitivity to issues surrounding sexual abuse, we are also only too painfully aware of these phenomena and their psychic consequences, often termed "traumatic stress disorder".

As I have suggested above, Kleinian writers, until recent decades, have perhaps been wary of acknowledging the contribution of environmental failures, at least in their writings, in contexts less obvious than that of sexual abuse or gross violence or neglect. The analytic method is to examine the part played by patients in their own pathology—in particular, the role of unconscious phantasy. However, to acknowledge the part played by extra-psychic failure in no way denies the importance of phantasy. Because Kleinians have—rightly, in my view—insisted on the importance and universality of unconscious phantasy (Isaacs, 1948) as underlying all thought processes and all behaviour, this does not mean that there is not a clinical responsibility to tease out, with every patient, insofar as it is possible, any contribution from the extra-psychic environment. Steiner states that

> pathological organizations have a particular role to play in the universal problem of dealing with primitive destructiveness. This affects the individual in profound ways, *whether it arises from external or internal sources*. . . . Traumatic experiences with violence and neglect in the environment leads to the internalisation of violent disturbed objects which *at the same time serve as suitable receptacles for the projection of the individual's own destructiveness*. [Steiner, 1993, p. 4, italics added]

Thus it is by no means a question of evading responsibility for destructiveness, rage, or envy, but of disentangling the projections into internal objects whilst acknowledging to the patient the parental failure when it exists in reality, insofar as this can be ascertained.

In many clinical situations there may be traumas that cannot be known about but only inferred through the countertransference, as in the trauma of non-containment. Or there may be other infantile traumas because of other parenting failures that are not obvious in the clinical situation and may only show themselves through the medium of apparently destructive behaviour. There is the possibility, which can be hard to detect, of parental projection into the infant, a phenomenon that can be traumatic if it is in the form of a violent evacuation. Bell (1998) makes the point that an external event, which may appear altogether trivial, can have a traumatizing effect on an individual because of the particular meaning it has for him. We need as clinicians to be aware of these possibilities of traumatic occurrence that the patients themselves may not be aware of. To attribute responsibility to a patient in connection with a traumatizing incident is to risk re-traumatizing them and may certainly lead to hostile and destructive responses.

An experience of trauma, which may be linked with catastrophic fears of terrifying fragmentation, may be defended against, I have argued, by means of a pathological organization or psychic retreat. I have shown that it is well agreed that inadequate containment can itself be traumatic. When a patient is close to a traumatic trigger, that may be the time when he or she is the most destructive. It is therefore important to understand what may be at stake for the patient when as therapist one may be under tremendous pressure from countertransference reactions to enact a critical, angry, or sadistic response.

In the context of the most horrific abuse one can imagine, Johns, in his review of *Treating Survivors of Satanist Abuse* (Sinason, 1994), makes the point that the book "raises considerations about the role of trauma in the genesis of mental illness and how the developmentally appropriate defences that are available to the immature child are used in an effort to protect it from the overwhelming impact of the trauma but will then result in maturational distortions ... there are important matters concerning

technique because the treatment of such brutalized victims has the possibility of retraumatization, either because of disbelief, or by a refusal to value some conception of the patient's personal history that would allow reconstruction of the horrific past from within the transference and countertransference experiences" [Johns, 1998, p. 1257]

I have argued that the same holds true when dealing with less obvious and less brutal abuse than that which Johns is describing, but which is nonetheless truly traumatic for the individual. In an earlier paper (Sacret, 1998), I have argued for the necessity of holding on to the healthy and sane part of the patient when under siege from the attacks, overt or covert, from a patient who is at that moment trying to keep the therapy from touching aspects of themselves that are felt to be unbearable and catastrophic. I would like to restate some theoretical and technical points about omnipotent defences when working with patients in these states, usually described as borderline.

When there has been a failure in the global situation of early containment, or other early trauma, primitive omnipotent defences are maintained when in normally healthy development, they are largely given up under the developing influence of the sense of reality, what Freud (1911b) referred to as the "reality principle", to be revived at times of particular stress, or as the result of trauma later in life (Garland, 1998). At the same time, there is the part of the personality, linked with the pleasure principle, that wishes to hold on to phantasies of omnipotence whether or not there has been any failure. Early omnipotence with its phantasy of possession of the mother/breast is thus a normal state of the primitive mind, related to the early dominance of the pleasure principle (Freud, 1911b).

The early response to frustration, the hallucinatory omnipotent phantasy of the need-fulfilling breast, has to be replaced by the recognition of a need that is not being met and the possibility of containing the frustration. If things go wrong, the early and normal phantasy of possession of the breast can become a denial of dependency and vulnerability consequent on the phantasy of omnipotent control, associated with its characteristic hallmarks, grandiosity and manic defences. There are massive projections into the mother, and later into other important figures, if containment is

inadequate, as a way of getting rid of unwanted feelings and to deny separation.

If containment and early care is good enough, thinking evolves in the gap between the experience of the need and its satisfaction and aids the process of tolerating frustration. If it is not, omnipotent phantasies persist in the form of the phantasied discharge or evacuation of unwanted, unmanageable sensations and feelings into the object. This has the dual function of ridding the psyche of unbearable feelings of rage, terror, and pain and of denying separation, as the object is now felt to contain large aspects of the self. The result is also a state of confusion of which the severity varies with the extent of the projections.

When, as a result of progress in therapy, omnipotent defences are threatened, a normal response is rage (Rosenfeld, 1971b). How this rage is understood and interpreted is crucial in the negotiation of this stage of the therapy. It seems to me that there can be two different aspects to this rage, distinguishable in principle but not necessarily in the clinical situation, which need recognition in the interpretations made. One component I would link with libidinal aspects of the personality, which relates to real failures in parenting and which I therefore think of as "realistic" rage. I think of this as "libidinal" because it seems to me to express a healthy wish for good-enough containment and parenting. This rage is directed at early failures that may have left a legacy such as, for example, an unalterable tendency to experience any meaningful loss as traumatic and/or a persistent potentiality to experience terror, pain, dread, or terrifying states of fragmentation and disintegration. It seems to me that this anger deserves recognition and the failure acknowledgement before a patient can move on to accept the pain of the reality. In the transference this becomes directed at the therapist as the present-day representative of parental failure, and one can see very clearly why Freud spoke about the transference as a defence against the recognition of reality. The rage can be used also to function as a defence against the pain of reality, which contains the normal but inevitable pains of loss and separation that expose the patient to envy and jealousy.

On the other hand, there can be a rage that appears more deadly and destructive or self-destructive. This kind of rage stems

from an omnipotence that hates reality, hates the conflict between love and hate, and hates the inevitable pains of living. This part of the personality demands control, certainty, and invulnerability. It operates like a dictator. It attacks the healthy part for being needy and dependent and hates the therapist for arousing those feelings. This kind of rage I think of as emerging from the "psychotic" part of the personality. It tends to be uncontained and uncontainable. Although it may also be, theoretically, understood as being defensive, at least in part, in being linked with profound failures in containment or massive early trauma, it becomes invested with a quality more connected to the death instinct. There can be pathological splitting with fragmentation and violent expulsion into objects, including the therapist (Bion, 1957). It is at this point that the therapist needs all his or her own capacity to contain their own countertransference because the patient may be intending to elicit in the therapist an angry, condemning, or sadistic response. The patient can then triumph in the therapist's "vulnerability" and in their status of victim. Vulnerability and dependency may be projected into the therapist, who is then derided for not being omnipotent.

The more containing and realistic the therapist is, the more the psychotic part of the patient may intensify its modus operandi. It is crucial at this point for the therapist to keep in mind the non-psychotic part that wants to be able to depend on help and to progress, and to try to talk to that part of the patient's personality, even when this healthy part seems to be entirely absent or completely submerged by the psychotic part (Bion, 1957). The therapist may be attacked for being the representative of sanity or reality, although this will be dressed up as something that sounds more like a realistic grievance. The omnipotent part of the patient may masquerade as healthy and be full of subtle strategies for representing the omnipotent position as the normal and sane one, off-loading responsibility for destructive behaviour onto the therapist (Lucas, 1992).

With some or all of these differing aspects of anger, rage, and destructive and self-destructive behaviour operating in a clinical situation, it can be an impossible task to do justice to them all. However, I believe that the important point is that a person who is

in the grip of a defensive system like a pathological organization may have suffered early traumatic circumstances that require sympathetic hearing (Rosenfeld, 1986), even though the "realistic" rage may be associated or fused with a more psychotic rage, which has to be stood up to with firmness (Lucas, 1992). This is where the work becomes very difficult, as the defences are powerful, as has been described. The perverse strategies that may emerge at this point may also be very hard to bear for the therapist, and it is helpful to keep in mind the terrors that may be being defended against. Such a patient will find it hard to accept and work through the reality of separation and the necessity of giving up phantasies of omnipotence. He or she may also find it extremely painful to acknowledge the need for reparation to parental figures, internal or external, who are also human and who may equally have been inadequately contained or traumatized themselves. This pain, depressive and reparative, is very hard to work through for such a patient. Rage, especially when it has a psychotic component, can also be expressed for prolonged periods in destructive or perverse ways and used as a defence against the pain and the acceptance of reality, past and present. This seems to me to be the territory on which the interminable therapies are operating. Often it is easier for the patient to keep the therapy stuck and the therapist impotent or "bad" than to face the pain of reality.

Some of the dynamics that I have been describing have been present in aspects of the therapy with a patient whom I shall call "Mr N".

Mr N

Mr N has been coming for therapy for seven years, three times weekly for most of that time. He is 36 years old. He was born into a working-class family in the north of England and was the oldest of three siblings: he had a sister six years younger and a brother eight years younger. He describes a close relationship with his mother until his sister was born, but after this point what he mostly remembers is incidents where he would be beaten by his mother with a cricket bat. His father was usually not there when these incidents happened, but when he

was, he did sometimes intervene. Early on in the therapy, these actions by his father were described with a self-satisfied grin and a comment that he could twist his father around his little finger.

Although I was quite horrified by what were described as violent and sadistic attacks by Mr N's mother, in monitoring my feelings I concluded that my reaction was one that stemmed entirely from myself—that is, at this early point in the therapy there was no projection into me of pain or anger from the patient. This alerted me to the fact that for Mr N there was no object available for projecting into and that we were up against a profound failure in containment. Quite a lot later I understood that when, quite regularly and untypically for me, I found my thoughts drifting off when Mr N was talking about apparently quite ordinary but in no way boring topics, I was being affected by Mr N's own annihilation of some of his past traumatic experiences. As we have become more in touch with the reality of the experiences and feelings, I have stopped drifting off. In time, I also connected the drifting off and Mr N's tendency to annihilate bad objects with the way he seemed to deny the existence of his siblings. Although he talked about the birth of his sister, for years I did not know of the existence of the younger brother, and both siblings would disappear altogether from his descriptions of family life, as if they truly did not exist.

Another prominent countertransference reaction was a sort of distaste I experienced at Mr N's obvious pleasure and satisfaction as he described these beatings and the way in which he boasted about them and showed off his bruises at school, even though I was aware of this as his inevitable defence in attempting to triumph over the trauma of being beaten by his mother. I felt this reaction of mine reflected also Mr N's healthy awareness of the perversity of this behaviour, since although there were clearly severe difficulties, Mr N could often elicit caring responses from me, from which I inferred healthy good internal objects that could at times exist in an undamaged state. On the other hand, I gathered from a dream, in which Mr N *threw off his dirty and soiled clothes, had a bath, and walked off with a*

"social worker" type, that Mr N, unsurprisingly, wanted me to rescue him in an omnipotent way from his past without having to come to terms with the pain and rage of it.

Mr N had come to therapy after the end of a homosexual liaison that had been characterized quite frequently by sado-masochistic violence, both emotional and physical. Finally, he had been left. During the relationship, Mr N had been very attached to this partner, who could, at good times, love him and support him. Although Mr N's suicidal feelings were angry for two years after this loss, and, again, I could not be used as an object to project into, his responses made me realize that he had a strong capacity for love, albeit in a narcissistic and unseparated way. He could feel pain about this partner that he had never felt about his mother. However, during this beginning period of the therapy, he acted out continually, in drinking regularly to stupefaction, in sexual seductions of married women, all the while coming to tell me of these episodes with the perverse sense of triumph that made me aware that part of this behaviour was intended as an attack on me by "proving" that I was useless and had not made him better. After about 18 months of Mr N telling me he did not want to come, that he did not need it, and that he was only here for his friends—whilst never missing a session and always arriving on time—he settled down into a pattern that continued for a few years and can still re-emerge in times of stress.

This pattern consisted in my being subtly invited to be the attacking mother by means of Mr N's intensely provocative and perverse behaviour. Sometimes Mr N could be sensitive and apparently hard-working in the therapy, although I think this could only happen when his own overwhelmingly violent feelings were totally split off and annihilated. But at those times I felt we could work together, and I felt we both learnt more about his internal world, which was full of confusion. However, whenever there was a "good" session in terms of a sense of contact being established, I was treated in the following session to behaviour that I found quite unbearable. There was a tricky, triumphing atmosphere where everything I said was attended to apparently seriously, but in reality was treated

with a response that I experienced as a contemptuous, belittling, triumphing annihilation of my efforts to interpret, reach, and stay in contact with a healthy part of him that did not want to be like that. These early attempts of mine were unsuccessful, and the perverse masquerade tended to be intensified.

At this point, I mostly found it impossible to hide my feelings of annoyance and sometimes anger. Nevertheless, I persisted in interpreting that he had succeeded in making me get angry and criticize him, which felt like his mother beating him, because he was so afraid of becoming dependent on me. I was also aware that I was being made to feel so hopeless and impotent because Mr N had split off the terrible hopelessness and despair in relation to his mother and, specifically, the helplessness in being unable to defend himself against his mother's violence. He had clearly, at some point, begun to provoke her to attack him, in order to feel in control of the situation, which he did with a masochistic triumph. I wondered if Mr N's rage was rooted in an earlier trauma of infantile non-containment, and whether it was this early fragmented state that was expelled violently into his mother, as it was into me, which his mother could not stand and which led later on to the beatings. In the transference, he was trying to continue with this strategy.

My sense of impotence was also linked with Mr N's healthy part, which was also completely dominated by the pathological organization and was therefore also impotent. This situation continued for a long while, where nothing seemed to change, or if it did, it seemed to be for the worse, and often I felt it was in reality truly hopeless.

In retrospect, I think that the only thing that helped Mr N was that I survived and did not throw him out. The fact that he came absolutely regularly and sometimes confessed that on occasion he made a special detour to drive past my house made me aware that there was something in him that was aware of what must have felt like an overwhelming and frighteningly regressive dependency. I noted that sessions that seemed to be filled with Mr N's perverse triumph increased in

frequency as we approached breaks. Gradually I was able to contain more and more the underlying rage, pain, and the terror he felt that he would fall apart if he allowed himself to be dependent, which was consequent on allowing me to be a helpful figure.

In time, I became an object into whom the rage could be projected. This was also difficult in the countertransference because of its overwhelming nature. It also appeared to be very primitive and linked with early omnipotence, as it arose in connection with developing conscious awareness in Mr N of feeling dependent on me. I formed the hypothesis that Mr N's problem with his mother had indeed started early on in his life, and that the traumatic beatings had revived an earlier trauma. I tried to interpret both what I have called the "psychotic" rage, Mr N's hatred of dependency and of me as someone who could help and thus aroused it, and also his realistic rage at having a mother who did not appear to have been at all able to help him with early, overwhelming anxieties that seemed mainly linked with loss of containment. I felt that she must have been a mother who could not allow a maternal reverie, who could not stand her baby's frustrations, and who always tried to gratify him. If she could not, she attacked him for his neediness. There seemed to be an internal situation of complete lack of separation, presumably brought about mainly by the wholesale projection of Mr N's primitive destructive feelings into his mother. In reality she appeared to have reenacted these in the beatings. On her own part, she seemed to have needed to be in total control. Now that Mr N is adult, she has reappeared, when he visits his parents, as a quiet, somewhat withdrawn figure who tries to help in Mr N's problems with his father.

Gradually, the powerful rage has diminished, and Mr N has become aware of becoming panicky when he felt I was out of reach, that when he starts to feel his dependence on me, he becomes very frightened. He fears loss of control and of becoming disintegrated. Occasionally, he touches briefly on feelings linked with his mother's attacks, and the pain feels truly

unbearable. I am aware he is now using me as someone he can project into as a form of communication.

Although the therapy can still be very difficult, and no doubt will continue to be so for some time, I believe that Mr N falls into the group of patients whose destructiveness was constituted less by death-instinct forces, with excessive psychotic rage; they are, rather, defensive against the terrors of disintegration linked with early problems with containment. His capacity to retain good objects and what is emerging as the beginnings of a true capacity for love and gratitude has helped him to make use of what I could offer.

Conclusion

In this chapter I have tried to illuminate aspects of the debate surrounding the relative importance of intra-psychic and external factors in the formation of personality. These will, of course, differ in any given individual; but I note that Kleinian thinking has developed since its earliest beginnings to a more realistic appreciation of external influences, or perhaps to a greater willingness to include them in the analysis of what are often complex interrelationships between internal objects and between internal and external objects. This, to my mind, makes Kleinian theory more fully object-related.

The universality of phantasy as underlying all conscious thought and feeling is accepted, but I have argued that failures in the psychic environment of the child, often linked with inadequate containment or other failures that can have a traumatizing effect, also require interpretation. I have also tried to disentangle different aspects of the rage that can emerge in a therapy, interpretation of which, it is hoped, can help in the containment of a patient during what can be a very difficult time for both patient and therapist.

CHAPTER FOUR

"Turning a blind eye": misrepresentation and the denial of life events

Mary Adams

A patient, Mr H, would often preface what he was going to say with the comment: "I know this is not really the case, but. . . ." He would then describe to me his own view of things that he knew other people would consider untrue. He was a bright young man in his mid-twenties, highly articulate and already successful in his career. However, he felt endlessly tormented by his view of the world, driven to violent rage by it, and unable to give it up. He seemed caught in a claustrum world where his only pleasure was in sadism and triumph. It was a world constructed to defend against the kinds of emotional experiences—painful or joyful—that were out of his control. It was a way, ultimately, I believe, of defending against unresolved oedipal guilt.

For the first two years of Mr H's life, as well as looking after him and his older brother, his mother was caring for her dying sister. Extreme rivalry for the mother's attention developed between the two brothers, which persisted throughout their teens and led to worrying physical violence between them. Although

guarded about this, Mr H described "whole holidays being ruined" by the viciousness of their fights. Tragically, during Mr H's adolescence his father became ill with a degenerating illness and remained in a nursing home until his death.

Although he sought therapy at the point when his father's death seemed imminent, Mr H attached no importance to this. He felt, he said, as though his father had died years before and had never really been a presence in his life anyway. What concerned him were his intense and violent feelings towards his girlfriend and his brother. While his father's illness was uppermost in my mind, Mr H felt that the real trauma in his life was shortly after his father first became ill, when his girlfriend had become pregnant and had to have an abortion. He described in dramatic detail the shame he felt at this, particularly at the fact that he had "turned away from her and tried to deny that it had happened". From that point he seems to have felt the accusing eyes of the world on him and lived in fear of being exposed and condemned for his "irresponsibility and cowardice".

Clearly, getting his girlfriend pregnant was a difficult and frightening experience for him. However, the depth of self-condemnation he expressed and the way he consequently threw himself into his studies had more the feel of fear and guilt towards a damaged and dying father. Mr H's continued conviction that it was his brother, not his father, who was his rival, taken together with his belief that it was his girlfriend's abortion rather than his father's illness that dramatically changed his life, conveyed a powerful message that this was an emotional area that could not be touched. What I want to focus on is the paralysing effect that I believe this kind of denial had on his emotional growth as well as on the therapy.

In his psychoanalytic study of the Sophocles plays *Oedipus the King* and *Oedipus at Colonus*, John Steiner discusses two different ways that Oedipus tried to deal with reality. He describes how in the first play Oedipus attempts to retreat from the truth by *turning a blind eye*, and Steiner argues that Oedipus both *"knew and did not know the truth of what he was doing"*. In the second play Oedipus is seen as expressing contempt for the truth by *turning to omnipotence and self-righteousness*, retreating from contact with inner reality,

and abandoning human values (Steiner, 1993, p. 116; italics added).

Mr H seemed to alternate between these two ways of denying reality. Both ways rely on what Money-Kyrle termed *"misrepresentation"*—namely, lying to oneself (Money-Kyrle, 1968, p. 417). The attempt to lie to oneself about reality inevitably interferes with the ability to recognize, value and accept the "facts of life"—specifically, one's dependence on internal and external objects, generational differences, the creativity of the parental couple, and finally the "inevitability of time and ultimately of death" (Money-Kyrle, 1971, p. 103–106). With Mr H, I was often left feeling how tragic it was that, in having to misrepresent reality to himself, he was left blind to the good will that existed towards him and to how human and understandable the feelings are of rivalry and exclusion that dominated his life.

Turning a blind eye

Mr H came into therapy plagued with images of his girlfriend having sex with other lovers. Rather than trying to rid himself of the images, however, he persistently goaded her into providing him with details of previous affairs—details that left him feeling inadequate by comparison. Apart from the obvious masochism involved, once he had the details, he felt fully justified in condemning her as a "slut who could never be trusted". He would become consumed with thoughts of her having "fantastic sex" with other men and would work himself up into a violent rage. This was truly an obsession with him, one that regularly filled his mind and kept him blind to the reality that she was in fact faithfully devoted to him. It was as though her very existence as separate from him represented a betrayal, and only in death would she be his alone. (For a discussion of the link between narcissism and jealous rage, see Fisher, 1999.)

As soon as he had sufficiently "disposed" of his girlfriend in his thoughts, he would then move on to someone else who elicited rage in him, most often describing his brother's "unforgivable behaviour" towards him when they were younger. The fact that they were now both adults with separate lives and hardly ever saw

each other made no difference and gives an idea of his ability to misrepresent the reality that time had passed since then.

Mr H's inner world was one of schoolboy one-upmanship in which you are either bullied or the bully—you are the one who counts or you are no one. There was no escape, no benign powerful figure to intervene. Perhaps most importantly, there was no forgiveness. It was a harsh, rigidly constructed, hierarchical world.

> In a typical dream, *Mr H was with a group of schoolmates, one of whom stood up and announced they were all displeased with him and disowning him. It was a sea of dark faces condemning him. He felt resigned to the inevitability of this and the humiliation.*

As long as he is resigned ultimately to have to face condemnation, Mr H can have little drive for understanding or developing concern for his object. Instead, everything is oriented to getting through the moment, relentlessly hounded by fear of condemnation and desperate to avoid it. Joan Riviere describes this essentially hopeless state of mind in her paper on the "Negative Therapeutic Reaction":

> All his efforts to put things right never succeed *enough*; he can only pacify his internal persecutors for a time, fob them off, feed them with sops, "keep them going"; and so he "keeps things going" . . . and *postpones* the crash, the day of reckoning and judgement. [Riviere, 1936, p. 314]

What Mr H brought to me were the raging inner battles with perceived rivals and betraying mothers and his wish to exact revenge. The only sense of a future was in some imagined final triumph and punishment of other people's wrong doings.

> In a recurring dream, *he and his brother are in a fight to the death. He fights with all his strength, beats his brother to the ground and feels good because this time he wins.*

The dream felt good, he said, because in reality he always had to back off. My sense is, however, that he did *not* back off. His story is one of always having tried to push himself forward and "eliminate" the competition.

Self-adulation as an attack on coupling

Mr H said that as a child he was always either annoyingly trying to push himself into the middle of everything to make sure he was noticed and admired or he was escaping into a world of his own. Neither of these states allowed him to notice or credit how much he actually might be valued and cared about. And it was still the case that no amount of adulation actually helped when he was caught between these two isolating ways of being, ways in which he felt profoundly unlikeable.

"Pushing himself into the middle" was something he still felt driven to, and had the quality of a child pushing himself between the parents to prevent any coupling from taking place, wishing to deny his position as the child. Mr H saw it in terms of "seeking adulation": "When I arrive at work each day", he explained, "I cannot just go to my office and get on with things. Instead, I have to spend ages making sure I have a chat with everyone from the porter on up, being sure to amuse them and have them admire me." As long as he could keep people admiring him, it seemed, he was both keeping them from being with others and postponing the condemnation to come.

Although successful in his career, he feared he could not live up to the expectations he had created. He felt he was "living a lie". If he did not need all the flattery and adulation, he said, he would prefer a simple, routine job. As it was, he lived in fear of either being exposed as not being up to the job or of having his childish, querulous, or violent self spilling out and ruining everything. I tried to point out to him the link between his inability to accept the reality of his parental couple as a couple, his own relation to them as the child, and his hatred of any evidence that he was anything less than adult.

Misrepresentation as a psychic retreat

In the analytic work, Mr H was quickly able to acknowledge how much his feelings of jealousy must have to do with his early experience and his wish to have his mother to himself. We could even marvel together at his choice of girlfriend, who, being older

than him, "confident and sexy" and someone who had undoubtedly had previous lovers, would be seen by him as much more the "unfaithful mother" than the "young, virginal peasant girl" of his sexual fantasies. Nor did he hesitate to admit that, in reality, his girlfriend was devoted and faithful to him. But still he clung to his own fantasy version of her infidelity. This was one of the most striking features of the denial—namely, his ability to hold two contradictory versions of reality simultaneously. The benefit of therapy, it seemed, was that he could tell me the details of his jealous fantasies and not have to put his girlfriend through so much heartache. Giving up the fantasies, however, did not seem to be an option.

In his book, *Psychic Retreats,* John Steiner describes how in most such retreats a special relationship with reality is established in which *"reality is neither fully accepted nor completely disavowed"*, and he sees this as "a perverse mechanism designed to keep the patient's idealized and persecutory versions of himself and his objects apart" (Steiner, 1993, p. 88). He refers to Freud's 1927 paper on fetishism, which discusses ways in which the child deals with facts of life that are difficult to accept. Significantly for this chapter, two of the examples Freud gives involve the inability of the patients (both male) to accept their father's early death. Freud says:

> It was only one current in their mental life that had not recognized their father's death; there was another current, which took full account of that fact. The attitude which fitted in with the wish and the attitude which fitted in with the reality existed side by side. [Freud, 1927e, p. 156]

Steiner maintains that "it is such misrepresentations of reality that are the chief obstacle when we attempt to help the patient come to terms with the reality of loss". He goes on to describe the situation in which, as treatment proceeds and the patient gains insight, he or she can no longer keep the opposing versions of reality apart:

> A stage is commonly reached when he can no longer maintain the split but does not yet feel able to tolerate the reality which integration brings. Perverse mechanisms then become accentuated and may lead to a stalemate if the patient is rescued by

> a pathological organisation of the personality which provides a retreat or shelter in which the perverse reconciliation of opposites is allowed. [Steiner, 1993, p. 94]

I believe it was this kind of stalemate that I reached with Mr H after two years of treatment as he found his own version of reality less and less tenable.

Misrepresentation of intercourse

A retreat from reality can sometimes mean a retreat to an anal world in which differences are denied and control of the object is paramount. Furthermore, "living a lie" and in fear of being found out restricts the spontaneity and risk-taking essential to real intercourse within the analytic relationship as well as in his personal life.

Mr H sought therapy genuinely worried about his potential for destroying everything and losing everyone. However, we were immediately faced with his wish not to know. From our first meeting he was telling me what he could not do and did not want to know. For example, he told me that he did not want to find out that he is homosexual. And he could not make any of the times I offered him, even though they had been made clear before we met. It seemed I was to fit in with his busy schedule.

Following our first (four-week) break in the therapy, Mr H chose to go away for another five weeks. This same clear message that he could not bear there to be any difference between us and that he was to be the one to control what happened was repeated with predictable regularity. It was the message when he cancelled sessions or came late after weekend breaks. It was the message when I announced my holiday breaks, and he immediately announced that he would be away before or after that. Despite the regularity of this response, he continued to take me by surprise, as it was in marked contrast to the intense involvement he conveyed in the sessions.

He invariably arrived late, huffing and puffing as though it had been a monumental task getting to his session. Once on the couch, however, he seemed settled in forever. Always earnest and hardworking, he conveyed that I was to take things seriously with

him, follow his lead, and restrict my interventions. The only thoughts he wanted me to have were those that came from him. In his view, any other thoughts that I might have had would have been from previous patients, evidence that there had been others before him. He would perform impressively and entertainingly, filling the time with the elaborate detail of the workings of his mind and creating a sense of intimacy between us, a pseudo-intimacy based more on a fantasy of our being the same than on any real emotional intercourse. To use Edna O'Shaughnessy's concepts of "enclaves" and "excursions", it was as though he were set on drawing me into a circumscribed enclave of over-closeness and then leading me off on tantalizing excursions, both modes of relating being designed to avoid real emotional engagement and facing reality (O'Shaughnessy, 1992, pp. 604–605).

At the end of each session, when I would indicate it was time, he would seem somehow stunned and would sigh and rub his eyes before reluctantly getting up. His departure was often dismaying, as he would fix me with a contemptuous look or become clumsy and in a mess.

An account he once gave of a meeting he had at work seemed similar to his sessions with me:

> "You see", he said, "in the past I would have been one of two ways. Either I would not have said a word, felt like I didn't exist, and allowed myself to be bullied. Or, I would have become loud, offensive and bellicose. At this morning's meeting, it was a set-up for all sorts of rivalry and competition, too many egos, a lot at stake. What happens now is different. I started off quiet and then gradually began to contribute more and more. The more people liked what I had to say, the more I liked the feeling, the attention, and the more I came to dominate the meeting. Then I cracked a joke, and it went down well, so I cracked another and then another. But then I felt unable to let go and let anyone else have a say."

Feeling unable to let go and let anyone else have a say, wanting to dominate and be admired leaves him little or nothing of real value or meaning to take with him. Either he is the one on stage or he does not exist. In his contempt, I am reduced to being of no impor-

tance to him. It is as though he were identified with a mother who had to fit him in, along with all the other demands being made on her, rather than a mother with whom he had a unique and meaningful relationship.

In the lead-up to our second holiday break, he was struggling with pressure from his girlfriend to make a solid commitment to her as she wanted children. Rather than focus on the emotional commitment involved, he became preoccupied with images of children mocking and humiliating him. When he returned after the break, however, he told me his partner was pregnant. While I felt shocked by this news, he seemed indifferent. He said that in his indecisiveness he had allowed it to happen but found that in some ways he liked it. Having her "on a ball and chain" he had less need to feel jealous. He even began talking about their having a second child. I interpreted his wish to sever any emotional contact between his partner and baby by keeping her constantly pregnant, producing more babies.

At this time, and six months into the therapy, Mr H's father died. Despite having been with his father during the week before, he hardly mentioned it. It was as though it had not happened, although my countertransference once again seemed to resonate with an anxiety and sadness he could not allow. Similarly, his dismissal of what his pregnant partner and now his mother were going through at this time—his annoyance with them, in fact—was disturbing. His partner was "becoming dowdy, losing her figure and her sex appeal". His mother in her grief was scorned as "getting old and repeating herself". When he talked this way, it was hard to picture how he was when actually with the people close to him, and it was often only by understanding the defensive nature of this apparent disregard for his objects, how he would idealize and denigrate them simultaneously, that I could listen sympathetically.

Ronald Britton describes how such patients feel they cannot afford to know the reality of either their internal or external objects as they expect to find them irreparably damaged, devastated or horrifying:

> They seek refuge in a state of unreality that characterises all their relationships. The "blind but seeing eye" is directed not

> only outward but inward so that it is not only the things of this world that are known and not known, but also all thoughts *and* feelings. In such persons their external perceptions lack significance and their inner experience lacks substance. [Britton, 1994a, p. 366]

At the same time, however, I believe Mr H was occasionally in touch with a part of himself that does value what others can give him. But it was a part, that presented him with the kind of depressive pain and guilt that he seemed ill-equipped to bear. Far from being contemptuous of all intimacy, he was increasingly bringing the pain of feeling caught between his wish for intimacy and his warring self. Caught in this dilemma, he would turn to fantasies to try to escape his need for others:

> In one he is a sports hero, the best there is and everyone is admiring and in awe of him. This is the "extrovert" him, he said. There is no competition involved, in fact no one else exists. In another he cuts off from the world completely, raising barriers around himself. "It is like going back into the womb or shutting myself away", he explained, "so that I can't see anyone and no one can stir up feelings".

These two states also seem to describe his alternating kinds of behaviour with me, one moment working hard to seduce me into his self-idealization, entertaining me with his colourful and dramatic descriptions, and the next turning in on himself, cutting me off, and disappearing.

The delusional retreat

Given his kind of thinking, it is not surprising that Mr H often talked about feeling trapped. Sometimes it was about situations such as being in a relationship and having a new baby, but more often it was about his own tormenting thoughts—thoughts that he produced incessantly, with clockwork regularity. When once I wondered with him about his inability to let go of his jealous thoughts, he responded, "No, it's as though they hug me". "You

make them sound almost comfortable", I replied. "Well, 'grip' then", he said, disgruntled.

No matter how persecuting the images were, the feelings that they produced were familiar, predictable, and under his control. There was a perverse kind of safety to them and a fetishistic quality in the way he was constantly working to keep the misrepresentation alive.

In one session I said, "One of the problems with holding on to such a tormenting view of the world is that it deprives you of feeling pleasure in your life, such as anticipating the birth of your first child." "I know no other way of thinking", he replied. "I don't know what pleasure is. I can never relax. Other people are able to feel the warm glow of pleasure of being in a relationship, expecting a child. That's just not something I know." This kind of despairing resignation to his fate seemed to contain the message that this way of being was not something he was about to give up. He seemed trapped in the kind of delusional pathological organization described by Herbert Rosenfeld (1971a), Edna O'Shaughnessy (1981), and John Steiner (1993), among others.

> The refuge can be a terrifying one but nevertheless is turned to as if the patient is addicted to it. . . . Once established, this type of retreat is very difficult to relinquish partly because the grievance provides a focus and purpose for the patient and partly because of other sources of gratification such as those related to triumph and to masochism. In some cases the patient appears to "feed" or "nurse" the grievance and gets gratification by "keeping old wounds open". [Steiner, 1993, p. 76]

Mr H's detailed descriptions of his various inner torments, although in one sense highly appropriate material for therapy, were like the kind of acting out described by Donald Meltzer as characteristic of the pseudo-mature patient, designed to control tightly what happens in sessions and to elicit praise rather than interpretation and understanding. Meltzer describes the subtle pressure put on the therapist to "join in the idealization of the pseudo-maturity" (Meltzer, 1992, p. 17). There were times when I felt pleased by how well we were working together and what a good patient he was, but then I realized how cleverly he would steer

things to maintain the *status quo*. Betty Joseph talks about the way defences are mobilized at the moment of nearly having to face psychic reality:

> [The patient] believes that [he] wants to be understood but [in his omnipotence] cannot tolerate not knowing. [His] aggression is mobilised when this omniscient balance is disturbed by my interpretations; then placating is mobilised to deal with this, as [he] unconsciously tries to draw me into [his] defensive organisation and keep us in perpetual agreement. [Joseph, 1983, p. 294]

When once I suggested that he was filling the sessions with his usual topics so that nothing more painful might arise, he responded with indignation and hurt: "What could be more painful than the mental torment I am bringing?" He then tried, in vain, to think of what he might be avoiding. I think his shocked reaction gives a sense of the power of the delusional organization as a defence in the way it clings to a belief that nothing could be worse than the pain already experienced—while at another level fearing a worse fate if reality is really to be faced.

The perverse retreat

In his attempts at self-adulation Mr H would, as I have indicated, escape into fantasies or daydreams of a sexual liaison with a young virginal woman—fantasies that seem to defend against oedipal jealousies. "She will have had no previous lovers, and there will be no competition", he stressed. A more debilitating defence against oedipal reality, however, is the establishment of the "perverse retreat", as described by Chasseguet-Smirgel (1985) and Steiner (1993). Both talk about the rejection of the genital universe for an anal one in which differences between the sexes and between generations do not exist.

In a rare comment about his father's death, Mr H said that his regret was that he was never able to show his father that he was his "equal". Perhaps far more painful would be to regret not having his father proud of him, for example, which would acknowledge the difference in age as well as the significant familial relationship between them. Mostly, however, his father was ig-

nored as if the generational differences were non-existent or at least insignificant. As Chasseguet-Smirgel observes:

> The abolition of differences prevents psychic suffering at all levels: feelings of inadequacy, castration, loss, absence and death no longer exist. [Chasseguet-Smirgel, 1985, p. 6]

Two dreams in particular seem to convey his use of retreat into an anal world:

> In one *he was having a torrid affair with a woman at work whom he had not much noticed. It was all secrets and hotel-rooms. Then he went to the lavatory. He had been constipated, and this felt a great relief.*

In the session we agreed that he seemed to see therapy as a "toilet" for relief. In terms of a retreat into an anal world it would seem that the "torrid affair" is associated with constipation, as though the "affair" were in "secret" places of his body and with his own faeces. His relief is to flush the feelings down the toilet.

> In the second dream, brought before a holiday break, *he needed to go to the lavatory and he went downstairs, but there was a queue of people waiting. He continued on down looking into the different rooms in the building. It seemed to be all baby-changing-rooms. Then there was one with a group of ten beautiful young women. They thought he looked lost and took him in, looked after him, made him feel wonderful. Feeling much better in himself, he continued on down. At one point he was in a wonderful sauna-room with beautiful wood panelling. When he looked into another room, a friend was there with her two young children. She looked shocked, not recognizing him, and went to protect them. A midwife was waiting. He felt he should not have been looking in. He continued on down and successfully found a lavatory.*

Mr H linked this dream with the fact that my consulting-room is in a tall building and that the lavatory had been occupied by another patient the previous day. I interpreted his being "taken in" by the ten beautiful women as his use of sexual fantasy to avoid the pain of separation after the session and during the coming break. The being "taken in" could even be a pun acknowledg-

ing some awareness that he fools himself with his masturbatory fantasy. Following Meltzer (1992), the *ten* beautiful women would seem to represent Mr H's ten fingers and an escape into anal masturbation—a state of mind of being the one in control. Masturbation in this sense is described as "any stimulation designed to induce a state of omnipotence" (Meltzer, 1971, p. 210). This can be seen as Mr H's way of coping while being made to wait, either during the holiday break or while his mother is preoccupied with a queue of others: father and brother, aunt or other babies.

The baby-changing-rooms seemed to relate to what goes on in the other compartments of the mother's body, and there was a sense that he is a threat to these other babies with his murderous wishes. Baby-changing-rooms imply dirty nappies, and one gets a picture of the baby in his idealized cot (beautiful wood panelling) being made to wait and discovering that he can control his own faeces and get physical pleasure from doing so. Meltzer suggests that:

> Entry into projective identification is a ubiquitous phenomenon in early childhood mainly instituted during conflicts over excretory processes and implemented through phantasies of penetrating masturbatory activities, especially anal masturbation. [Meltzer, 1992, p. 118]

Particularly striking is the image of the therapist as "waiting midwife". Perhaps internally Mr H was developing a sense of the therapist/midwife in a helpful role and his new thoughts as being a creation of the therapy. Perhaps he was valuing her experience and containing function, even if at another level he was reducing her to a servant taking orders as the new thoughts emerge from him alone.

The denial of birth and death

For many patients the death of a parent or the birth of a child are key events that allow for new growth and understanding in their lives. They provide a sense of "moving on" in life, "growing up", acquiring a new, more mature identity—all of which would involve a process of mourning. For Mr H, however, these events seemed to pass him by.

In the first session after the birth of his child, Mr H made me wait for most of the session before mentioning it, and even then I was given little detail. He also seemed to be turning away from his girlfriend. I commented: "It is as though her body has become indistinguishable from your mother's, and you can only see all the rival men and babies that have been inside her." He referred to his wife and mother as "old and needy". "You make them sound like used goods", I said. He latched onto this, embellishing his condemnation of them: "I get filled with indignation if other people need me", he said, "outraged if they are no longer there servicing me and I'm expected to service them." Mr H's ability to reduce those people most important to him to the realm of "servicing" slaves and prostitutes was perhaps an indication of his unconscious fear of losing them to a fate of deterioration like his father or his aunt.

Meltzer points out that the damaged object does not merely lose the qualities of "goodness, age, beauty, strength, and contentment" that make up its parental character—they are replaced by persecutory qualities. Through sadistic attack on the object it becomes "old, ugly, functionless and resentful" (Meltzer, 1971, pp. 212–213).

In a subsequent session Mr H became weighed down and worried. He could only see "a long dark tunnel ahead, with no light at the end", and I found my mind filled with an image of his father's illness. It was as though, unconsciously identified with his father's long, slow death, he was not allowed a life himself and had split off the unbearable feelings and projected them into me. The denigration of his objects denies the fact of life of goodness coming from the object. In addition, he also denies to himself the reality of mortality, birth, and ageing. In his inner world, birth seems to be equated with the appearance of mother's other babies who will compete with him, while death seems to be equated with murdering one's competitors. This leaves him in a joyless, static world, unable to "move on" emotionally. For as long as life events have to be blocked from having any real meaning, there can be no learning from experience. In the therapy, Mr H would "practice", as he puts it, how other people might view a situation, but any experience of direct emotional engagement with me would be followed by his immediately cutting off in some way.

A hint of what his father's death might mean was expressed in his telling me that he felt unable to read the letters of condolence. He had to push them away, otherwise he would have "cried uncontrollably and been speechless in front of everyone". Even at moments when he gets close to his grief, we find him in front of a hostile or mocking crowd in his mind. Once he had to go to a memorial service for a colleague. "What happened", he told me, "showed how many defences I have. They get stripped away at such occasions, and I find myself in tears. All my life I seem to go between feeling either vengeance and violence or tearful, weak, and fragile." He continued: "I thought about my father and know that's sitting there. But it doesn't feel like it's that. It feels like my brother."

This had been a session with genuine contact between us, so I should not have been surprised when he did not appear the following day—a Friday—and I heard nothing until he came for his session the following Tuesday. He apologized. What happened was typical, he said, and had to do with his being late everywhere. He had set off for his session but found himself "gridlocked" in traffic. When he did finally get here, he just "froze" and felt unable to come in. Instead, he spent the time sitting in the car trying to understand what was happening. He identified four stages:

In *stage one* he feels resentful at having to leave where he is. He knows he is procrastinating and that he will be late, but he ignores the consequences. In *stage two* he is on his way and busily trying to think of an excuse for being late, even though it means lying. *Stage three,* "the worst point", is the moment of confrontation when he meets the person's eyes, gives his excuse, and faces their anger. In *stage four,* if his excuse is accepted and no anger shown, then he feels a reprieve. He added that the way he froze on the Friday reminded him of when he was 16 and had to face his girlfriend's father's rage when she had to have an abortion. He felt like "the scum of the earth", he knew he was to blame and had no excuse.

Mr H's wish to "stay where he is" can be heard as the addictive pull of the psychic retreat. Emerging from the retreat, he faces exposure of his fraudulence (the lies, the misrepresentation) and a confrontation with reality (the eyes and a different point of view). Since I represented for him the aspects of reality that he could not face, I was the one he must control and keep away.

I think with this incident we were beginning to reach the point to which Steiner refers in which the possibility of keeping the opposing views of reality apart was becoming more difficult for Mr H. Once I said to him, "It is striking how clearly you describe your own tormenting view of things as well as what you know to be the reality. In fact, you seem to keep the two separate from each other, as though that feels somehow safer." He tried to think through for himself what might happen if he brought the two sides together. "I suppose I would have to accept the impossibility of my infantile wishes, that I was never going to be the best, the only one", he said.

The unbearable oedipal reality

I believe Mr H's "four stages" can be seen as a picture of how he was constantly thwarting any move from the paranoid–schizoid to the depressive position in order to avoid being confronted by his own emerging conscience and the pain of all he must mourn. The image of his "turning away" when confronted by his girlfriend's father seems a turning-away from reality to avoid feelings of pain and guilt, the girlfriend's accusing father having come to represent his own dead internalized father as persecutor (Klein, 1955, p. 161). For as long as Mr H has no concept of forgiveness and understanding and merely deals in accusation and counter-accusation, feelings of guilt are intolerable. Instead, he must rely on the use of projective identification, splitting off the feelings into internal and external objects and then punishing or rejecting them. He feels so much better, he says, now that he stays away from his brother—"staying away" being his only way of feeling better. As we have seen, this pattern was repeated regularly in the relationship with me as he found reasons for "staying away" from sessions, particularly before and after breaks. These were occasions, of course, when unconsciously he could picture me as finding something or someone else more interesting than he.

What was trapping him in particular was the difficulty in facing oedipal reality. While his father's importance is denied and the couple that he is attacking is his mother and his brother, the reality of the parental couple cannot be faced. His mother and

brother are not a "parental" couple. This constitutes, in fact, an attack on the reality of the generational divide between his parents and him and his brother. Similarly, the generational divide represented in his being the patient and my being the therapist he found intolerable. I could absent myself when I chose, but for him to absent himself was like being the delinquent child.

For Mr H, it is as though fantasy became reality when his murderous wishes towards his father coincided with the father becoming terminally ill. Unable to contain such trauma and guilt, he then had to create his own delusional reality, distorting the truth, "living a lie", and blocking any grieving process.

As Steiner (1993) and others emphasize, only by being faced with clear parent/child boundaries and a true parental couple in the transference can a move to the depressive position take place. And it is not until loss and mourning can be experienced in the containment of therapy and parts of the self begin to be reintegrated that Mr H will have the strength to mourn his father's death. Perhaps only then would he be able to see his father's illness as a tragedy to be grieved for rather than something for which he must feel shame.

Mr H's ability to observe with me the emotional trap in which he found himself seemed impressive and hopeful. "How do I unpack all of this?" he asked. "Maybe it is more a question of how you let go of it", I responded. "Well, that's a good question. I seem addicted to it", he said. It was another of those moments of emotional contact between us, and perhaps the hope it inspired in me was an indication that he would find it too much.

Unfortunately, soon after this and following another summer break, he wrote, asking to reduce his sessions from three times a week to once a fortnight, quite aware that I would not be happy with this. I replied that we needed to talk it over, but I had no response. It was as though he had begun to allow the experience of a good object but that this brought with it the fear of more real emotional engagement than he could bear. As a result, I was left feeling suspended between two opposing versions of reality: the therapy was both over and not over. We were "gridlocked", it seemed, over the patient's need to misrepresent life events.

CHAPTER FIVE

Tolerating emotional knowledge

Stanley Ruszczynski

The primary task of psychoanalytic clinicians is to listen to and observe everything that is going on in the consulting-room: in the patient, in the therapist, and in the relationship between the two. This is usually referred to by the concept of the total situation of the transference (Joseph, 1985; Klein, 1952). This primary task also requires that from time to time we say something to our patient about what we have heard or observed. This usually comes in the form of a description, which, if we have listened and observed sufficiently acutely, will inevitably include meaning or interpretation. Understanding or insight may emerge.

This clinical stance has long informed clinical practice. Freud recommended that we listen to our patients with free-floating attention; Sandler advocates free-floating responsiveness; Bion tells us to listen with negative capability, with no memory or desire; Betty Joseph promotes a detailed tracking of every moment in the session; Dennis Carpy and Irma Brenman-Pick (amongst others) describe, respectively, the necessity of tolerating and then working through in the countertransference.

There is probably little argument with these clinical parameters, all of which address us in relation to our clinical receptivity. However, psychoanalysis has developed as a result of the constant interplay between clinical practice and theoretical understanding, because we all need to have some sort of theoretical construct in our minds, which meets with what we hear and observe and helps us to organize our experience. In addition to our receptivity, therefore, we are required to have available an active mind that might process our experiences. Bion writes that such organizing of our experience leads to the emergence of what he called a "selected fact"—a sort of meta-observation that links the disparate facts and observations and might result in a comment to the patient or an interpretation. He stresses that "the selected fact is the name of an *emotional* experience, the *emotional* experience of a sense of discovery of coherence" (Bion, 1962b, italics added).

Whatever our theoretical framework might be, our comments and interpretations will only be useful to the patient if they make links between the bewildering variety of material presented to us. To arrive at the "selected fact" that creates a sense of cohesion, we often need to bear long periods of uncertainty, and often confusion and anxiety. This is probably the most difficult aspect of the psychotherapeutic process.

Steiner and Britton (Britton, 1998; Britton & Steiner, 1994) warn us to take care not to confuse the eventual emergence of a "selected fact", which does actually link disparate data together, with what they call an "overvalued idea" offered defensively by the therapist so as to avoid confusion and uncertainty. They suggest that the emergence of the "selected fact", precisely because it does make links, gives coherence and meaning and so produces in the patient the sense of being contained. The emergence of an "overvalued idea", on the other hand, because it makes spurious connections in a defensive attempt to deal with anxiety and fragility, will not be containing, though the patient might collude with the illusion that it is. In a similar way, patients themselves may produce and promote overvalued ideas, sometimes seducing the therapist into compliance and sometimes finding the therapist colluding for his own defensive reasons. Not infrequently, patients overvalue facts rather than attempting the hard work of discover-

ing meaning, which can only be found through the making of links. This is not an uncommon experience.

In this chapter I have tried to write about a particular constellation of ideas that I have found useful in my clinical thinking and practice with individual patients. I have already written about some of these ideas in relation to psychotherapeutic work with couples (Ruszczynski, 1997).

Mrs F

I will start with some material from a patient. Mrs F is American-born but has lived in this country for most of her adult years. She is in her late forties and is employed as a personnel manager. She is married, with three daughters, two grown-up and married, with their own young families, and one in further education. She has, by her account, an interesting and full life.

She came into treatment complaining about unspecific dissatisfactions, periods of depression, outbursts of verbal aggression, and a general feeling of insecurity and lack of fulfilment. In the first session she said, "It is as if I have something in my hands and it then slips out of my fingers. I look around at what I have, I feel very fortunate, and suddenly it all sort of crumbles . . . something goes wrong, and I have nothing. I know. . . . I think I know. . . . that I don't actually lose things, but at the same time I feel as if I do. . . . or at least I think I do."

She settled into intensive therapeutic work quickly and very rarely missed sessions even though she had a busy professional and social life. In the transference, for some time she experienced me as a good object, specifically as someone prepared to be available to her and engage with her. She brought dreams and free-associated to her material without great difficulty. She seemed to have an available and enquiring mind.

However, alongside this at times suspiciously positive atmosphere, there also emerged a quite different dynamic. Mrs F has the most extraordinary capacity for observation: she noticed minor changes in the consulting-room—for example, a book shelved in a different place in my bookcase; she noticed par-

ticular verbal expressions I might use, or the detail of my words to end a session. When arriving for the session or when leaving, she noticed the different cars parked outside or near the consulting-room and she noticed various people near the house. She was often acutely sensitive to and accurate about those who might be patients. Sometimes she told me about what she had noticed; at other times, I would later learn that she had withheld her observation with a sense of triumph and glee.

When she is in this acutely watchful state of mind, I often come to feel increasingly uncomfortable: I become aware of being very watchful of myself because I fear that at any moment I might do or say something that she would notice, deeply disapprove of, and seek her revenge. In this state of mind I can feel quite disturbed and not be able to think of much other than this sense of threat to my own survival. Everything she says I find myself treating with suspicion and guardedness. I find myself preoccupied with this sense of danger and become aware of highly paranoid object relationships both internal and external to me.

I have come to realize that before I become consciously aware of my anxieties, the patient and I engage in superficial and spurious work, no doubt as a product of the anxiety that begins to fill the space between us. In this atmosphere Mrs F loses her capacity to symbolize and to think more reflectively (as I eventually do too). She becomes quite concrete in her thinking, and nothing can be explored for its meaning. For example, rather than think about what it meant to her that I had apparently used two different ways of finishing the session on two consecutive days, she simply insists that I confirm that I had done so. That new book in the shelves—she would ask—did I buy it and read it over the weekend or had I simply put it there from elsewhere in my shelves? Any attempts to interpret her intense curiosity about my weekend activities are totally ignored. In this state of mind facts become overvalued and the search for meaning disintegrates.

What is interesting is that though this more paranoid atmos-

> phere does break the emotional contact between us—my thinking mind disappears, as does hers—we can and do re-establish a more thoughtful and reflective relationship. Sometimes this follows my interpreting, using my countertransference, something of the unbearable nature of her unknowing state of mind and the paranoia it produces; at other times the atmosphere changes for reasons I am not clear about, but which are probably related to my regaining my receptivity to her. This movement in the sessions could be understood as the oscillation between the depressive and the paranoid–schizoid modes of functioning, *in both directions*: movement from the depressive position to the paranoid–schizoid position each time new material emerges relating to unknown matters, and movement from the paranoid–schizoid position to the depressive position as a result of some move towards integration (Britton, 1998).
>
> What the more paranoid interaction does do, though, is fracture the impact of what understanding we may have generated between us—it undermines or breaks links already made or those that are in the process of being made. Mrs F will talk over me or announce that she has not heard a word of what I have said; at other times she says that she goes dizzy, her mind "spinning away". This we came to understand as an attack on the thinking state of mind and the therapeutic process, but the interesting fact is that it is rarely a total attack. The reflective capacity and the therapeutic relationship can be re-established and made further use of, but only in the shadow of likely future disappointment. Suspiciously and carefully watched, it can only ever be partially made use of. Equally, however, often in retrospect, I become aware that the relationship is never totally lost. Some sort of space for thought and reflection is maintained but never allowed to be fully trusted.

I shall return to this patient later, but at this point I will introduce some of the theoretical ideas that I have found useful in my clinical understanding of this and similar patients.

It has been argued that, in a particular way, Bion has significantly developed the psychoanalytic tradition of viewing the Oedipus complex as being at the centre of psychic life.

Bleandonu, for example, in his biography of Wilfred Bion, concludes that Bion "intellectualized" the Oedipus complex. He writes that Bion "transforms the budding Oedipus into someone who is more intellectual than libidinal. . . . Bion inverts the values of the Oedipus complex: the arrogance of seeking to lay bare the truth at any cost overrides murderous sexuality . . . psychoanalysis is devoted to the search for truth" (Bleandonu, 1994).

Symington and Symington write that for Bion, "the mind grows through exposure to truth". Later they say that "Emotional growth has taken the place of sexual libido in Bion's formulation" (Symington & Symington, 1996).

Bion significantly developed a particular strand of the Freud–Klein tradition: his contribution follows both Freud's emphasis on the achievement of insight as being necessary for growth and development ("where id was there shall ego be"), and also Klein's emphasis on the epistemophilic component of the libido, which includes innate knowledge of, for example, the breast, and the penis and vagina and the meeting between the two. In their different ways all three (Freud, Klein, and Bion) emphasize the gaining of knowledge of the self and of the other as being central to psychic health and emotional development.

What Bion has done for psychoanalysis, therefore, is not to abandon the centrality of the oedipal story (which is what I think is suggested in the Symingtons' book) but to emphasize and develop a particular aspect of it. *Coming to know and coming to tolerate the pain of acquiring knowledge are crucial to psychological development.* The question that this raises is how exactly this self-knowledge is achieved and what this knowledge fundamentally consists of.

This leads to a consideration of Bion's concept of "container–contained", which, crucially linked to the notions of "thinking" and "knowledge", refers to an emotional experience originating, in health, in the relationship between mother and infant (Bion, 1962b). The concept of container–contained refers to the maternal provision made available via the mother's reverie to the infant, but the concept is also used to describe a certain aspect of the psychoanalytic process. However, is containment best understood as something that takes place simply in the relationship between infant and mother alone?

I recently came upon the following in Enid Balint's writings that puts my point rather lucidly. In her paper, "Fair Shares and Mutual Concerns", she writes the following: "The quality . . . of the object relationship between the mother and the father, as seen and felt by the child in the degree of their capacity to convey mutual concern and fair play, *is a more important introject than the function of either parent taken individually*" (Balint, 1972, p. 68, italics added). Mrs Balint stresses that she is speaking of this experience not only in the oedipal phase of development but in the pre-oedipal period, which involves, for the child, "the beginning of the awareness and the introjection of private and intimate, almost unobservable, collusive, mutually acceptable activities between the parents themselves and between the parents and the child. . . . Once the endurance of this strain has become tolerable to the [child's] ego, there is then the possibility of the development of the idea of fair shares" (Balint, 1972, p. 68).

Enid Balint is talking about the development of the capacity for concern—an emotional capacity comparable to the Kleinian concept of the depressive position. She then overtly expresses her disagreement with writers such as Winnicott, who suggest, she says, that the capacity for concern can be developed in a two-person relationship alone. Her question, she says, is whether this is true or whether "a certain kind of multi-person relationship is also needed. We are now considering a process which starts in the two-person mother–child relationship but needs, if it is to develop fully, *a particular kind of multi-person relationship*, the structure of which has not been described but which deserves serious study" (Balint, 1972, p. 69, italics added).

Britton's paper, "The Missing Link: Parental Sexuality in the Oedipus Complex", written 27 years later, in 1989, addresses precisely this issue so vividly put by Enid Balint. Starting from Klein's views of the early oedipal complex and Bion's concept of container–contained, Britton describes in detail how, if the child is to move towards more mature relating, towards the depressive position, he has to come to tolerate the triangular nature of the oedipal situation. It comes to be seen as truly triangular when the child is able to recognize not only his own relationship to each of his parents, but, in addition, the link between the parents as a couple.

Contemporary psychoanalysis has for some decades now emphasized the *relational* nature of the therapist–patient relationship. Paula Heimann's 1950 paper on the countertransference, based in part on Klein's 1946 delineation of schizoid mechanisms, particularly that of projective identification, dramatically changed our understanding of the nature of the analytic process (Heimann, 1950; Klein, 1946). The fundamental change was to shift the clinical interest away from what was going on inside the patient's mind, to a focus on what was going on in the psychotherapist's mind and in the relationship between patient and therapist.

This is most clearly demonstrated by the clinical emphasis given to the analysis of the transference–countertransference relationship. A deepening understanding has developed of the ways in which the patient, via projective and introjective identification, unconsciously influences the therapist to become involved in and to enact aspects of the patient's internal object relations in the transference–countertransference relationship. As Bion puts it, we find ourselves, "being manipulated so as to play a part, no matter how difficult to recognise, in somebody else's phantasy" (Bion, 1952).

In making this clinical observation, Bion promoted the idea that projective and introjective identification is both an intrapsychic and an interpersonal process. He added to Klein's understanding his view that not only is projective identification an omnipotent phantasy, but the projector unconsciously gives effect to his phantasy by evoking or provoking aspects of that phantasy in the recipient, using verbal and/or non-verbal means. The containing object (initially mother) receives the projection from the other and via her reverie eventually metabolizes it into something manageable and understandable. This is then available for re-introjection by the projector, who not only regains that aspect of himself previously split off and projected, but, crucially, also introjects the experience of containment and specifically the experience of thinking, through which he comes to know himself, and consequently, the world. This process constitutes a potential source of experiential knowledge both about the self and about the other.

This container–contained model has therefore closed the gap between cognition and emotion: gaining knowledge is understood to be fundamentally the result of an emotional interaction. Fur-

thermore, it seems that for Bion the external object is an integral part of the system. Mental understanding by the containing other makes it possible for the individual to develop mental understanding in himself and move towards developing his own mind. (Caper, 1999). As with Klein before him, Bion considers the environment to be crucially important to psychic development, and by using the concepts of projection and introjection he describes the dynamic involved in the mutual interaction between container and contained (Spillius, 1994).

This theoretical development of the container–contained relationship emphasizes the gaining of knowledge as being at the centre of our understanding of psychic development and, therefore, central in the focus of psychoanalytic theory and practice. No longer do we simply think of a patient misperceiving the therapist. We now understand the patient as unconsciously doing things to the therapist—projecting aspects of their internal world into the therapist in a way that affects the therapist. Countertransferentially based experiential knowledge of the patient tends now to be at the heart of clinical practice.

Bion emphasizes the centrality of this process of projective identification to psychic growth and development, be that of an infant or a patient, and particularly at those times when the feelings aroused are felt to be too powerful to be contained within the personality. He says: "Projective identification makes it possible . . . to investigate . . . feelings in a personality powerful enough to contain them." In reality, of course, this process is never quite that smooth, because, on the one hand there may be a disposition in the infant or patient to excessive attacks on and hatred and envy of the object, and, on the other hand, the environment (be that mother or therapist) may not be sufficiently receptive to the projective identifications. Bion goes on to say that "Denial of the use of this mechanism, either by the refusal of the mother to serve as a repository for the infant's feelings, or by the hatred and envy of the patient who cannot allow the mother to exercise this function, leads to a destruction of the link between infant and breast and consequently to a severe disorder of the impulse to be curious on which all learning depends" (Bion, 1959, pp. 106–107).

In his examination of the concept of containment, Britton reminds us that there is a third influence on the containing process

between infant and mother—that is, "the identity and personality of the other member of the early oedipal situation, namely the father" (Britton, 1992a). He describes how the father might be either hostile to or solicitous and supportive of the nursing couple, and that this will have a direct influence on both mother and child; but he also stresses that, by identification, the father's attitude can become an internal object capable of either giving aid to or sabotaging the nursing couple (Britton, 1992a). As did Klein and Bion before him, Britton, too, refers to both the constitutional and the environmental factors in the infant/mother/father interaction.

Freud first delineated the Oedipus complex as it manifested itself in the 3- to 5-year-old child with regard to the relationship with the mother and with the father. However, he came to see that the young infant not only wanted to secure the love of the parent of the *opposite* sex, but that this was inevitably pursued with ambivalence because it was felt to be at the expense of an affectionate attachment with the parent of the *same* sex. This dilemma or ambivalence may, in fact, be considered to be nearer to a true understanding of the *triangular* oedipal situation. Though the relationship to mother may be primary, periods of relating to mother *and* to father by infants of both sexes, is probably a more realistic picture of infant development.

Those writers influenced by Klein's clinical work with infants distinguish between the less mature and the more mature forms of the Oedipus complex and so describe the initial anxieties, defences, and object relations relating to the oedipal situation at a more primitive, paranoid–schizoid, level.

Britton has elaborated an additional dimension to the oedipal situation (Britton, 1989) by highlighting that, as well relating to the parents as individuals—as mother and as father—the young child, driven by his natural curiosity, is confronted by the dim recognition of a link between the parents, ultimately their sexual relationship. Later, the child also realizes that there are differences between the relationship of the parents and the relationship between parent and child. Because of the generational difference, the parents may not only exchange physical sexual gratification, but their intercourse may also lead to the actual creation of a new

baby. In this process the infant and child is confronted with the pain of acquiring knowledge of the true nature of the parental relationship and of the true reality of the oedipal triangle. If he is to come to tolerate this knowledge and integrate it, he has to relinquish his omnipotence and narcissism. He will have to come to bear "the basic element of human reality: the double difference between the sexes and the generations" (Chasseguet-Smirgel, 1985) and begin to tolerate "the facts of life" (Money-Kyrle, 1968). If this can take place, more mature object relationships begin to be realized.

Britton makes the further point that if the child can tolerate this link between the parents, it provides him with a blueprint for an object relationship of a third kind in which he is witness and not participant. (The first two relationships link the child separately to the mother and to the father.) "A third position then comes into existence from which object relationships can be observed. Given this, we can also envisage *being* observed. This provides us with a capacity for seeing ourselves in interaction with others and for entertaining another point of view whilst retaining our own, for reflecting on ourselves whilst being ourselves" (Britton, 1989).

The development of this capacity for self-reflection (knowledge of the self) and for having the other in mind (knowledge of the other)—clearly achievements of some substantial psychological maturity—constitutes Bion's third factor of psychic life, that which he called "K" or knowledge (Bion, 1962b). By this he meant *not* intellectual knowledge, but knowledge based on experiencing, feeling, and thinking. The other two factors are "L" and "H", love and hate. The integration of the capacity for "K"—for experiential knowing—may be said to be a development of the capacity for containment: a capacity to emotionally manage the likely vicissitudes of human relating, be that the therapist–patient relationship or the parent–child relationship (or the intimate adult couple relationship—see Ruszczynski & Fisher, 1995).

Bion also introduced the notions of "minus-K", whereby from internal sources the infant destroys understanding and learning; and the notion of "no-K", whereby the infant has no (maternal) object available to take in and process his projective identifica-

tions. "Minus-K" is understood to be the product of envy and "no-K" to be the product of the lack of a container in the external world through which the infant's mind might develop an apparatus for thinking. Britton has recently offered a suggestion that "minus-K" might be understood not solely in relation to envy but as the product, in part, of an antipathy to knowing anything that is different (Britton, 1998).

Hanna Segal, in a commentary on Britton's paper, suggests that this "triangular space" created as a result of the recognition of the parental link as described by Britton is an *extension* of the original relationship between container and contained as defined by Bion. The *important* difference, she says, is that, "in the original situation the child is a participant and a beneficiary of that relationship. Recognizing the parental couple confronts him with a good contained–container relationship from which he is excluded. It confronts him with separateness and separation as part of the working through of the depressive position" (Segal, 1989).

The development of this sense of the triangular space also offers the opportunity for the infant to begin to learn that there are different types of links and relationships. Some he will always be excluded from, some he will be included in, and some he may create for himself, in his own right, at some future time. The development of this capacity to tolerate this configuration of object-relationships, clearly a capacity of some substantial health—places the individual in the human community.

I would like to suggest that this triangular space as described by Britton, within which the possibility of observing and being observed takes place, is also a more accurate way of understanding the *process of containment*. The third position, from which observation takes place and from which thought eventually emerges, exists in a relationship with the receptive process. It has often been stressed that the container–contained activity, if it is to lead to psychic change, depends on the containing object coming to be able to offer and have accepted not only receptivity but also the insight and knowledge produced by the metabolizing process. Successful containment provides a sense of integration and the experience of being understood, but lasting psychic change does not come automatically from such containment. Containment provides the context for further development to take place, but only

with the acquisition of insight and understanding by the patient (Steiner, 1993). Developing an interest in understanding, which reflects the beginning of a capacity to tolerate insight and mental pain, is understood to be associated with a move from the paranoid–schizoid to the depressive position.

The container–contained process requires both the receptivity of the containing object and the object's ability to engage in a reflecting/thinking dialogue within itself, from which emerges an observation or interpretation—this internal activity and the offered interpretation is symbolic of activity other than that engaged in by the infant in being received by the containing object. Symbolically, it may be considered to be the interaction between the female element and the male element that might produce something new as a result of that intercourse. Britton has described how one of his patients, being unable to tolerate him trying to think within himself, screamed at him, "Stop that fucking thinking"—as though she were in the presence of a persecutory couple locked in an intercourse that excluded her (Britton, 1989).

A final point I want to make relates to Segal's comment about the child being a participant and beneficiary of the containing process as is the patient in the psychoanalytic situation. In mother–infant or therapist–patient relationships, the nature of the relationship is necessarily and appropriately asymmetrical, being more for the benefit of the child or patient. Even though such a division of emotional labour will be, from time to time, appropriate within the adult relationship, a healthy adult relationship requires the capacity for symmetry, as there may often be two "equal" claimants for the benefits of the containing process. We could say that this capacity is inherent in the notion of the depressive position. Understanding the nature of adult relationships may, therefore, be significantly aided by adding to Bion's more linear model Britton's notion of the triangular space within which the participant is not only and always a beneficiary of the containment but has to come to tolerate the needs of others who come to be seen as separate objects (Ruszczynski, 1997).

Steiner describes the requirement of mourning the loss of the possessive narcissistic relationship so as to allow for a degree of separateness to take place. He writes that if this can be achieved, "Disowned parts of the self are regained and this ultimately leads

to an enrichment of the ego. In the process, however, guilt and mental pain have to be experienced and these may be difficult to bear. If they are bearable the sequence can proceed and further separateness is achieved by progressive withdrawal of projections. More realistic whole-object relationships result . . ." (Steiner, 1990, p. 88).

Mrs F (continued)

Let me now return to Mrs F. I described earlier the way in which our analytic relationship could be fractured and our capacity to find meaning and understanding be undermined. It was as if we could and did have a thinking space within which we could develop links, but this would then be damaged and lost. This oscillation between a reasonably containing relationship and a breakdown in our emotional contact, between depressive and more paranoid–schizoid anxieties, defences, and object relations, became the main theme of the first two years of our work.

About 18 months into the treatment, Mrs F visited her family home in America and found herself going through her dead father's papers. He had died about ten years previously and so this was not the first time she had done so, but on this occasion, for the first time, she let herself come across and see diaries and letters that showed her that her father had left her and her mother when my patient was about 4 years of age. According to the letters, he stayed away for about a year and then returned.

Mrs F returned to the UK earlier than planned and subsequently returned to the therapy in a state of profound shock. What then emerged was some further understanding of the oedipal situation of her earliest years. As we had already discovered in the transference–countertransference relationship, there could be a—perhaps fragile—reflective space within which there was some capacity for containment and the gaining of understanding. However, this could be fractured and lost, and more paranoid and narcissistic object relations estab-

lished. Could this be understood to be the result, in part, of the profound fracture in the oedipal triangle when the father disappeared from the family? Undoubtedly the parental receptivity of both parents would also have been flawed as a result of whatever tensions existed before the father's leaving and no doubt on his return too.

As we worked with this material, Mrs F began to refer to her sense of herself being "in a bag with a hole in it"—meaning, we came to understand, that she kept losing her sense of having a skin or boundary: she kept losing her sense of containment. There is a constant "leakage", she would say. But worse than that, she felt that she could not fully trust anyone and had only herself alone to keep "topping up her leaking bag". This seemed a vivid way of describing her oscillation from some capacity to feel contained, which then feels to be punctured and has to be shored up narcissistically.

Mrs F then brought some material to a Monday session that was helpful. She told of three events as if they were one story. The first was of new regulations at the American Embassy and the Passport Office, which meant that the way in which she now had to renew her passport was totally different from the way it had been in the past. For some weeks, she said, she would be without a passport and so would feel herself to be "stateless with no identity". She described herself as the victim of a Kafkaesque situation, where it was not possible to find out what was going on, even though she was being profoundly affected by the change.

She then referred to an argument with her husband over one of their children—an argument for which, she felt, she was partly responsible.

Thirdly, she told me about a dinner party at the weekend when, for no apparent reason, she felt totally excluded and not wanted by the other guests, leaving her feeling isolated, even from her husband. However, during the course of the evening she became aware of there being no reason for these feelings, and she thought that she would bring this experience to her

session on Monday. Almost immediately on having that thought, she said, her paranoia disappeared, and she enjoyed the remainder of the party.

I cannot go into the full details of our work with this material, but, in summary, I found myself suggesting that in the course of our separation over the weekend she could find herself in at least three states of mind. The first was the rather Kafkaesque sense of something happening that she had no way of understanding—something that she thought she knew and had available to her was suddenly removed. She was simply a victim of external forces.

The second state of mind was one in which she felt that she had some responsibility for the events taking place, as in her story of the argument with her husband. This had some specific transference implications in relation to a recent discussion we had had about her four sessions being Monday to Thursday, leaving, at her specific request, a three-day weekend.

The third state of mind was more disturbing: something destructive came from within her, as at the weekend dinner party, and she could feel paranoid and rejected even though the external circumstances did not warrant these feelings. She gained relief from this only when she could establish contact with a thinking part of her mind, represented at present by me.

I suggested that this might be a way of beginning to understand what emerges in the therapeutic relationship and no doubt in her real relationships. There could be a sense of a relationship that she takes some responsibility for: that with her husband/therapist. However, this could easily be fractured, and sometimes she felt attacked from outside, by my "Kafkaesque" disappearance at the end of each week, and at other times she felt the impact of powerful forces from within her, which could only be mediated by rediscovering my presence and availability for her.

Just as I was about to finish speaking, my patient suddenly spoke over me and said that she could see patterns in the way my books were arranged in the bookshelves. Immediately she

added that she had now gone dizzy and was spinning in her mind and had lost what I had said. "Where are you?" she said. I suggested that for a moment we had perhaps understood some patterns that were worth keeping, like the books in the shelves. But then immediately something dizzy, perhaps even crazy, in her mind spins her away from that insight, and she loses it and also loses her contact with me. Where was I? she had said. In Bion's terms minus-K had come into play, and her dizzy mind attacked possible understanding. However, it is also interesting to wonder whether she became aware that I was about to finish speaking and what she felt terrified by was my impending disappearance, like that of her father concretely, but probably of both her parents in relation to their capacity to keep her sufficiently in their minds. It left her dizzy and spinning.

I think that Mrs F is a good illustration of a patient for whom there is the possibility of movement into the depressive position and its associated anxieties and defences. However, this can also be lost and more primitive anxieties come into play, as a result of which there is a loss of contact with the object, which leaves the patient feeling that her mind is threatened.

Ms B

The second patient I want to briefly discuss is located earlier in the developmental line. Ms B is in her late thirties, is in a stable lesbian relationship of some year's standing, and works, very successfully, as an unqualified architect. I have been seeing her for over three years twice a week, sitting up in a chair. Though it has often come up in the material that two sessions are insufficient, and the possibility of further sessions has been offerred, my attempts to understand this self-deprivation are completely dismissed. Also dismissed is reference to the possible use of the couch: when I interpret something about the couch from her material she very aggressively refuses to consider it and restates rather thoughtlessly that she has no intention of using the couch. To date it has been impossible to understand this beyond vague thoughts of a wish to remain in control.

Bion's notion of no-K, of no available thinking capacity—comes to mind when Ms B is in this totally unavailable state.

When Ms B sought psychotherapy and was referred to me, her father was seriously ill, and he died about six months after we started working together. The most interesting theme in her initial presentation was her bald statement that she wanted to come into psychotherapy primarily because she knew that her father's impending death would be devastating for her, but she was not willing to talk about him and their relationship!

Her other main concerns centred around feelings of frustration and constraint represented most concretely by her having repeatedly delayed, for many years, taking her final professional examinations, even though all her colleagues tell her, and intellectually she herself knows, that she would have no great difficulty in passing these exams. Other concrete areas of constraint and hence frustration included the nature of her social, personal, and sexual life.

Ms B leads an extremely restricted and limited life, tightly controlling all her objects and experiences. "I don't feel jealousy.... I don't get angry.... I don't see why I need to be aware of ambivalence ... why should I not idealize my partner or my father ..."—are the sorts of regular comments she makes. She insists that I have to accept these as truths, and what she finds extremely threatening and persecutory is that sometimes I might have an alternative version of truth or even that I might be curious to understand with her why, for example, she says that she dismisses people who disagree with her by "killing them" in her mind, whilst she goes on claiming never to feel anger or murderousness.

Only much more recently has she allowed herself to consider the possibility that she in fact kills off her feelings and ambitions and that she also feels that I am trying to kill her if I introduce an idea different to hers. Her intolerance of difference is a central theme in the clinical work. I mentioned earlier that Britton has suggested that attacks on thinking may be linked, in part, to an antipathy to knowing anything that is different (Britton, 1998).

It was not possible for a long time for me to have any sense of there being any contact and understanding between us. Any comment or interpretation I made was either totally robbed of any emotional meaning by her intellectualization, or she would very aggressively accuse me of twisting and distorting what she had said and making it unrecognizable. She would subsequently recall these "distortions"—as she called them—and berate me with her protests about them weeks later.

Through my countertransference I came to realize that either I was being totally destroyed by her intellectual responses, which had the effect of a black hole, in that, whatever links I tried to make, she made disappear again, and my sometimes successful attempts to think about my experiences were experienced as violent and persecutory—she attacked and, in her mind, destroyed what I had tried to communicate of my understanding; or, alternatively, whatever I said was experienced as coming from an object that was distorting and perverting her integrity. In other words, the coming together of my thinking about my experience was seen as an act producing something perverse. I often had the experience that Ms B had no internal world of meaning but, rather, managed herself, somewhat anxiously, with her sophisticated intellect, which was at best simplistic and spurious but more often perverse in its clarity and certainty. She seemed willing to sacrifice understanding and knowledge for omniscience.

I want to report two dreams both of which show the nature of her internal world and its object relations and the movement in the psychoanalytic process in the two years or so that separate the two dreams. In the first dream, in the second year of treatment, *Ms B is in a very restricted space with a man whom she is kissing and caressing. She feels a mounting excitement and becomes aware that they are moving towards sexual intercourse. But then, somehow, the space that they are in feels too restricted for intercourse and so instead she finds herself masturbating the man. As she is doing, so the man suddenly changes into a woman, and the penis transforms into two breasts. She continues to stroke and "masturbate" the breasts until each breast "ejaculates" as if it were a penis.* This was all very erotic, she said. When she woke up, she said,

she smiled to herself about the dream, but as the day wore on she found herself feeling increasingly disgusted and disturbed by it.

Though my patient could not associate directly to the dream, she said that she was excited and intrigued by the transformation of the man into the woman and the penis into breasts and especially so as neither transformation quite completed itself. Both the initial excitement and then the disgust were, she said, particularly because of these bizarre images.

This dream was useful in that over the next few weeks we were able to use it to consider that in the restricted space of only two sessions of psychotherapy, her intellectualizations were felt to be masturbatory and not the intercourse she actually wished for. The therapeutic container could only be allowed to produce spurious or even perverse contact, about which she could feel perversely excited.

What I could also now say to her with added conviction was how in her mind there could be a very disturbing contact when intercourse is sought which distorts and transforms the experience into something bizarre. Men and women, penis and breast, semen and milk all become confused with each other. Perhaps an alternative to these bizarre and horrifying conjunctions was the killing off of any contact or intercourse via her intellectualization or spurious certainties. I was also able to suggest that the smile at the end of the dream suggested that the perverse part of her smiles in triumph and is in some part pleased with this outcome. As time wore on, however, she could find a state of mind that found it increasingly disturbing.

This dream seemed to prove to be helpful, and there developed a less distorting attack on my comments. What emerged was a fragmented array of belittled, wimpish, disappointing, and stupid men, admirable men (though this was usually the image of her father), and, equally, threatening women, women who had to be protected, and admirable women. Though these figures continued to be part-objects, they were, compared to the figurers depicted in the dream, less splintered and less often joined in bizarre ways.

In the transference I could be any of those figures, sometimes rapidly changing from one into another in the course of a few minutes. Though this produced a very fragmentary experience in the therapeutic process, there was occasionally a possibility of some understanding and meaning being generated. The difference was that any links I might make did not result in bizarre and perverse conjunctions but could very occasionally produce a thought that she could entertain, or sometimes one that even produced understanding.

I had learned that Ms B was brought up by a parental couple who had a very disturbing relationship. Each had a series of affairs throughout her life, but they stayed together mostly because her father was a man of some public stature that neither he nor his wife wanted to threaten with a divorce.

Being the elder of two, she found herself closer to her father, whom she came to idealize consciously. Her mother, feeling threatened by the relationship between father and daughter, was very undermining and dismissive of my patient.

What emerged was a terror in Ms B that there were no constraints or boundaries to her incestuous wishes for her father. There was no sense at all of a parental relationship, and neither was there much sense of a more fundamental container–contained relationship with her mother: her father was seductive and the mother was attacking and dismissive. Emotional contact was, therefore, experienced as perverse or aggressive and attacking. There appears to have been no containing or thinking mind available to her. In Bion's terms, we would refer to no-K. It seemed that Ms B became identified with both the male and female figures, a warring couple in bizarre conjunction.

Something did come to shift for this patient. A dream nearly two years after the one reported previously seems to suggest some struggle towards a sense of ambivalence and the establishing of appropriate generational boundaries.

In this dream, *my patient, not clear whether as a child or as an adult woman, is sitting next to her father. She is stroking his thigh.*

He takes her hand from his thigh and places it on the seat between them. Not deterred, she goes to replace her hand on his thigh, but as she does so, she brushes against his erect penis inside his trousers. She puts her hand on his thigh but freezes with confusion and fear. She thinks that it is not right that her father should be aroused to erection whilst with her. Father then takes her hand off his thigh, places it on the seat between them and holds it down with his own hand.

The work with the dream suggested some clear progress from the previous dream. In this dream there is a suggestion of fragile generational boundaries, though with father and daughter both aroused by each other. Unlike in the previous dream, the figure of the father/man has substance, his existence as the father/man is not in doubt. In addition, there is also a suggestion that the father is determined to try to hold down proper boundaries, even though he might be tempted towards or aroused by my patient. The patient can now hold some thoughts in her mind and establish some thinking space with me, though the seductive pull towards a more incestuous and perverse encounter is ever-present.

* * *

To summarize, then: Bion established the centrality of the container–contained relationship both to the process of psychological development and to the establishment of the capacity for knowledge and self-knowledge. He added the function of Knowledge to those of Love and Hate. He also spelt out the attacks on self-knowledge either from within ("minus-K") or from without ("no-K").

Britton has elaborated the importance of the infant's relationship to the parental couple in this containing process, which, by definition, has to involve an intercourse from which the child is excluded. This brings the role of the father fully into the picture. The capacity to mourn the loss of sole possession of the object and to tolerate observing good intercourse outside oneself is a necessary step towards a more mature capacity for object relating.

The infant's realization and toleration of the link between the sexual parental couple allows for the creation of a triangular space

bounded by the three persons of the oedipal situation and all their different relationships. This space provides the arena within which self-reflection, awareness of the other and thought can begin to take place. Out of this there will begin to develop the possibility of a "mind of one's own" (Caper, 1999).

In his observation of and availability to the patient, the psychotherapist is likely to come to know aspects of the patient's internal world and its structures as these are recreated and enacted in the patient's stories and particularly in the transference. In this presentation I have tried to show some of the theoretical ideas that I find useful as I observe my patients and myself in an attempt to contain the bewildering array of experiences they bring to me.

CHAPTER SIX

Psychoanalytic psychotherapy for chronic depression

Noel Hess

Depression is undoubtedly among the commonest of the complaints that bring our patients to us for help and from which they seek relief. We do also know that "depression"—or what our patients may call depression—can conceal a myriad underlying pathologies and can be of many and varied types, in both depth and severity. Perhaps the most important diagnostic judgement in determining the particular kind of depression with which a patient presents has to do with the degree to which the depression has infiltrated the structure of the personality. At one end of the spectrum is the presentation of a previously well-functioning patient, with the capacity to form and sustain relationships, who has managed some level of personal, professional, or material achievement, but who is suddenly felled by a depressive episode. This may be apparently inexplicable or, more usually, related to an experience of external loss, such as death. We know that mid-life is a time of particular vulnerability for such episodes (Jaques, 1965), when underlying omnipotence and narcissism (often quite hidden in the personality) are severely challenged by the reality of ageing, loss, and death.

It is, however, the patients at the other end of the spectrum of depression whom I want to discuss here. We, increasingly often I think, see patients who give us the impression that they have been depressed for much of their lives. I mean by this that there seems to be present a kind of chronic mild or severe depressive quality to the personality such that the possibility of enjoyable relationships and successes in life has been impossible. Such patients have a long history of inhibition and under-achievement, being unable to utilize their particular talents and intelligence to provide themselves with a meaningful career and a sense of ambition. Relationships, such as they are, are usually short-lived and unsatisfactory, and these patients are invariably dogged by a feeling of apartness, isolation, loneliness, or even a feeling of freakishness.

Bleichmar (1996), in a comprehensive review of the different types of depression and the various intrapsychic pathways that lead to their formation, distinguishes between depression that is a component part of many different kinds of disorder and depression as an entity in itself, which dominates the whole mental life. Depression, in all its destructive potential, can be said to have pervaded the personality to a profound degree. Rather than being encountered at a particular stage of development, to be negotiated in the context of previous good experience and possible success, it seems to have always been present. It is not always easy or possible to tell whether we are fundamentally dealing with the depressed infant in the patient, or with identification with depressed parents, or both. What is clear is that depression has been a kind of lifelong companion.

Diagnostically, the patients I am describing often contain marked schizoid, narcissistic, and borderline features. However, I think the assessment we are actually attempting to make in these situations is an assessment of the patient's internal world. Specifically, this involves not only an assessment of the various repetitive patterns of internal object relationships but, crucially, an assessment of the capacity for good experience and for sustained good, loving relations internally. For the patients I am describing here, such a capacity is severely limited. This capacity is, however, the basic foundation on which our therapeutic work is built, which it seeks to strengthen and render more robust against the destructive attacks of depression.

To place this idea in context, it is necessary to remind ourselves of the knowledge and understanding of depression that psychoanalytic research has so far given us. Freud's (1917e) monumental work on mourning and its relation to clinical depression illuminated how these two conditions—the one usual, ordinary, commonplace, the other pathological—are closely related. Central to the aetiology of both is an experience of loss of some kind and internal resistances against facing the loss and relinquishing the lost object that are very powerful, such that ordinary mourning can lead into pathological depression when there is a failure to mourn. Paramount among the many insights this work offers is the crucial role of identification. The mourner's identification with the lost object and the unconscious wish to join the object in death serve the function of keeping the object within the ego's possession as well as serving the ego's unconscious need to suffer. The need to suffer arises from a cruel and critical superego, which takes the ego as its object and subjects it to a continual torment because it believes that the ego needs to be punished. This cruel and punitive treatment of the self is a reflection of the unconscious hatred felt towards the lost object, both because of its imperfections while alive and for having abandoned the self by dying. Hatred evokes guilt, which can only be assuaged by endless suffering and torment. This torment is what our patients and we usually see as the clinical entity of depression. The superego dictates tyrannically that the loss must not be faced, the object must not be surrendered, and life must not go on with any enjoyment or satisfaction. The lost object becomes installed in the ego and is continually attacked by the superego.

Melanie Klein (1935, 1940) added a vital third dimension to Freud's work on the failure to negotiate loss in depressive states by focusing on the importance of the internal world. Mourning in adult life, she argued, re-evokes the infantile mental processes of the depressive position, when the baby has to face relinquishing control and possession of mother's breast, which is the first experience of loss in normal development. The breast stands for life, love, goodness, and security in the infant's mind, and its loss by separation is felt to have been caused by the infant's greedy, possessive, and destructive impulses. However, her most important contribution in this area, both theoretically and clinically, was the

idea that a good internal mother is felt to be lost, leaving the infant's internal world devoid of goodness and in a dangerously unstable state, as bad objects predominate. It is this internal loss, triggered by or represented by the external loss, which the depressed patient is actually troubled by and needs help to address, because the ramifications of such a loss on the balance of their internal world are felt to be catastrophic. Riviere (1936) has given us the most vivid description of just such a devastated internal world.

The internal world of the particular category of patients I am discussing—patients who seem to have conducted a lifelong losing battle against depression—is not only categorized by unstable and often transient good experience and good internal objects, with a preponderance of bad and persecuting objects; in these patients, there is also a particular quality of emptiness, leading to despair. It is not simply that paranoid anxiety predominates, although that is true. Good internal objects either do not seem to exist, or do exist but are unable to connect in a meaningful way. They appear cut off from each other, reflecting the way in which the patients often feel themselves to be cut off from sources of help and understanding. Hope is a fragile commodity. This is related to Stewart's (1985) distinction between schizoid emptiness and depressive emptiness, where the former is understood as arising out of schizoid hatred of the object but is transformed into depressive emptiness by concern for the object. Rey's (1988) work on the internal world of schizoid and borderline patients is also of relevance in that he sees these patients as harbouring internally dying or half-dead objects who are brought to analysis for repair. His description of claustro–agoraphobic anxieties in these patients is also useful, in that it offers a meaning for the particular relation these patients have to work and relationships; nothing is allowed to become too important or valuable, for fear that it will either take over possessively (stimulating claustrophobic anxiety) or be lost (stimulating agoraphobic anxiety). Steiner (1993) sees these patients as stuck in an early phase of mourning, where the full brunt of depressive anxieties—arising from an experience of the reality of the loss and an acceptance of responsibility for it—are kept at bay. I have described elsewhere (Hess, 1995) an extreme version of this situation, whereby even fatal somatic illness can

offer a defensive retreat from depressive anxiety. The object is never mourned and surrendered, and death is felt to be preferable to a psychic catastrophe, leading to madness or suicide, which is feared if the loss of the good object is faced.

EMILY

I want to illustrate these ideas by describing the treatment of a patient, Emily, who brought many of these dynamics to my awareness in a very meaningful way. She presented for help at the age of 42, a single and childless woman who had become depressed after having been made redundant in her job, which involved clerical work in a large organization. It was clear, however, that she had been depressed for much of her life, the current episode being only the most recent efflorescence. Although she was clearly intellectually very able and had received a high-level university education and then professional training, most of her working life had been spent in low-grade clerical or administrative work. Her view of work was of something purely functional, to provide sufficient income to pay for her few expenses—few, because she led a very austere life—and not as something that would either require emotional involvement or be likely to provide emotional satisfaction. Such a notion she viewed, rather sneeringly, as "careerist"—meaning, I think, that she despised and envied people with ambition and with a belief in their own potential for advancement. This kind of subsistence existence was an external representation of an impoverished and inhibited inner world.

Her history of relationships was sparse. In the 20 years of her adult life to date she had had relationships with four or five men, usually lasting for a few years, and these relationships tended to have a sado-masochistic quality in that she felt generally mistreated or even emotionally abused. The one exception to this pattern was a relationship with a man when in her mid twenties, with whom she had lived for four years, and which had proved to be the most stable period of her life. This relationship foundered, however, when he had wanted to proceed to marriage and a family and she did not then feel ready for this. At the time of her presentation, she had just ended a relationship with a man, which had been the most frankly abusive of her life. Physical violence

was not involved, but she felt—it seemed with some justification—hated and exploited by him, and at her most wretched when it came to an end.

Emily was the younger of two daughters of a middle-class professional couple. The family had lived in a situation of some isolation in rural Wales, although they were well-respected figures in the local community. Her parents' first child had been stillborn, and she had felt that this was a loss from which her mother had never fully recovered. This was of central importance to her emotional development. Both parents worked, and her mother was perceived to be often tired and emotionally unavailable, while her father was felt to be generally more interested in his work and his gardening than in his daughters. The family was well provided for materially, though their life was simple and without extravagance, and the parental relationship, as far as we have been able to reconstruct it, seemed to be reasonably stable.

There was, however, a marked absence of a genuinely interested, loving parental object; a particular incident in her early childhood encapsulated this sense particularly well. Emily had apparently fallen off a swing when she was 2 or 3, and her parents—especially, in her mind, her mother—had failed to notice that she had damaged her leg and was limping when she walked, until this was remarked on by a family friend. The picture in her mind was of parents who were both physically present but emotionally somewhat absent, too caught up in their own preoccupations actively to notice and be interested in a damaged and distressed child. On closer examination these objects had a more sinister quality for Emily. Father was seen as charming, but evasive with a seductive edge, and mother as often quite resentful of her daughters' attempts at achievement and independence. Much of Emily's adolescence was spent in a silent but ferocious battle with her parents, feeling that her bids for freedom were being constantly undermined rather than supported. Both parents were dead by the time of her presentation for treatment, her mother having died three years before and her father one year before. As she was herself childless, as was her sister, she conveyed a powerful and painful sense of having no family and, in fact, of her family line having been extinguished.

My first direct encounter with Emily was memorable. When I went to open the front door of my consulting-room to meet her, I saw her pressing her face against the glass and peering into the house, as though from an urgent curiosity about what or who was inside. I got an early indication of someone who felt constantly on the outside in life, both shut out from the desirable place and seemingly desperate to get inside in order to feel safe and protected. The very fact of the existence of the barrier (a front door) to immediate contact was something that provoked very hostile feelings.

Psychotherapy began at three sessions a week, but this soon proved to be inadequate to address the degree of emotional pain with which she suffered, and her sessions were increased to four and then five during the first two years. Emily showed herself to be very stricken with depression and hopelessness, leading an isolated and impoverished life as a consequence, but also possessing a courage and honesty in our work of exploring the origins of these feelings. Her utmost commitment to the treatment was never in doubt, and, the constant attacks upon it notwithstanding, it was often acknowledged to be a lifeline for her.

The first few years of treatment were dominated by an often silent battle with me. This had the atmosphere of a power struggle and of a determination to defeat me in my therapeutic endeavours to reach her suffering and to provide her with understanding. Such endeavours were generally viewed as arising from my wish to aggrandize myself and humiliate her, to push her cruelly into the position of a helpless and dependent infant. Slowly, her underground attacks on my work were able to be made overt and some ownership taken for them, as well as a sense of relief that I had not been defeated and joined her in mutual provocation, or fallen into despair.

It became apparent that the issue of her childlessness was of great emotional significance. Despite the limited number of sexual relationships and an awareness of her increasing age, Emily nonetheless believed that "one day" she would have a baby. When she entered treatment, she had had to face the fact that this possibility had passed her by, and this was, at one level, the object loss—of the baby she would now never have—which precipitated her

most recent depressive episode. Her profuse weeping when she spoke about this had the quality of racked torment and unbearable pain, and her weeping gave little relief. This is akin to Britton's (1994b) comment on the "almost pure psychic pain" experienced by depressed patients during periods of analysis.

For a long time she clung tenaciously to the construction of this loss as cruel and unfair—that life had maliciously robbed her of this most desired possession. It was only as a result of patient and careful work that she came, over a period of years, to be able to accept some responsibility for her own unconscious choice not to have a baby, and indeed to face her own doubts about her maternal capacities. It was possible to work from her experience of an internal mother who jealously robbed her of her babies and her adult femininity and sexuality to an ownership of these projections of murderous jealousy felt towards that creative mother and of the very unforgiving attitude she harboured towards her own mother's failures. Facing the emotional pain arising out of this unconscious choice to be childless was very testing for her, but ultimately liberated her from the persecution and hatred, which her childlessness had previously aroused.

Her mother's unmourned stillborn baby was also crucial in understanding the dynamics of my patient's unconsciously chosen childlessness. It became clear that the whole notion of pregnancy was imbued with such anxiety—even terror—for her as to be unmanageable. This anxiety was not only a function of her phantasy of the baby as an internal persecutor; it seemed to be much more understandable as arising from a belief in the likelihood of catastrophe—a catastrophe that her mother had suffered, and from which neither mother nor she had ever fully recovered. This was expressed very plainly when, on one occasion, Emily was recalling a previous boyfriend who was an architect, and she remembered her amazement that he could design buildings in the confident belief that they would stay up rather than fall down. Faith in reliable, robust supporting structures, or good internal objects, was extremely limited, and consequently risk-taking and adventurousness were nearly impossible. Life had to be lived with a kind of monotonous safety, which allowed very little opportunity for creativity and liveliness.

And yet, paradoxically, there did seem to be a half-formed belief that her psychotherapy was a source of real help for her. As I said earlier, the treatment, even in the stormiest, almost despairing periods, was felt to be a lifeline, and this may seem to contradict the basic notion of a lack of reliable supporting structures. Sessions were rarely missed or attended late, and indeed her commitment to the treatment gave me a reasonably firm sense that internally something had survived. This sense in me generally came from the repeated experience of good work that could be achieved within a particular session, even though it would always become precarious as the end of the session approached and the hatred provoked by the rejection and abandonment of the end of our contact threatened to gain the ascendance. Despite this, the fact that good work and useful understanding was possible instilled in me a basic hope that she could be helped by the psychotherapy. It could be said that a belief in the possibility of growth, change, and development was projected into me for safekeeping.

As would be expected, weekends and holiday breaks were a major issue and were both profoundly disruptive and ultimately crucial to an understanding of the patient's difficulty in managing separation and maintaining a secure link with the good internal object. The end of the session and the end of the week were experienced as a cruel rejection that threatened to wipe out any good experience that may have accrued. She would leave the session in a characteristic way, usually marching angrily towards the door and rarely looking back at me, saying goodbye, or doing anything that might denote some degree of acceptance of the external reality that our time was up. Weekends were spend in an empty, miserable, abandoned state, in which she would take to her bed and have great difficulty in fulfilling the minimum requirements of caring for herself. She was not actively suicidal, but at one point in the psychotherapy the extent of her symptoms of clinical depression necessitated a psychiatric consultation. Although she felt considerable relief that I had taken the severity of her mental state sufficiently seriously to arrange this for her (and that I had acknowledged within myself that my treatment alone might not be enough to contain her symptoms), the psychiatric help offered

(medication) was rejected, and continued psychotherapeutic work enabled her to emerge from these deeper levels of depression.

One of the significant changes that occurred as she began to improve and to gain some freedom from her depressive imprisonment was that weekends, instead of being experienced as empty and objectless, in which a crying baby was unheard and unattended, began to involve a search for substitute parental figures and parental couples. While at one level this indicated a wish to replace the lost therapist, it also seemed to me to imply a growing belief in her mind that such helpful figures did actually exist somewhere. On some occasions these objects would be found concretely in friends, and on other occasions they would be sought more symbolically through books and other cultural experiences, in which she would immerse herself, and which provided her with enjoyment and stimulation, as well as some degree of inner security by virtue of feeling a connection with me internally. In short, the change was to an active object-seeking rather than a miserable or masochistic withdrawal.

This important advance could be achieved as a result of the psychological work of mourning. Just as by facing the pain and responsibility of unconsciously electing to be childless, her torment and anguish at being in this situation could be modified into sorrow and regret, so a true mourning of her lost but essential internal mother could move her internal world on from a state of emptiness and abandonment to one in which some reparation and reconstitution of the object was possible. It is one of the strange and mysterious paradoxes of Klein's (1940) model of working through the depressive position that it is only when the lost internal object is felt to be actually lost and given up that it can be successfully and helpfully restored. Perhaps, rather less mysteriously, this means that an object cannot be found until it has been lost or until it is acknowledged as lost.

The work of mourning involves a series of complex and emotionally demanding stages. First, the object must be seen and experienced to be both essential and lost. Steiner (1993) has shown that many depressed patients become stuck at this stage, fearing the loss but being unable to experience it, because facing the psychic reality of such an essential loss entails a threat to the patient's survival. The second stage involves an acceptance of responsibil-

ity for the loss, evoking depressive guilt. This is also a precarious juncture in the process, as the cruel superego can exploit the depressive suffering of the patient and convert depressive guilt (responsibility) into persecutory guilt (sadistic accusation). The final stage is the mobilization of reparative impulses, which involves a wish to restore the lost object by repairing the damage done to it. A successful mobilization of such wishes is dependent on a belief that partial repair is possible and on an acceptance that partial repair is good enough. The object cannot be fully restored, because the damage has been done. As can be appreciated, there are many places in this intricate sequence of emotional movements where progress can be threatened, usually resulting in a retreat into the familiarity of paranoid functioning. Each movement forward entails new anxieties and new sources of pain, each testing the patient's capacity to bear the pain. The capacity to bear emotional pain is to some degree determined by the capacity to respect pain as an inevitable consequence of growth, as opposed to believing that it should not exist (Bion, 1970).

To illustrate this, I want to describe some clinical material in which these emotional tasks I have described were being struggled with by my patient. It is important to emphasize that while, I believe, this material does show Emily beginning to face some of the work of mourning and of negotiating her way through the testing terrain of depressive anxiety, these insights were followed by retreats away from this particular pain and awareness before they could be approached again. Over and over again, the process of progress followed by backward movement was repeated.

The following clinical material is taken from a midweek session in the fifth year of treatment. For some months prior to this point there had been evidence of a slow movement away from a predominantly bitter and belligerent mood towards one tinged with a feeling of acceptance and regret. She began the session by saying that she had felt really terrible the previous day and also felt that way that morning, lying in bed crying, feeling powerless and hopeless, and thinking, "help me, help me". She then remarked, in a more lively way, that on her way to a meeting the previous night she had taken the tube in the wrong direction—in fact, in the direction she comes to see me. She said with some humour that she thought that she was behaving like a homing

pigeon! After a brief silence she went on to talk about a colleague at work, Mary, someone who felt very aggrieved at being badly treated because of a dispute with her boss. She said that Mary had been talking to her about it the previous day and was trying to make my patient feel that she should come up with the solution to her predicament, to rescue her from it in some way. In listening to this, I thought that Emily felt somewhat torn between, on the one hand, feeling angry with the boss and aggrieved on Mary's behalf and, on the other, angry with Mary for shifting the responsibility for her situation onto Emily's lap, but that the fact that she could feel torn in this way represented an improvement for her, as previously her natural inclination would have been to join in with Mary's grievance. It was as though a previously stillborn part of the patient's mind was coming to life and able to tolerate conflict and ambivalence.

I said at this point that I thought that she recognized Mary's drive to make someone else feel responsible for her own situation and was possibly also feeling guilty for being in a better situation because she so often wanted me to feel that it was my job to rescue her from despair and hopelessness. She agreed with this and said that she has often felt like saying to me, "You sort it out, that's what I pay you for". She also said that she thought it was unusual for her not to just take up Mary's cause with a degree of relish.

Emily then went on to say that she had been listening to the radio that morning and had heard a court report about the verdict in a case of two children who had been accused of the murder of another, younger child. The radio reporter had been in court throughout the trial and spoke in a really interesting and insightful way about it. The boys had been found guilty of murder and the judge had apparently attributed their actions to violent videos they had seen, which, Emily said, she found stupid and offensive. The implication, as I heard it, was that this was an attempt to explain away their actions, to blame it on an external source rather than to help them to take responsibility for such extreme destructiveness.

She then went on to say that she had felt particularly moved by an interview with the mother of one of the convicted boys. I asked her what it was that she had felt moved by, and she replied that the mother had accepted that her son had really committed mur-

der; she did not try to deny it, but she said she thought he had been weak.

There was at this point in the session a powerful sense of deep emotion, especially of empathy with a tragic situation of destruction, loss, and guilt, which was evoked in my patient and which she was communicating to me. Most of all I had a sense that Emily was in touch with feelings that had to do with a kind of tragic acceptance and sorrow, conspicuously and unusually unaccompanied by the bitterness and rancour that were more often to the fore. I said that I thought that she, like this mother on the radio, was feeling able to accept painful and destructive aspects of herself that do considerable damage to a small child within her, as well as to a mother inside her, and that it moves her to hear this mother say, "He's my child, I own him, and he is responsible for a catastrophe which really has happened and cannot be undone".

She cried in response to my interpretation, and her crying had the quality of a kind of quiet but deeply felt sorrow rather than the kind of tormented weeping that was more usual. After some time, when she remained silent, I said that I thought she was expressing tears of acceptance and of a mixed feeling that had to do with a sense that this catastrophe and despair was to some degree counterbalanced in her mind with the perception of an interesting and insightful reporter, of my insightful voice, which she homes in on, like a homing pigeon, to help her with her despair at outbreaks of destructiveness in herself, and of her attempts to shift the responsibility, like Mary and like the judge who blamed the videos.

I had a sense that she was aware then of the end of the session approaching, and after a few minutes of silence she said, in a slightly agitated voice that had an edge of impatience, that she also did not want to accept these things. If she accepts one thing, she will accept everything, all the injustices of the world, and it will feel like being trampled over. The session then ended, with an experience of me seemingly forcing something unwelcome on her, which she was somehow right to resist.

To some degree this session is atypical in that there seems to exist in Emily's mind from the start of the session a notion of a helpful object. Whereas normally there would be a quality of complaint, resentment, withdrawal, or resistance to work through, in this instance the patient talks of saying "help me, help me" while

feeling paralysed and depressed, implying that somewhere there is an object who can help, if only he can be located. The patient is not unconscious of the fact that this object is her psychotherapist, as she demonstrates with the mistake made catching the tube train going in the "wrong" direction and referring to herself as a bird looking for a home. The capacity to accept her own aggressive evacuation of responsibility for her plight, as Mary does to her, is also atypical but is the cumulative effect of much work we have done in this area.

What I think is most interesting are the fluctuations in the quality of her internal world as the material of the session unfolds. The picture at the beginning of the session of isolation, despair and paralysis (though, as I have said, with some vague sense of a source of help somewhere) moves on to one of one person treating another unfairly and aggressively, with elements of dispute and victimization, and on again to the much more complex picture that is contained in the material about the murder trial. A disaster has happened; destructiveness exists; loss has occurred; ownership of this and the consequent guilt can be tolerated. Good objects begin to appear—an insightful reporter, a courageous and truthful mother—who can be appreciated and admired, to counterbalance the bad objects of victimized Mary and the stupid judge. Ultimately, there comes to be in the room a couple—helpful psychotherapist and patient searching for help. This leads to an affect of sorrow and regret, of appreciation for what is good and acceptance of what is bad, although this acceptance takes on a different quality, of something that should be resisted and fought against as the end of the session threatens the delicate equilibrium within the patient indicative of a move towards a more positive and balanced internal world.

Hinshelwood (1994) has described how the achievement of the depressive position is to sustain the feelings of concern without always reverting to paranoid anxiety. For this patient, Emily, the end of the session very often threatened that achievement, as can be seen here in the material when the end of the session provokes a paranoid identification with the murdered boy who is trampled over.

Klein regarded the mobilization of concern for the lost object as the hallmark of the depressive position, as it is this concern that

activates the wish to repair. My patient demonstrated feelings of concern for a mother who had to bear an almost intolerable burden of guilt and responsibility, but who could also both accept and forgive her son's murderousness. Internally, this stands for a reconciliation between the patient and her objects, notably a mother who can be perceived as accepting and forgiving of her child's destructiveness, as well as concern for a mother who has to bear the burden of grief for a dead child. Mutual concern between mother and child, psychotherapist and patient becomes evident. Such mutual concern does not imply equality, but in fact a tolerance of inequality (Balint, 1972)—an important step forward for a patient like Emily, who was usually much preoccupied with issues of inequality, injustice, and unfairness—even though a step back in this direction is made at the end of the session. Furthermore, the discovery of a forgiving object makes self-forgiveness a possibility. In this way, a barren and persecutory internal world can be modified by one inhabited by more humane, mixed, and ultimately more supportive internal figures, which in turn makes for a richer and more secure inner life.

I want now to focus on some aspects of Emily's relation to her father, who had died only a year before she entered treatment. Although often viewing him as a rather untrustworthy and tantalizing object, there was also a strong sense of her as a special daughter to him. Memories of emotionally charged shared experiences, such as going to the theatre with him or working together in the garden, began to appear in sessions, providing some evidence for this view of a special, somewhat secret bond. Emily was consciously very angry with her father for dying and felt that at last her chance to have him to herself was thwarted by his wish, as she construed it, to join his wife rather than be with his daughter. His death was catastrophic for her—acknowledged in some ways as a reality but its emotional ramifications for her denied.

The following dream, which occurred in the sixth year of treatment, shows some of these aspects of her struggle to mourn this lost object. The background to the dream was that she had ended a relationship with a man, Jim, some months before; she found the split particularly distressing because he was a more genuinely supportive and caring object than she usually gravitated towards, though he was unable to make the commitment she wanted. Pre-

dictably, she found him very difficult to give up, and she often fantasized romantically about getting back together, even though rationally she knew this to be impossible. In the transference, although she often related to me in a provocative way, there was always a sense underneath that she believed herself to be my special patient, as though one day I would make the commitment to her that she wanted and relinquish my ties with my wife and family to be with her.

After several weeks of intensely silent resistance and withdrawal, she presented a dream a few days before I was to take a short break. She related the dream in an unusually lively, even excited way, and she announced that the dream had "come to my rescue" (i.e. the patient's), meaning that it had broken through the silent resistance. In the dream she was in Spain and a battle was going on in the village below, probably to do with gang warfare. She was in a house on a hill, and shots were being fired at the house from the village. She became very frightened that a bullet would kill the father in the house that she was in. She was helped to escape by two men, rather serious and unemotional types, who led her to safety through a series of garden sheds. The dream then changed to her being in a room, not unlike my consulting-room, with Jim, who was sitting at a desk. On a couch behind him was a dead man, dressed in striped trousers. She said to Jim that it was his dead father, but he was unable to turn around and look at him. Her associations were that Spain was somewhere she had recently gone on holiday, that the two men who helped her to safety, stood for me, and that the striped trousers on the dead man reminded her of the way capitalists were often drawn in the propaganda cartoons of Russian Communists at the time of the Revolution (she has an interest in Russian history and politics).

We were able to understand several important dynamics from working with this dream, and indeed she often referred back to it during subsequent sessions. As we understood it, the war going on in the village represents her own destructive feelings, especially directed at the father/psychotherapist in a higher position on the hill, who leaves her to go on holidays, and her fear that these destructive feelings will indeed both kill him and a part of her in a more loving relation to him. She is brought to safety by the helpful figure of the psychotherapist, but she is again faced

with the problem of looking at a dead father, now located in my consulting-room but represented as Jim's dilemma. The dead object is lying on the couch, indicating her own identification with it, keeping her dead, and her inability literally to face it, give it up, and go on living. She is aware that a part of her inability to face this dead object and mourn it comes from her hatred of the object, fed by propaganda and caricature, which distorts the object into a capitalist exploiter.

As significant as the content and meaning of the dream was the very striking relationship the patient had to it. Although she spoke of being "rescued" by it, implying something rather passive, she was able to feel excited by it and to value it as a worthwhile production of her own mind, as well as something that I might be interested in and value also. Dreams have been brought from the beginning of her treatment, but usually without associations, handed over to me to do something with, very rarely in a spirit of joint work. This dream seemed to offer an important assurance to her that her mind could produce something valuable and meaningful, something that could help me to help her.

The work of mourning in relation to this object, through an integration of the endangered father, the helpful therapist, and the hated dead capitalist, is still to come, as are an awareness of the good qualities of the parental couple and a possibility of termination. Yet significant advances have been made, externally and internally. An enjoyable social and cultural life is now possible, though sustained close relationships continue to be difficult; responsibility can be taken for destructive impulses and concern felt for the effect they have on objects; weekends and holidays can be enjoyed and used; psychotherapeutic work can be appreciated and valued, as well as hated for its impositions, frustrations, imperfections, and limitations; the parental objects can to some degree be forgiven their imperfections, rather than constantly opposed and punished. Life can be lived with some sense of vigour and adventure rather than in a spirit of rigid, depressive monotony.

Money-Kyrle (1971) has defined the aim of psychoanalysis as an acceptance, rather than an evasion, of the facts of life, which he defines as the love and need for the good object, the creativity of the parental intercourse, and an acceptance of the reality of time

and death. The latter fact is of particular relevance for this patient as a sense of time and age and the biological limitations they impose, as well as the actual death of her parents, had brought her into treatment. It is also a piece of external reality we come up against in every session, given that our time is limited to a finite amount. When, over time, the hatred of this reality diminishes and the object can be seen to survive the attacks, then the time available to us can be used, even enjoyed, despite being limited.

* * *

I have tried to show that patients with this kind of severe, debilitating depression can be helped with intensive psychoanalytic psychotherapy. We can, however, only build on the inner foundations of love, hope, and goodness, even if they appear to have been lost, fragmented, or destroyed. If such foundations exist, then the link with the good internal object can be strengthened as a result of the emotional work of mourning, and a barren and stultified internal world can be modified into one that is varied, balanced, and alive.

CHAPTER SEVEN

Notes on a case of paedophilia

Jean Arundale

Since the 1970s psychoanalytic psychotherapy has had to focus on the structure and dynamics of sexual perversions for a number of reasons: not only in order to understand and treat the overt sexual deviations, child sexual abuse, and the various types of antisocial and criminal behaviour appearing in consulting-rooms, but also because the close link between perverse states of mind and psychotic states has gained recognition. Perverse functioning is now seen as a feature in the borderline and narcissistic personalities, and the presence of unintegrated perverse areas can be found in many different patterns of psychopathology (Bion, 1959; Meltzer, 1973; Rosenfeld, 1971a). Furthermore, Glasser (1978) has pointed out that towards the end of many analyses—even those of neurotic personalities—perversions emerge, particularly in creative people. The psychoanalytic theory of polymorphous perverse sexuality suggests that perversions are ubiquitous and capable of unconsciously infiltrating all human relations. Thus, investigations in this area can reveal, writ large, problems of the widest relevance in object relations theory.

The psychoanalytic literature

Many of the contributions to the literature on perversion point to the disturbance of the early relationship to the primal object, especially in regard to innate aggression and envy, including infant self/object confusion, bodily fusion states, and the desperate distancing mechanisms that result as an attempt to differentiate and maintain a sense of self against the fear of disintegration and psychic death, shared by all the perversions (Gallwey, 1978; Glasser, 1986; Khan, 1979; McDougall, 1972, 1986; Stoller, 1976). These authors also refer to the style of communication in perversions—the disturbances in symbolic functioning leading to concrete thinking, omnipotent autistic domination of the object, and excessive use of projective identification—as often underpinning the severe disturbance in object relationships, together with an interference in thinking and reality testing.

Most psychoanalytic writers treat the perversions as a unitary phenomenon, discussing the features shared by all the perversions. Meltzer (1973) writes of four features that are characteristic: inhibited genital sexuality, inadequate identifications, strong defences against depressive anxiety, and a sado-masochistic narcissistic organization. He notes an absence of dependence on the internal parental couple in which the mother functions as a feeder and a container for persecutory anxiety and the father's penis functions as a protector of mother's body and her babies. Instead, anxiety is regulated by means of the deviant sexual act in which there is a "triumphant abolition of depressive and even persecutory anxiety". Meltzer writes of the presence in the internal world of a "stranger" who hates the primal scene and creativity.

Khan (1979) speaks of the use of the sexual object in the perversion as an "as-if transitional object" directed against anxiety states in an act of reparation to the self, creating an infant self idolized by the mother. He stresses the importance of power and will as a defence against psychic pain, rage, sadism, and hate, and he places importance on the fantasy work involved in the formation of what he calls the "collated internal object" that creates the aberrant sexual choice. Similarly, Stoller (1976) stresses the role of fantasy and the responsibility that the sexual deviant holds for the formation of his deviancy.

Glasser (1988) is one of the few writers who focus on the specific psychodynamics of paedophilia. He has observed that paedophiles experience the wish for love and intimacy as annihilatory; they fear being taken over totally. It is felt to be too dangerous to make the identifications with parental objects, enabling development of the self structure to take place, because of a fear of invasion and possession. The paedophile, fuelled by an inordinate degree of castration anxiety, defends against the catastrophe of fusion or possession by narcissistic withdrawal, self-preservative aggression, and the domination and control of objects such that they are given no independent existence. The paedophilic act bestows upon the child self the love that the paedophile was deprived of, without the necessity for a real relationship. Further, Glasser (1978) also writes of a sado-masochistic relationship with the superego and the projection onto the parents of the bad child self.

The theories concerning the paedophile's preferred object choice (babies, young children, or older children), of type of contact (penetrative sex or masturbatory activity), and why paedophilia is preferred to incest, homosexuality, fetishism, phobias, or other conditions attributed to castration anxiety can be inferred from psychoanalytic developmental models. Penetrative sex and the disorders stated above are seen as more advanced in terms of psycho-sexual development, in which some negotiation and resolution of oedipal anxieties has taken place. One central issue is the degree of innate aggression that contributes, through projective processes, to the extreme degree of castration anxiety, driving the personality to defensive splitting and a massive retreat from oedipal and genital object relating. These ideas are developed in the discussion following the case study. In the treatment, the ongoing focus of interpretation in the transference on the patient's aggression, on the projection of poisonous and dead mental states, and on attacks on linking was the crucial factor that enabled the patient to become more emotionally present. The understanding and containment offered in the therapeutic relationship of the patient's sadistic hatred of both his needy child self and the hated parent, fostered the reintrojection of a less fragmented and dead child self, allowing some degree of a sense of separate self to emerge, with accompanying sadness and loss.

MR L

At age 35, this slim, attractive man, Mr L, public-school-educated and working in a profession, approached his GP to ask for treatment for his compelling need to go to parks and pick up pre-teenage boys, whom he would then undress and engage in masturbatory activities. He felt that he must stop this, being troubled by his fear of arrest by the police. The consulting psychiatrist first sent him for behavioural treatment, which included aversion therapy, wherein penile shock was applied while viewing images of pre-pubescent boys, then withdrawn when shown images of women. This the patient experienced as humiliating, painful, and completely useless. Wishing to pursue help for his problem, he was offered private psychoanalytic psychotherapy with me, which he took up rather reluctantly, insisting that he could pay only a low fee.

On first starting treatment, Mr L refused my attempts to help him to tell his story and spent his time either in turgid silence or, alternatively, in arguments and attempts to convince me that sex with children should be allowed. He believed that society was mistaken in its values and laws—the ancient Greeks had had it right. The paedophile's principal desire, he claimed, was to make boys happy, to give them love and affection, and he fantasized about utopian countries in which sex with children was permitted. His arguments were, apparently, based on the assumption that all children were as bereft of affection in boyhood as he was.

As I repeatedly commented on his reticence in speaking of himself and his life, Mr L began to describe his childhood in a stilted and broken way, a small bit at a time, occasionally tearfully, describing the terrible loneliness and isolation that he had experienced as the third and last child of busy professional parents who seemed to have nothing to give him emotionally. In his account, his parents had had no patience with his awkwardness and helplessness, nor with his inability to play with other children or to join in happily on almost any sort of occasion. The images were desolate and depicted a passive, helpless, extremely unhappy little boy, able to take very little of

what was available or given. He spoke of his brother's cruel treatment of him and his, and other children's, refusal to play with him; he described the humiliation of consistently being chosen last when teams were formed for games. His best friend and closest companion was the family dog, and he remembered being brokenhearted when it died. His mother's authoritarian treatment of him would only be shaken when, occasionally, he would make a huge fuss and then get his own way. This would then feel entirely unsatisfactory to him, because, whatever had been the issue, he felt his mother had not given in to him willingly because she loved him, but only because of his loud rebellion. Whenever his parents would try to joke with him and tease him out of his ill humour, he would become even more sulky and infuriated. Reparation and forgiveness were not part of his repertoire; his rejection of the adult world was complete. He reported curious mental states of passivity as a child, when he would be lying still, completely unable to move a muscle in spite of desperately trying, until someone—the au pair or his brother—would come along and touch or arouse him.

There were some areas of good object relationship that he would get in touch with from time to time. His sister, 10 years older and mostly away at boarding-school, was kind to him. His GP father would take him on house calls, and he remembered waiting for him in the car, although when he became impatient he would, in despair, tear at the upholstery in the back seat with a penknife. Music was his means of contact with his father—a father otherwise subdued and withdrawn, dominated at home by the mother. His attachment to this father was inarticulate and formal, but he would lie under the piano, or in a play fortress, listening while his father played classical music. He began piano lessons but would stop playing if anyone came into the room or complimented him, refusing to give pleasure to others or to please them. After beginning therapy, he bought a piano and began to play again, and much of our language in the transference was of musical imagery. Another memory he returned to again and again was of an idealized time during the summer holidays, when he had met a boy who

had chosen him as a playmate, and together they had an idyllic hour playing games on the beach—a reflection of the analytic hour. At boarding-school he fell in love with several of the boys his age and older, and he realized that it was not only the sex play that drew him. He would follow them around, feeling emotionally dependent and needy in relation to them. He knew even then that he would not outgrow his love for boys.

His early relationship with his mother was depicted in a screen memory in which he approached her while she sat reading, and, unable to get her attention, he bit her on the ear. This so angered her that she grabbed him and bit him back. He remembered being extremely hurt and upset by this, and from then on he completely turned away from his mother emotionally. I understood this screen memory to refer to his primal infant object relationship with his mother—a violent, mutually attacking, bad relationship, later to appear in the transference, compounded with castration fears.

At about the 18-month point in the therapy there was a critical juncture. Mr L became disillusioned with the treatment and lost hope in it as a means of changing his sexual orientation. Up to this point, his sexual outlet was to masturbate on the weekends while smoking cannabis and having fantasies of boys. Incited by the news of a proposal in Holland to lower the age of consent for homosexuals, he began to hint that he was going to return to the active practice of paedophilia. His threat to begin picking boys up again presented me with a conflict: if I maintained a neutral stance, he would resume his sexual activities with boys, yet if I took a stand against it, we would re-enact the scenario with his forbidding, possessive mother. As much for my own ethical needs as anything else, I said that if he were to start again, I would not be able to continue to see him, as paedophilia was not only against the law but against what I felt to be good for boys. I told him that I could not continue to help him if it would mean helping him to break the law and go against my beliefs. He produced arguments against this, struggled with his anger and despair, but gradually seemed to accept it. Of course, I could never be completely sure that he was not picking up boys, but his reproachful ha-

tred towards me subsequently suggested that perhaps he was not. I worked interpretively on the identity in his mind between me and his mother—that he felt that I deprived him of all pleasure of any kind and that I wanted to dominate him. My stand against his return to paedophilic acts was accompanied by my repeated emphasis on his need for help—a need relating to his whole life, not simply to his sexual orientation.

After this period the climate in the sessions, which had always been difficult, became extremely uncomfortable. He often retreated into aloof silence, during which I would experience feelings of isolation, constriction, and despair. I interpreted that this silent rejection of me was to show me how alone and snubbed he had felt as a child, deprived of friendly contact. I continued to try to interpret, in the transference, his wishes for me to care for him and his child self, while also interpreting his fear of me and his anger and destructive feelings towards me and the therapy.

As the therapy continued, his withholding extended to the fees, which I had increased annually, as is my usual practice. Each time he was hurt, upset, and withdrawn, feeling that it meant that I did not care about him and was only using him for my own needs.

Yet, little by little, the story of his emotionally arid life continued to unfold, and after about five years he began to bring dreams. There were many of *terrifying female figures—monster women with tentacles or snakes for breasts, evil, wild-haired women with a missing arm or leg, waiting for him in a cave or at the end of a tunnel.* I interpreted these as images of me that referred to his horror of being with me a woman, without a penis. He had memories that revealed sexual confusion and anxiety about his body.

He would not take his shirt off at the beach, because he was convinced that his body looked like a girl's, with skinny arms and heavy hips and legs. When I suggested that it was upsetting to him when he discovered that little girls don't have a penis, he responded with a memory of being excruciatingly embarrassed and upset at seeing a little girl, a visitor to the

family, naked in the bathtub, with the adults gathered around. His mother urged him to join her in the bath, but he refused, feeling terrified that he would lose his penis and that his body would become just like hers.

Another memory in relation to his mother emerged in connection with an event that was crucial to his paedophilic development and was to play a significant role in the treatment. At about age six he had been caught playing sexual games with two other boys. Instead of admonishing him at the time of the incident, his mother had waited until bathtime. As she was drying him off, standing over him while he was naked and vulnerable, she severely reprimanded him, telling him that he must never play such games again. After he had his pyjamas on and was in bed, she came to his bedside and ran her hand up his pyjama leg as if to go for his penis, terrifying him. This incident made him feel that his mother was claiming him sexually for herself and wanted to remove his penis; he marked this as the beginning of his real terror of women as sexual beings. This led to a dramatic focus in the transference around his fear that I would try to claim him or his penis for myself. Was this why mother/I was trying to stop him from playing sexually with boys?

There have been observations by other writers on the perversions of deadness in the transference and inarticulate silences, and these persisted in my patient. To a comment I might make on his aloof withdrawal, he would respond archly, "Someone has tampered with my soul, and I must hide away to be safe and secure"—illustrating Steiner's "psychic retreat", a defence based on grievance and revenge, smouldering on, clung to, and even regarded by the patient as a strength and purpose (Steiner, 1993). In Mr L's retreat, he was isolated within his internal world, illustrated by a dream:

I was alone in a cold, dead, grey forest surrounded by small, blind, armoured creatures, like armadillos or turtles, creeping aimlessly and slowly at random around me. I came upon a little glass box which was emitting light and colour and exciting images. When I looked into it, I saw that it was the social world of people talking and being

together. I felt excluded, but I didn't want to have anything to do with it.

I interpreted this dream as his putting me under his control, enclosing me in the glass box, while he shut himself off from me and remained alone in his dead inner world, wanting but refusing to link up. As we worked on this dream material, unbearable feelings of non-existence or overwhelming sleepiness were induced in me and made me feel like one of his blind, stupid, meaningless creatures from the dead forest. In this way he dehumanized us both, and eventually I began to understand this as his trying to expel bad feelings into me instead of experiencing and thinking about his problems and how to relate to me. As I spoke to him of these things, he remained wooden and armoured, while I continued to experience the painful deadness that was both an attack on my thinking function and a communication of his blind, cold, dead internal world in which he would allow nothing to live. I pointed out that this was a way of showing me how shut out, helpless, and angry he had felt as a child. I also suggested that it gave him relief to push these painful feelings in to me, ridding himself of them, leaving me to deal with them and seeing whether I could bear them.

He then brought three short dreams that marked a significant change in the therapeutic relationship. I understood the change as having been brought about by our consistent work on his anxiety about linking with me, with the analysis of his symbolic material representing a link between us and the attempt on my part to relate to his child self.

Two boys were in bed, I was one. I began stroking the other one and it turned into a girl or, perhaps, I thought, a castrated boy. I went to ask permission from someone to be in bed with her.

A cat was tied to a post, starving. A scientist was looking on, waiting to see what the cat would do, either eat a poisoned chocolate mouse that was offered to it or starve.

A frozen, tattered, disfigured old woman, starving, with skin like a chicken leg, was told by a scientist that she had just spent all her money, millions, on jewellery.

The first dream indicated that he was beginning to accept me as a woman he could tolerate being with in the session, but he needed permission. However, in the second dream he was clearly playing a game of cat and mouse with me, cruelly attacking me with his passivity, revengefully starving himself of emotional nourishment before my eyes and getting pleasure from it. When I said this to him, he gave a smile. I was clearly the mouse, poisoned by his projected anger, and he was afraid to take anything that I offered, making me in the third dream into a tattered, disfigured, frozen, starving old woman with nothing to give him. I could not disguise my anger at this point, saying that he was self-destructively starving himself in front of me, expecting me to stand by and watch, like the scientist in the dream, and this affected him. He admitted that he wanted to row with me and told me how, as a child, he would provoke his mother into anger and then get upset by it. At the end of that session he asked for an increase in the number of sessions per week.

The following week he brought another dream.

I was inside a round stone building that had all the windows and doors bricked up. I was alone, with nothing to do but eat a plate of unappetising porridge that had grit in it. I knew I could try to escape, but I was afraid that jailers would chase and capture me.

I interpreted that, by increasing the sessions, he felt closer to me, but this also felt like a jail to him, and he was afraid that moving closer to me meant that I would take him over. He felt terrified that I would penetrate into his world and into him, to give him the security of being safely held in the therapy/prison. Inside these walls he could imagine himself to be self-sufficient and in omnipotent control of me and the therapy, although this meant emotional malnutrition.

During the next two years he felt somewhat more present in the therapy, but I consistently needed to focus on his anxiety about being close to me and how this aroused aggressive and violent feelings towards me. He had frightening and destructive dreams that he took pleasure in—for example, one about

two huge alien spaceships that were shooting at each other and he felt pleased about the destructiveness. Then he would deaden himself or make himself soporific in a passive defence against anger and violent feelings, reporting dreams in which *we were fused together as a giant slug in a defensive merging.* I was both a persecuting absence between sessions and a persecuting presence in the sessions.

I understood the material during this period to relate to a battling parental couple, as well as attacks on our coupling in the therapeutic relationship. However, a number of his dreams during this period were also reparative—as when, for example, he dreamt about *reconstructing a house and building new structures on dilapidated buildings.* He continued to use me as a vessel into which he projected his bad feelings of helplessness, hopelessness, and fury, wishing to induce me to become enraged and attack him, thus enacting with him his sadomasochistic internal object relationships. He agreed that if I did attack him, he would then be able to feel something in relation to me. It became clear that having affectionate feelings towards me, or even speaking openly with me, was terrifyingly dangerous and would lead to—and was unconsciously equivalent to—a violent, castrating sexual relationship. Here was his fundamental confusion between sex, affection, and aggression. When I said that he didn't know what an affectionate relationship with me would feel like, he said, in his aloof way, "something like white noise—soothing in a way".

As time went on, I began to have more of an existence for him. He told me about his present life, his problems at work, his relationship with his boss and colleagues, and his struggle to get a promotion. Gradually, he began to speak of wanting more from me, saying that he was afraid I did not care about him. He liked me to remember what happened in previous sessions; it made him feel cared about to know that I kept him in mind. He admitted to feeling abandoned between sessions, not liking the fact that we stopped on time, wanting to go on, wanting to be my favourite. He dreamt of *a child in prison who was being rescued,* clearly his own child self becoming freer and

making contact. He complained that each sessions was too difficult to begin and that the ending was felt to be a rejection, bearable only if he deadened himself and did not allow spontaneous feeling. Yet he was slowly becoming more able to tolerate the pain of need, desire, and separation, and his expression of these things and my empathic responses marked a more open feeling in the analytic space, often to close up again. When I would speak about this difficulty in taking something good away, to hold onto between sessions, he said that if he were to do that it would make everything ordinary between us, indicating his feeling of magical control, bringing me to life in the sessions and giving me no separate existence.

Evidence of his splitting appeared in a dream during the eighth and last year of treatment, which Mr L remembered in response to my saying how hard it was for him to see me on his side. He dreamt of *two houses side by side. In one was a boy with large genitals, masturbating; in the other was a dangerous, powerful woman.* I said that the houses were he and me, side by side, to which he replied that both houses were parts of him that he keeps separate, representing sexuality and anger. If they were joined together, there would be "murderous sexuality".

He continued to connect shame, guilt, and disgust with adult sexuality: he stated, "Sexual feeling between adults is perverse", and he had a dream of *his parents having violent, disgusting sexual intercourse, smearing shit.* After a visit from his parents, during which he experienced his mother as still dominating and manipulative towards him, he could say for the first time that he hated her and later reported a wish that he could kill them both.

It was unfortunate that therapy had to end prematurely when his company sent him abroad to work. The ending phase was painful and tearful as he acknowledged his dependency on me, and he spoke of the significance of our relationship. He asked me to write to him, and I did, sending him at his request the name of a psychotherapist in the southern European city to which he had moved.

Discussion

I would like to examine Mr L's therapy as it revealed and recapitulated features of his development and object relationships, especially in relation to his perverse object relations.

It has been noted that all of the perversions have in common severe sexual conflict and unconscious guilt (Welldon, 1996), although consciously Mr L's paedophilia was ego-syntonic. His sexual anxiety encompassed all psychosexual relations, from the primary infant–mother relationship to the anal battle for control, the oedipal arena, and the primal scene. Mr L told me how, during a desperate bid during adolescence to be normal, he had made several traumatic attempts to date girls. They all ended in complete failure, helplessness, and humiliation, a *cul de sac* that resulted in the blocking-off of heterosexual development and the directing of his libido towards pre-pubescent boys—the age before the bodily changes due to adult sexuality and masculine aggression occur. His disgust and hatred of the primal scene, containing his own projected genital sexuality and aggression, resulted in a sexualization of all relationships, which he confirmed when he told me that he had sex in fantasy with everybody he met. His hatred of the devouring, castrating primal object made contact with me nearly impossible in the early period of treatment.

Within Mr L's paedophilic organization one could see a hidden incestuous relationship. As put by McDougall (1986): "... neosexual inventions are, at one level, an attempt to short-circuit the multiple effects of castration anxiety and to maintain, camouflaged within the sexual scenario itself, the hidden incestuous links to infantile sexual wishes." In the paedophilic act, the "true" primal scene is established, the parental couple is wiped out, and secret possession is made of the father's penis and the mother's breast simultaneously. Chasseguet-Smirgel (1974) discusses the idealization of pregenital sexuality as a hallmark of the perversions, with its desire to return to the bliss of oral union and the excitement of the anal battle for control with the early mother. As oedipal material began to show up in the treatment during the last year, it was unfortunate that he was sent abroad before sufficient working-through could take place.

The second feature of Mr L's personality that I want to discuss was his problem of identity, also noted as a feature in these patients by others who have worked with perversions. Due to splitting and projection of parts of the self, his needy, aggressive, dependent, and vulnerable selves, there was extreme identity confusion. Freud (1914c) writes of the failure of paedophiles and homosexual patients to project primary narcissism onto the father and then to identify with him, so providing the basis for a sense of self as an adult male. In Mr L's development, primary narcissism was retained and transformed into the ideal child self. His father's protective aspects, stripped of humanness, were internalized as music and used narcissistically to cancel out the father's sexual, oedipal function. Without a containing maternal figure as well, there were not the female identifications that can be found in homosexual development, in which sexual conflict is resolved by incorporating a creative feminine receptivity that allows an internal space and fertile interrelationships. In the idealized child self, Mr L established for himself an identity based on a sense of his own moral superiority in relation to what he felt was the vicious, depriving adult world.

He thus omnipotently regulated his own self-esteem, enabling himself by this means to have some sense of stability and integrity. In the paedophilic act, he reinforced his idealized self-image and nurtured his deprived child self by ritually undressing and masturbating boys. In this act of reversal, the humiliation and forbidden sexuality at the hands of his mother was erased, and he could triumphantly establish himself as an adored little boy on whom attention and affection were lavished. In doing this—which he consciously rationalized as a loving act—he could act out a hidden, unconscious, vengeful attack on mother and her babies. With the persecutory objects, the sexual parents and the adult world, split off and projected, together with his own hateful and uncaring child parts, the idealized child served to contain the psychotic anxiety of his aggressive and fragmented child self, helping him to survive the threat of disintegration.

In the therapeutic relationship, as he began to reintroject a more intact child self, aided by empathic and symbolic linking with me, Mr L's psychotic anxiety became more available, appearing in dreams and in the perverse transference.

Akin to the transference neurosis and labelled "transference perversion" by Etchegoyen (1978), these patients form, in the perverse transference, a therapeutic relationship characterized by erotization, passivity, the provocation of irritation and impatience in the therapist, and the projection of painful feelings both defensively and as attacks (Joseph, 1971). Meltzer (1973) comments on the perverse attacks on the therapeutic process which result in sterility, the *raison d'être* of perversion. Defiance and rebellion in the transference has been noted (Etchegoyen, 1978), defeating the attempt to form a therapeutic alliance. The strength of rebellion was powerful in my patient; the wrongness of the paedophilic act, he admitted, provided much of the excitement, repeating a childhood situation of always being in the wrong in his family.

With this patient, an important feature was the sadomasochistic perverse transference employed as an anxiety-driven defence against dangerous object-relating and depressive anxiety. The perverse transference could also be construed as Mr L's sadistic wish to enact destructive internal phantasy relationships, in which he sought revenge on his depriving, sadistic objects. The absence of good internal objects meant that each session was an encounter with a hated, dreaded person, who must be put off, obscured, obfuscated. Glasser (1988) mentions the quality of "dullness" in the paedophile that interferes with the therapist's mentation. Gallwey (1978), too, speaks of the heaviness of dullness in the countertransference, by which the patient conveys anxiety of a trapped and claustrophobic variety, with negativism and mental paralysis, representing a petrified area of the patient's mind that protects him from his need for others. This is similar to Bion's (1959) idea of the attack on linking and Rosenfeld's (1971a) narcissistic organization, both features of my patient. McDougall (1986) points out that the states of inner deadness are adopted to counter the danger of sadistic and destructive impulses and so to protect the self and objects from damage. The sexual act brings the paedophile back to life, counteracting narcissistic and psychotic anxieties, omnipotently establishing him as the perfect child.

The inner deadness in this patient was, I think, due to immense hatred and aggression towards his needy child self in an attempt to obliterate it. My interpretative focus was on his aggression and rage towards me and towards his parents, expressed primarily

passively in destructive negation, a refusal to take whatever was offered in childhood and in the therapy. His aggression was linked to his envy of my ability to think and to care—the food that therapy could offer him. As he was confronted constantly in the therapeutic relationship with aggression and my acceptance and toleration of it, he felt understood and began to tolerate his own need of me.

Related to issues of aggression, Etchegoyen (1978) discusses the strong propensity in the perverse personality for splitting of the ego. This is a wilful attempt on the part of the whole personality to maintain splits, deny reality, and project undesirable parts of the self—as, for example, my patient's sadistic hatred. When Mr L erased the differences between himself and children, he created a situation in which, as Etchegoyen (1978) points out, the "perversion is not a defence against psychosis but the psychosis itself", constituting a psychotic overthrow of reality. Then, when he comes back into contact with the denied reality, he is further maddened by its intransigence, and he has to face the inevitable truth that he is not actually a child, and paedophilia is illegal.

As long as Mr L could identify with the idealized child, the loss and damage of childhood was denied and mourning and reparation were blocked. As the therapeutic work proceeded, some experiences of separation, loss, and need were tolerated by Mr L. When he had the stone house dream, there was a feeling of containment and security in the therapy, but still an illusion of omnipotent control over me.

In the next period, his violence, appearing in dreams, seemed to signal a sense of separate self in attack on a separate, uncontrollable object. Following this, reparative dreams and more intimate disclosures in regard to his day-to-day life appeared in the sessions. Because of my containment of his aggressive projections, I believe I began to be experienced by him as someone with a real personal existence and therefore of use to him. During the last 18 months, he could express dependency and a sense of loss and separation between sessions.

Therapeutic change

Change in therapy is signalled by the renunciation of narcissism in favour of dependence on good objects, as pointed out by Meltzer (1967) and others. Whole-object relating becomes possible at the threshold of the depressive position, introjective processes predominate in psychic reality, and the excessive use of projective identification is given up. A working-through of the Oedipus complex can then take place. For Segal (1997), therapeutic change takes place as the fragmented object is transformed by projection and reintrojection in the therapeutic exchange, enabling the patient to internalize a more whole and intact object, with ambivalence as a factor.

How much structural change actually occurred in his therapy is uncertain, but Mr L was able to make more emotional contact with me and to express some need and dependency. However, it was impossible to tell how much introjection of the therapy, of me and my concern, was allowed and how much of his intense anxiety about relating was worked through. He certainly continued his use of projective mechanisms until the end.

Although he relinquished some of his omnipotent defences and was able to have some depressive-position experiences (Ogden, 1992), Mr L continued to feel disappointed that his desire for sex with boys was still active and that I prevented him from having this pleasure. He would talk in his stilted way about friendships that he would attempt to have, but it was difficult to tell whether his relationships actually improved. Once I came across him in my neighbourhood, speaking vivaciously to a woman. I was amazed by this evidence of his splitting, seeing in him a lively and fluently talkative person, who was completely different from the deadened self he displayed in the sessions. In the therapy some modification, I believe, was made of his fearsome primal relationship, his splits and projections, and his fear of aliveness, and I thought I could see some sign of the formation within him of an inner space that could contain objects and bring them to life.

CHAPTER EIGHT

When is enough enough? The process of termination with an older patient

Evelyn Katz

The subject of termination is a complex and problematical one, theoretically, clinically, and technically. At the simplest level, all therapies come to an end one way or another, sooner or later. However, there is all the difference between the precipitate, premature termination and interruption of a therapy for external reasons or due to therapeutic impasse, and a planned ending arising naturally as part of the evolution of the therapeutic process. In the latter, therapist and patient may be engaged in a painful but rewarding process which forces both to face and work through yet again issues of separation, loss, and mourning and all their underlying phantasies.

Schachter (1992) tells us that according to numerous surveys, in only 50% of cases is there a termination that has been mutually agreed upon and, by implication, that experiences of mutually satisfying endings are relatively few in the lifetime of a therapist. Indeed, most endings belong in the murky area between the two extremes mentioned previously, and for the most part termination stirs up many anxieties for patient and therapist alike. Despite the repeated experience and working-through of separation and loss

associated with the breaks between sessions, weekends, and holidays, the patient faces the undeniable fact of having to bear the final separation alone, and to mourn the loss of this "strange" relationship without the help of the therapy he* has come to rely on. While he might look forward to his independence and freedom from the therapy, he also has to struggle with the regressive pull to perpetuate the comforting relationship of dependency inherent in the therapeutic relationship. On the other hand, the therapist has to contain anxieties about the timing of the termination and whether a "good-enough" therapeutic outcome has been achieved. The well-documented phenomenon of an apparent relapse or the recurrence of symptoms in the terminal phase may be alarming to both therapist and patient and lead both to question not only whether it is the right time to end but whether it was right to have begun in the first place.

Reich (1950) noted that the topic of termination had received very little consideration in the psychoanalytic literature. Almost half a century later, relatively speaking, the same may still be said to hold true. It is interesting that no mention is made of it, as an independent entry, in either Laplanche and Pontalis's *The Language of Psycho-Analysis* (1973) or in Hinshelwood's *A Dictionary of Kleinian Thought* (1989), and it is tempting to speculate that this might reflect the more general anxieties associated with endings or their inextricable association with death. Perhaps the very word "termination", associated as it is with terminal illness or termination of pregnancy or even extermination, suggests something so irrevocable and final as to stir up the primordial fear of one's own death, which we might wish to deny.

In this paper I focus on the process of termination particularly in the older patient. The ending of a therapy has perhaps different implications for this group of patients, in whom a growing sense of mortality and the likelihood of no second chance lends an intensity and a poignancy to the process and whose age and stage of life may impact on both the timing of termination and the process itself. If we accept that, unlike medicine, psychoanalysis does not provide a "cure" of the illness, how are we to know when the

---

*For the purpose of this paper "he" refers to the patient, and "she" to the therapist.

work is done? This brings us back to the perennial debate about the terminability or interminability of psychoanalysis. The psychoanalytic literature, following Freud, has differentiated between analyses that end satisfactorily and may be considered terminated and others that might be thought of as interminable because of the limitations of the patient, the analyst, or psychoanalysis itself. In the latter case, a second analysis may be required in order to complete the process. Grinberg (1990) and others believe that the process of psychoanalysis is interminable and is a lifetime's project. What ends, either more or less satisfactorily, is the analytic relationship, which has existed between two people over a period of time. Indeed, the working-through of the ending of this relationship is a necessary and desirable part of the ongoing process and has consequences for both patient and therapist. However, this way of conceptualizing termination has its pitfalls if it denies the fact that psychoanalysis, as it occurs within the context of the analytic relationship, is different from the process, which hopefully continues internally throughout life.

Historical overview

Perhaps because of the anxieties surrounding the subject of termination, much of the literature has been concerned with the elucidation of those criteria by which one might judge whether the work of an analysis has been successfully completed. In an area filled with doubts and uncertainties, the need to have something definite or concrete to hold on to becomes paramount. Such considerations are invariably linked to the aims or goals of psychoanalysis, and the fact that the two are often considered interchangeably is, I think, inevitable.

Freud at first placed emphasis on external criteria, such as the capacity for work and love. Later, with the development of the topographical model of the mind, the aim of psychoanalysis was to make the unconscious conscious. With the introduction of the structural model of the mind, the strengthening of the ego in relation to the id, superego, and reality was to be its main goal—"Where id was, there ego shall be" (Freud, 1933a). In 1927,

Ferenczi provided a somewhat optimistic picture of a completed analysis, together with advice on technique that, if adhered to, could result in a satisfactory outcome. Freud's seminal paper, "Analysis Terminable and Interminable" (1937c), is a sober antidote to such idealism. In this paper Freud elaborates further on what he considers to be the necessary conditions for termination of an analysis. The patient should be relieved of all his neurotic symptoms, inhibitions, and abnormalities of character, repressions should be undone or corrected, to be replaced by ego-syntonic controls, and the infantile amnesia of the third and fourth year should be filled in and replaced by a reconstruction of the childhood history. Freud addresses whether it is always possible to bring about such change and so effect a cure. While agreeing that a completed analysis is sometimes possible, he suggests that one cannot prevent either the occurrence of a new neurosis or the return of a neurosis that has already been treated. Thus, in this paper, Freud appears to have moved away from the idea of psychoanalysis as capable of cure. He asserts that the question of the termination of an analysis is largely a practical matter, and that the analyst may consider his task completed when he has achieved "the best psychological conditions for the functions of the ego" (Freud, 1937c).

Over the years, other authors have added to the list of criteria for termination, and there have been several reviews on the subject. Rickman (1950) provides us with his list of criteria but suggests that it is not possible to single out individual ones. Rather, a point of irreversibility is reached, if the analysis has been successful, when all these factors combine to make it apparent that the patient is able to continue the work of the analysis on his own. Glover (1955) writes about a survey he conducted of the members of the British Psychoanalytical Society on the subject of criteria, in which the criterion most favoured was that of personal clinical intuition. Pedder (1988) provides us with a useful summary of the work done in this area. He divides the criteria into two categories—those that are to do with a lessening of defences, internal splitting, and dissociation and others to do with increased ego strengths and a less severe superego. He goes on to suggest that latterly there has been a move away from more formal criteria for

termination towards a more modest, realistic assessment of the patient's mental state, such as his emotional growth. Both he and Schachter (1992) are in agreement that the criterion for termination that is receiving the most interest of late is the capacity for self-analysis, which arises out of the introjection of and identification with the analyst's capacity for self-analysis. It is the establishment of this internal analytic object that enables the patient to deal with the anxieties associated with termination and with the difficulties he may encounter in his life after the analysis has ended.

De Simone Gaburri (1985) notes the "feeling of imprecision, vagueness and dissatisfaction" when reviewing the literature on termination and blames the inevitable confusion between the goals or aims of psychoanalysis and its ending. For her, there is no need to formulate such criteria. Indeed, they do not exist. The problem of how to end an analysis does not exist either, what is necessary is the elaboration of the "fantasy (or idea) of the end of the analysis and how and when to elaborate it." More recently, Quinodoz (1993) has written about separation anxiety and its modification over the course of an analysis as one of the important criteria for assessing the patient's development. For Grinberg (1990), who is critical of the use of such criteria as a way of highlighting the essence of the psychoanalytic process, it is the internalization of the psychoanalytic process itself that indicates that termination can begin to be thought about.

Melanie Klein contributed to the symposium on the "Criteria for the Termination of Analysis" held by the British Psychoanalytical Society in 1949 and elaborated these ideas in her paper on the same subject (Klein, 1950). In these papers she acknowledges such well-established criteria as the capacity for love and work, heterosexual potency, and object-relating. However, for her, all these criteria are connected to and underlie what she sees as the central criterion for the termination of analysis—the lessening of persecutory and depressive anxieties associated with the working through of the infantile paranoid–schizoid and depressive positions. This, together with an increased capacity to deal with the external world, enables the patient to deal with the "situation of mourning", akin to the infantile weaning process, which is an inevitable part of the termination of an analysis. Klein's theoretical

delineation of the movement from the paranoid–schizoid to the depressive position has been further developed to include the notion of a lifelong movement from the paranoid–schizoid to the depressive position and back again—a continual reworking of both positions. Since the internal world is in a constant state of flux, the assessment for termination would be viewed less in terms of the achievement of specific goals and more in terms of a capacity to manage independently the anxieties, persecutory or depressive, that threaten to disrupt psychic equilibrium.

Hannah Segal sees the capacity for depressive-position functioning as an essential prerequisite for the termination of an analysis. She reminds us that a complete resolution of the depressive position is never achieved. The hallmarks of the paranoid–schizoid mode of operation are splitting and projective identification. On the other hand, the depressive position is characterized by an increased capacity for object relationships, both internal and external, and a capacity to tolerate separateness, conflict, loss and anxiety. Being able to learn from experience, to internalize a good experience, to accept hatred as a part of oneself, and to come to terms with death, and particularly one's own mortality, are also a part of depressive-position functioning. It is the patient's demonstration of having made a sufficient move from paranoid–schizoid to depressive functioning that is the important criterion in any assessment for termination. In her words, "The assessment has to be about the severity and persistence of bad states of mind" (Segal, 1988). This implies the intermittent return to such "bad states of mind", and it is the degree to which they take over the internal world and the patient's insight into and ability to contain them and work through them for himself that would be the necessary hallmarks of someone approaching the end of the process.

Steiner's (1996b) paper on "The Aim of Psychoanalysis in Theory and Practice" highlights the importance of the re-introjection of projected aspects of the self as a fundamental goal of psychoanalysis and therefore as an essential aspect of termination. Klein's concept of projective identification has lead to an understanding of how the splitting of the ego and its object is followed by the projection of split-off parts, which are subsequently disowned and attributed to objects in the external world. This allows for a rethinking of the aims of psychoanalysis in terms of the re-

integration of such split-off fragments, previously unavailable to the personality, through increased insight into unconscious processes. Steiner contends that it is through the process of mourning that the projections are removed from the object and returned to the self. Thus not only is the reacquisition of parts of the self an important criterion for termination, but the process of termination itself promotes the conditions whereby this vital aspect of the work of the therapy can take place.

The process of termination

The process of termination can be thought of as a kind of adolescent rite of passage. Like all rites of passage, it is fraught with anxiety, and, like adolescence, the capacity to deal with its vicissitudes is dependent on what has gone before it. Like others, I think that it is impossible to think of it in terms of the patient alone. Since termination has an impact on the therapist as well, perhaps it is important to think not only in terms of the patient's readiness for termination, but also the therapist's readiness to let go of the patient. In any case, it is through the dynamic interaction between both members of the analytic couple that the process of termination must be viewed.

There is no doubt that the main preoccupations of this process are to do with mourning, separation, loss, and death. The patient has to mourn the loss of someone—perhaps the only one—who has listened and tried to understand him. He has to give up the object who has been the container of his infantile projections. He has to accept his own separateness and the undeniable fact of the therapist's separateness from him. As a part of this, he has to accept that the therapist, representing the parental sexual couple, has a life of her own. In addition, he has to come to terms with his eventual replacement by "mother's" new babies—the patients who will succeed him. As a part of this mourning process, he has to acknowledge the help he has received and come to terms with the limitations of the therapy and the fact that he is one of the family and not the "special" one. Indeed, it is the loss of not only the object but of the rhythm of the ongoing therapy and the familiarity of the setting that is to be mourned. Therapy becomes a part

of ongoing life, the loss of which may drive some patients towards a search for immediate substitutes to fill the gap.

The therapist has to mourn the loss of someone with whom she has become intimately involved over a long period of time and to accept the frustration of not being able to know the next chapter of their lives. At times she may have to bear the guilt of feeling glad that it is all over. Most important is the giving up of infantile omnipotence in patient and therapist alike. The therapist has to accept that what she has been able to achieve may be less than she had wished for, that some aspects of the patient's difficulties may not have been dealt with at all and others dealt with superficially or inadequately. Similarly, the patient may have come to therapy with phantasies of an ideal outcome. While the process of therapy may have helped to modify these beliefs to some extent, the ending, with the unavoidable recognition that time has run out, will provide a last opportunity for working this through.

Issues of transference and countertransference are important aspects in the process of termination. One of the questions preoccupying writers in this area has been whether and how the therapeutic relationship changes as termination approaches, and whether the transference is ever completely resolved. While there is likely to be a move towards seeing the therapist as a real object, a complete resolution of the transference is perhaps not possible. With the growing awareness of separateness and curiosity about the therapist and her life, the patient becomes increasingly able to challenge the therapist, to show concern for and consideration of her as a real as well as a transference object, and to have an insight into the difference between the two. The therapist has to differentiate between her own capacity to deal with mourning and separation and her countertransference responses to the patient's projections or pathological defences. While we may all have experienced the difficulty in remaining dispassionate in the face of an unexpected wish to end therapy, it is important to sort out one's own emotional responses and the reasons for them from the countertransference pressure to react with anger, rejection, or reassurance. Grinberg (1990) reminds us that patients may also provoke feelings of depression in us, so that we express the mourning that they are unable to face.

Does termination begin once the decision to terminate has been taken, or, because the idea of the end of the therapy is present from its inception, is it indistinguishable from the ongoing work of the therapy? For many patients, anxieties around the need for and dependence on the therapist are inextricably bound up with the eventual ending. Indeed, some patients are so concerned about coping with termination that they cannot begin the process for fear of committing themselves to a relationship that is destined to end. For others, it is these concerns that may result in a premature breaking-off of the therapy. Conversely, it may be the terror of endings, for both patient and therapist, that leads to collusion and the continuance of the therapy far beyond its appropriate ending. Yet others, aware of their difficulties with separation, come to therapy specifically to work through these issues. While the fear of separation or endings is present throughout the therapy and is an essential part of its work, I think that it is important to differentiate it from the process that is set in motion once the actual decision to end has been arrived at.

Meltzer conceives of termination as a weaning process that begins "when the feeding relation to the breast at infantile levels begins to be acknowledged in the experience of the transference" (Meltzer, 1967). From this point onwards, the danger of premature termination becomes ever more apparent. This acknowledgement, while setting the stage for the actual termination, may precede it by months or even years. It is a time in which there is a heightened interest in the analysis, a valuing of its beauty and goodness as a means of uncovering the truth, and an increased interest in dreaming and dream analysis. This is the evidence that indicates an acceptance of infantile dependency and the introjection of the capacity for analytic thought. Once an ending date has actually been set, ushering in the final phase—a "going over" of the analytic process—begins, the purpose of which is to test out, through the patient's own memories, the extent to which he has been introjected into the mind of the analyst. This manifests itself through "do you remember" types of enquiries. Thus Meltzer differentiates two stages in the process of termination and is quite specific about the kinds of preoccupations apparent in both of these.

The terminal phase, with all its pressures and the powerful feelings it arouses, is an important and active phase of the therapy. It provides the opportunity for a re-working and working-through of old themes, but with a heightened intensity. Like the terminally ill patient who realizes that he has nowhere else to go and that there is no turning back, the last months and weeks in the life of a therapy, with its progressive and regressive cycles, may provide a synthesis of all that has gone before. As Miller has said, perhaps it is "the most important phase for which the patient has been prepared by the lengthy (and not to be minimized) analysis which has preceded it" (Miller, 1965). What is different about this phase is that both therapist and patient are forced to face the painful truth that time has passed for both of them and that "illusory timelessness is transformed into a real temporality, and the omnipotent phantasies and those of immortality are limited" (Grinberg, 1990).

Clinical material

I will now give some clinical material to illustrate some of the issues discussed above.

Mrs M

Mrs M was 55 years old when she sought help, following the break-up of a two-year relationship. She had become increasingly alarmed by unbearable depression, panic attacks, and unpredictable swings of emotion, which could overwhelm and incapacitate her. She feared that her state of mind would prevent her continuing in her post as the curator of a prestigious art collection. Mrs M dressed smartly, paying great attention to detail. While her body language was careful and studied, her speech was equally precise and proper. Her eager and expectant manner was, as I came to realize, meant to please and appease, while anything threatening was to be kept out.

Following the death of her mother when she was two, Mrs M was brought up, but never formally adopted, by her maternal aunt and uncle, who were childless. Neighbours had discov-

ered her, sitting next to the body of her mother, many hours after her death. Her father was away from home at the time. Her aunt was a strict no-nonsense "mother" who took her duties and responsibilities as surrogate very seriously. Educational achievement, duty, and obedience were paramount. Her uncle was, for the most part, uninvolved in her upbringing, and remains a shadowy figure, unfulfilled in life, resigned to Mrs M's presence, but perhaps resentful of never having had any children of his own. Father was remote but idealized—someone who, she felt, constantly disappointed her. Mrs M was a sensitive, weepy little girl, who, having had no help in dealing with the tragic events of her young life, felt that her presence was merely tolerated, and that any misdemeanours might result in her permanent expulsion from the home of her "adoptive" parents.

The trauma of her initial abandonment runs like a leitmotif through her life. Not long after she came to live with her aunt, she was evacuated from London and sent to live with her grandparents in Scotland. She was a sickly child, and there were two periods of hospitalization during which her aunt was prevented from visiting her. Several times in her young life she was taken to live with her father and a new partner, only to be unceremoniously packed off back to her aunt when things did not work out. When she was 12, her father remarried, and yet another unsuccessful attempt to incorporate her into his life was made. Mrs M refused subsequently to have anything further to do with him until adulthood; contact was resumed after the birth of her first child.

The relationship with her "adoptive" parents continued along its rocky road, with Mrs M being openly compliant and dutiful and secretly resentful and rebellious. She disappointed her aunt when, in her twenties, she married someone deemed eminently unsuitable. This relationship, although exciting to begin with, soon palled. Her husband found her prissy and "schoolmarmish", while she experienced his unpredictability, and later his philandering, as yet another of life's betrayals. Her son was aged 17 and her daughters 15 and 13 when the marriage finally ended.

Gradually Mrs M reconstituted her life. Her successful career provided some solace. She eventually began a new relationship, which has since ended, and her son and older daughter, who had chosen to live away from her after the end of their parents' marriage, returned to live with her in her new home. As one might expect, the relationship with her children has been tricky and painful, and issues to do with separation and loss associated with their growing up have been difficult to negotiate. All three children left home within the last eighteen months of the therapy, and Mrs M has since lived alone. At the end of the fourth year of treatment, when she was 59 years old, and after a long and successful career, Mrs M elected to retire from her post to give herself time to pursue other interests. These interests might reflect less of her responsible, obedient self and more of the sensitive, creative aspects of her personality, which have slowly become more apparent and available to her through the work of the therapy.

In the early months, Mrs M attended her sessions dutifully. Her polite and pleasant exterior was an attempt to hide a wary child, constantly on the alert for telltale signs of my displeasure. Often she would regale me with stories and events from the workplace in an attempt to engage my interest in her and her life and to join up with me in an equal partnership of two interested professionals. In the transference I was sometimes felt to be a demanding aunt/mother and she my clever daughter, who hoped to earn her place in my affections by being my interesting and special patient. At other times I was to be her student, admiring the depth and breadth of her knowledge as she lectured me on her subject, providing me with all manner of academic information.

Much of the session time in those first months was taken up in a painstaking elaboration of the early years of her life. Like someone picking through rubble after a disaster, Mrs M searched her mind for fragments of memory of her actual mother and wept when there were none. While she could admit her anger and bitter disappointment with her father and with her aunt and uncle, it took some time for her to be able to express the negative feelings about her mother and her deepest

fears that she had been responsible for her death. She would sob inconsolably and would report feeling "wiped out" by these sessions.

At first Mrs M responded with curiosity, and sometimes impatience, at my transference interpretations. During this phase of the therapy Mrs M's idealization of and identification with her academically gifted father was often re-enacted in the transference. At times I was made to feel like the ignorant child, full of envy and awe in the face of her own intellectual brilliance, whilst on other occasions I became the idealized therapist/father who could pull things together brilliantly. Anger and hatred was not to be part of our relationship but was to be kept in the external world and projected, at times, into her children, with whom she would then enact some dreadful row. She would emerge from these rows feeling battered, misunderstood, and very much the victim. These incidents, which mostly occurred prior to her return after a break, would precipitate severe attacks of stomach pain, accompanied by depression and feelings of hopelessness and despair. Gradually she came to understand these occurrences as an expression of her anger and hatred of me, who, like her mother and father, was felt to have abandoned her completely during my breaks.

Two-and-a-half years into her therapy, Mrs M reported financial difficulties and insisted that it was time to leave. The work of this period marked a turning point in the therapy. In response to my interpretations, in which I pointed out her fear of being needy of and dependent on me, she screamed at me, full of hatred and rage, "How long do I have to be tied to your apron strings?" My firmness and resolute manner, I think, helped her to feel that I could withstand her attacks and aided the recovery of an internal maternal object who could focus on her and give meaning to her life. Soon after this she began to bring dreams, which until then she had been unable to do.

After four years of therapy, Mrs M again raised the question of ending, in connection with her planned retirement some months later. Financial reasons were cited. After retirement she would be living on a reduced income and would find it

difficult to balance the books in the interim period, until she found some other means of employment. She had no choice, she felt, but to retire from both her career and her therapy at one and the same time. Despite the fact that I had anticipated this, I found it difficult to listen impassively to what she was saying and was filled with anxiety about this attitude of "throwing the baby out with the bathwater". However, it soon became apparent that the way in which she was bringing this material was very different from the body-blow I felt that I had been dealt some 18 months previously, when she had first raised the issue. It was clear that I was not being dismissed but was being invited to give my opinion and to enter into a process in which we could begin to think together.

While she had made considerable use of the therapy, I felt initially that to talk of ending was premature and, in its timing, was an unconscious repetition in the transference of the all-or-nothing quality of her early life experience. The work at this time involved an appraisal not only of what had been achieved, but also of the limits of what she would be capable of achieving, given the stage of her life and what she needed to go on to do in it. While Mrs M reiterated her understanding that the work of the therapy may have been incomplete, she conveyed rather powerfully an awareness of her own mortality and the need to move on to develop other aspects of her life while she was still well and able to do so. These feelings had been exacerbated by the discovery of a benign ovarian cyst, which had caused much consternation prior to its diagnosis and had been successfully removed during the third year of her therapy. I found the decision to end the therapy a painful and worrying one to make, and was well aware that I may have thought otherwise, had Mrs M been 20 or 30 years younger. The work of the next three months enabled us to reach a mutual decision to terminate some nine months after the date of her retirement. Given my knowledge of Mrs M's capacity to use the therapy, the length of time of the terminal phase provided some reassurance that more important work could still be done.

Mrs M returned from the summer break, which initiated the

terminal phase of the therapy, in a depressed and dispirited mood. The planned trip to Australia, in the company of her father, had not materialized. Instead, she had reluctantly taken up an invitation to visit her ex-sister-in-law and her new husband in Canada, where she had felt left-out and lonely and without the necessary finances to travel further afield to places that interested her. This material impressed me in several ways. At an oedipal level, she planned to leave me while she went off triumphantly on her travels in the company of her father, unconsciously standing for my partner. When this attempt at oedipal triumph did not work out, however, she discovered once again her exclusion from an oedipal couple, who, she felt, abandoned her to her own inadequate resources. More importantly, this material and the atmosphere of the sessions made me realize, yet again, the existence of a bad oedipal couple in her internal world. It is clear that the actual loss of parental figures at a vitally important period of her life had lead to a deep sense of abandonment by failing parents, unable to be a real parental couple. As a consequence, she felt that she did not have the resources to carry on without the actual therapy, and I began to doubt, once again, the wisdom of the decision to terminate.

From the perspective of her adult life, Mrs M was facing the loss of a career of some 35 years without the knowledge of what would be available to her in the next and final period of her life. Although she welcomed the opportunity for change, her sad and depressed feelings were indicative not only of the loss of the workplace as a container for her projections but also the loss of a vital phallic defence, since her work had always provided an arena in which she felt potent and in control. Moreover, the break had served as yet another reminder of her loneliness in the absence of an actual partner. As such, it had also been a reminder of the failure of both her marriage and the subsequent relationship that had prompted the quest for therapy.

The examination and processing of these issues initiated a period in which Mrs M began a systematic and thorough sifting through and clearing up of her actual house, accompanied by

its psychic counterpart within the therapy. As she reached into the furthest corners of her cupboards and recesses of her mind, she recovered both concretely and psychically the photographs and mementoes of her childhood and marriage, discarding what was no longer of any use, and she faced things that had for so long been buried. Mrs M seemed stronger and more able to deal with aspects of her past in the present and could begin to think and talk about the future. These sessions were at times filled with a poignancy that moved me to tears. Two dreams from this period serve to illustrate Mrs M's state of mind. In the first:

She was observing a woman in the middle distance, smartly dressed in black, white, and yellow, and she felt that she ought to be smart like her. While she was dressed in a yellow top, her bottom half was clothed in a dirty pink skirt made of the same material she used for cleaning her house.

Her associations to the dream included mention of a black, white, and yellow 1920s creamer and sugar bowl, which she had bought many years ago and which she had of late come across again in her kitchen cupboard. She spoke of how the recently rediscovered pleasures of rummaging in bric-a-brac shops had lead to her purchasing a matching cup and saucer, all of which was now on display in her kitchen. The pattern of the china was important, consisting of a series of linked dancing figures painted around the belly of each piece. The yellow sweater reminded her of the mustard-coloured coat she had worn as a little girl, hand-made by her paternal grandmother and handed down within the family. Yet another association was to her aunt's skirt, which she had had re-modelled for her, and her disappointment with it, since it had turned out nothing like the original. This important dream, I think, provides evidence of the introjection of a well-put-together, thinking (smart) object in Mrs M's internal world (me in the transference), with whom she identified. However, the dream indicates that the identification was partial, and some splits remained. While Mrs M had been able to bring together past and present and to feel that her internal world was more integrated (the linked figures on the china), such progress was

perhaps felt to be insubstantial and fragile, like the china, because the end product, like aunt's remade skirt, was felt to be a disappointing compromise.

In a subsequent dream:

Mrs M, wearing her black work suit underneath a dressing gown, ducked under a barricade, taking a short-cut to reach the train which was to take her to work. Later, she was at an Indian party, sitting on a low chair that had no legs.

Her association to the latter part of this dream was to that of a female character in a play she had recently seen, an alcoholic vicar's wife, who has a passionate sexual relationship with an Indian storekeeper. With reference to the first part of the dream, I interpreted Mrs M's anxiety that she might be ending her therapy prematurely, taking a short-cut to reach her destination. I added that the dream material indicated that the area that she felt had not been adequately dealt with in the therapy was her sexuality. She agreed readily with my interpretation.

The subsequent sessions marked a return to old patterns of relating to me. Mrs M was polite but distant as she lectured me in the crisp schoolmistress tone that had been such a feature of our earlier sessions. My countertransference feelings of detachment, confusion, and sleepiness alerted me to Mrs M's unexpressed anger and hostility towards me. After some time she admitted that my highlighting what had not been worked on thoroughly enough had panicked her, because she felt that these things might never be dealt with and might indicate that it would be impossible for her to have another relationship. She was angry with me for not having mentioned this before and for not having helped her sufficiently with such an important aspect of herself.

She described a visit from an old work colleague whom she had not seen for many years—an only child who had lost out on life's opportunities while caring for her sickly, demanding elderly parents. Having eventually married in her forties, she found herself in a difficult marriage with an alcoholic husband, who disturbed the peace and became violent when drunk.

"Talk about repeating malignant problems!" she said. I interpreted her fear that she would be unable to escape her past, which, she feared, would cripple her always. She said that as an only child with her life experience, perhaps she had to accept that she was too self-centred to be able to share her life with someone else, and that while she liked people, she liked her own space more. I said that the moment I interpreted her fears about leaving too soon, she experienced me as a clingy, demanding, inadequate parent who disturbed her peace, and who, she felt, was unable to let her go to live her own life.

Later, referring to the earlier dream of the smartly dressed woman, I said that while the therapy may have helped her to have greater insight into her internal world and to have some optimism for her future, she would have to come to terms with the disappointment that there were some aspects that she would have to deal with by herself in the future, and some that might never be dealt with at all, given her age and stage of life. For myself, I had to come to terms with what may not have been adequately explored in the therapy and my worry about letting her go too soon. I had to differentiate between the countertransference feelings of anxiety and my own anxieties about my abilities as a therapist, and to acknowledge to myself uncomfortable feelings of disappointment for having let her down.

Looking at this material another way, I began to question further what sort of an internalized figure I was for Mrs M and how this might link with our mutual concern that she was taking a short-cut. I realized that I found it difficult to assess whether the smart aunt figure of her internal world was indeed "smart" or whether this dream was evidence of a "smart" self falsely pulling herself together in a phallic, manic way in the face of yet another abandonment, as the child/she must surely have had to do. If this was the case, then these were not resources she needed: the work was indeed being cut short and the ending premature.

In a subsequent session she wept as she spoke of the realization that she would not be seeing me any longer, and she said

that she had felt angry with me for "rubbing her nose in it" by reminding her of the finality of the ending when she had not wanted to face it. Moreover, she felt that I was deliberately reminding her of the loss when I interpreted how her wish to focus on the possibility of her returning to therapy at some time in the future was perhaps also an attempt to deny the ending.

In the final weeks Mrs M's enjoyment in her life and the tentative exploration of new possibilities was very evident. A rekindled interest in music and particularly in singing had lead to her joining the Unitarian church choir. She began to work for a charity shop and enjoyed learning about retailing and creative window-dressing. Conscious attempts to nurture the relationship with her elderly father lead to an elaboration of her early life experiences by him, all of which she brought to share with me. I acknowledged her pleasure at feeling that she did indeed have a voice with which to sing but also commented on her need to convince me about how well prepared she was for ending. We were to have a "unitarian" point of view about her readiness to leave therapy. She reiterated that it was not only the finances that had prompted the wish to end but a time commitment too. There were things she wanted to do with her life, and time was running out.

Recently Mrs M had made a concerted effort to re-establish a good working relationship with her ex-husband in an attempt to provide a more united front for their three children. She felt that they were still struggling with difficulties that had to do with the break-up of the family unit. She had had some success in this area, and her ex-husband had invited her to dinner with other family members. She approached this event expectantly but came away with a splitting headache and in a depressed mood, having had to face yet again what was possible in that relationship. She talked bitterly and disparagingly about his excessive drinking, foul language, adolescent sexuality, and the disastrous financial investments he had made. This material was interpreted in terms of her worry about having made a bad investment with me and her fear that she would be unable to keep alive inside her a picture of her and me as a

couple, working together to look after the child/her. Alternatively, she worried that I might feel that I had made a bad investment and would feel bitterly disappointed in her and the outcome of the therapy.

While I felt optimistic about Mrs M's concerted efforts to bring things together, it was also apparent that the value of doing so could easily be wiped out and that likewise the value of the therapy was easily disfigured. It was obvious that what was being projected into her ex-husband was a useless, failing part of herself, so that she did not have to face the much more cynical and bitter attitude she had towards the ending and the outcome of the therapy. This process was not new to me. Her attempts to join up with her ex-husband or her father in a different way had often lead to despair and disillusionment, followed by an attempt to come to terms with the reality of her objects and of herself in relation to them. In this example, some days later Mrs M told me that she would have to accept her ex-husband for what he was. He was still the father of her children, and they needed him. She would have to help him to realize how important she felt their joint effort was in helping their children to establish themselves in their lives.

In the final dream of the therapy, which she brought in the penultimate week:

She was in her garden walking down a brick path. A wizened old man was steering her by the elbow towards an almond-shaped basket, which she had previously forgotten at the end of the pathway. She felt irritated by the old man's presence.

In a second part of the dream, *she was with a colleague on a train that was at first an underground train and then became an overground one. They were going somewhere but had arrived at the wrong place.*

Finally, *she was at a clinic with me. I had given her some small books and electronic equipment to take away with her, which she realized were important. An elderly woman walked in with a small, ill-proportioned little girl, and she pointed to me as the one who was to answer their questions. She had to leave the room for ten minutes so*

that I might speak to the little girl. Later she found me again in the library.

She said that she had been gardening the previous day and had constructed a path like the one in her dream. The almond-shaped basket was like the one she had bought in the 1960s, when she and her ex-husband had visited Italy. At that time things had still been good between them. Nowadays the cat liked to crawl into the basket and seemed to like it in there, except that its shape meant that she and the basket would frequently topple over. The colleague on the train was a very inexperienced graduate in her twenties, whose mentor Mrs M had become at work. She was someone who was quite naive but who learned amazingly quickly and had the potential to be very successful. However, she died soon after succumbing to leukaemia. The train journey may have referred to her journey to the chapel the previous Saturday, where she was to try her hand at flower-arranging. The clinic was where she had first had her assessment for therapy, which had lead to me. The small books were like the first cardboard books she had had as a child.

This multi-layered and complex dream could be understood in several different ways. At one level, it illustrated Mrs M's wish to lead herself "down the garden path", back towards the womb, like the cat in the basket. It was a wish to wipe out the reality that where she was inevitably being lead was to death—as indicated by the frail old man, the dead colleague, and the flower arranging in the chapel. The reference to the young woman cut off in her prime could also be seen as yet another reference to the premature ending of the therapy. In the third part, although the dream indicated her wish to return to the beginning (the clinic where she was first assessed), she now had me with her, providing her with the basics, the ABC of life. I was not altogether certain about the meaning of the electronic equipment I had given her. Perhaps it stood for more sophisticated newly developed internal capacities, as well as aspects of the well-put-together "smart aunt", which continued to worry me. While the small, sibling child was disfigured by Mrs M's projections, the dream indicated that she

was prepared to step aside and make way for the new child, at least for a limited period of time. The reference to the library may have been an indication of her belief that she could maintain contact with me through books once her therapy had ended—something she confirmed later when she mentioned a desire to begin reading up on psychoanalysis.

Conclusion

In this chapter I have provided clinical material illustrating the complexity of the process of termination. It is clear from a discussion of the literature that the decision to end a therapy is extremely complicated and cannot be based purely on a checklist of criteria, even though it might be important to bear these in mind. In the case of Mrs M, the process of arriving at a decision to terminate involved a careful consideration of her total situation. Whilst I felt confident that she was capable of further work, I took seriously her desire to get on with her life and was anxious not to be offering her ongoing therapy as a substitute for it. She wished to embark on a further course of study that could lead to real opportunities for employment and also to travel abroad while she was still young enough to do so. Furthermore, I understood that this patient's tragic beginnings had made her overly cautious and compliant in her life and that she longed to break free of these constraints. Part of the ongoing work of the therapy and the terminal phase had involved helping her to come to terms with what was and was not possible in this regard. In other words, the decision to terminate, although mutually arrived at, was not clear-cut for either of us, and this remained so until the very end.

Despite the misgivings, Mrs M's capacity for depressive-position functioning was reliably evident. The clinical material demonstrates, I think, the ongoing movement between paranoid-schizoid and depressive functioning as well as her ability to recover from so-called "bad states of mind" (Segal, 1989). This was illustrated by the response to my interpretation about what may not have been adequately dealt with by the therapy. In her improved relationships with others it was clear that she had been able to

take back projected aspects of herself, as described by Steiner (1996b) and others. This could be seen in the work following the dinner party with her ex-husband. Whilst I was aware that she had been able to make good use of the help she had received until then, the decision to terminate initiated a period of intense involvement in the therapy. During this time there was not so much a return of symptoms, but a resurfacing of old anxieties and a reworking of all the strands that made up the fabric of the therapy—separation, loss and abandonment, and anger and disappointment with her failing, inadequate internal objects with whom she was identified.

The terminal phase provided the additional opportunity for Mrs M to mourn the loss of the phantasy of me as the idealized mother who would take care of all her needs. Her anger with me for letting her down gave way to an appreciation of the help she had had and an awareness of me as an object separate from her. In mourning the loss of me and the therapy she was also able to mourn the loss of the real mother she could not remember and the aunt/mother whom she now viewed from a different perspective—someone who loved her and was proud of her and who did the best by her, given her own limitations and the situation she found herself in. Mrs M mourned as well the lost opportunity to have a different relationship with her aunt, whose early death prevented the reparation she now longed for. Similarly, the work of the therapy—and the terminal phase in particular—had allowed for a more realistic picture of her father and her birth mother to emerge, and she could face their inadequacies and be grateful for the substantial help she had received from her "adoptive parents". In other words, increased ego strengths and a lessening of a harsh superego accompanied the reduction in the defensive use of splitting and projection.

Mrs M approached the last months of the therapy as though there were indeed "no tomorrow". In this I am convinced that her age and stage of life played a significant part. While the younger patient may feel that there are years ahead in which to sort things out, she was painfully aware of how much of her life had passed and was under no illusion that such an opportunity would easily come her way again. In my role as therapist, the process of termination involved an acceptance that just as I had not provided a

perfect therapy, I was unlikely to provide a perfect ending. I had to contain my uncertainties about whether sufficient progress had been made to warrant ending and not lose sight of the gains achieved. Finally, I had to hope that what she had internalized would be sufficient to see her through the years ahead and to accept that she was indeed no longer "tied to my apron strings".

REFERENCES AND BIBLIOGRAPHY

Balint, E. (1972). Fair shares and mutual concern. *International Journal of Psycho-Analysis, 53*: 61–65.

Baranger, M., Baranger, W., & Mom, J. R. (1988). The infantile trauma from us to Freud: pure trauma, retroactivity and reconstruction. *International Journal of Psycho-Analysis, 69*: 113-128.

Bateman, A., & Holmes, J. (1995). *Introduction to Psychoanalysis: Contemporary Theory and Practice.* London: Routledge.

Bell, D. (Ed.) (1997). *Reason and Passion: A Celebration of the Work of Hanna Segal.* London: Duckworth.

Bell, D. (1998). External injury and the internal world. In: C. Garland, *Understanding Trauma: A Psychoanalytical Approach.* London: Duckworth.

Bion, W. R. (1952). Group dynamics: a review. *International Journal of Psycho-Analysis, 33*: 235–247.

Bion, W. R. (1957). Differentiation of the psychotic from the non-psychotic personalities. *International Journal of Psycho-Analysis, 38*: 266–275. [In: *Second Thoughts* (Chap. 5), 1967.]

Bion, W. R. (1959). Attacks on linking. *International Journal of Psycho-Analysis, 40*: 308–315. [In: *Second Thoughts* (Chap. 8), 1967.]

Bion, W. R. (1962a). *Learning from Experience*. London: Heinemann. [Reprinted London: Karnac Books, 1984.]

Bion, W. R. (1962b). A theory of thinking. *International Journal of Psycho-Analysis, 43*: 306–310. [In: *Second Thoughts* (Chap. 9), 1967.]

Bion, W. R. (1967). *Second Thoughts: Selected Papers on Psycho-Analysis*. London: Heinemann. [Reprinted London: Karnac Books, 1984.]

Bion, W. R. (1970). *Attention and Interpretation*. London: Tavistock Publications. [Reprinted London: Karnac Books, 1984.]

Bleandonu, G. (1994). *Wilfred Bion: His Life and Work 1897–1979*. London: Free Association.

Bleichmar, H. (1996). Some subtypes of depression and their implications for psychoanalytic treatment. *International Journal of Psycho-Analysis, 75*: 935–945.

Brenman, E. (1985). Cruelty and narrow-mindedness. *International Journal of Psycho-Analysis, 66*: 273-281.

Brenman-Pick, I. (1992). The emergence of early object relations in the psychoanalytic setting. In: R. Anderson (Ed.), *Clinical Lectures on Klein and Bion*. London: Routledge, 1992.

Britton, R. (1989). The missing link: parental sexuality in the Oedipus complex. In: R. Britton, M. Feldman, & E. O'Shaughnessy, *The Oedipus Complex Today*. London: Karnac Books.

Britton, R. (1992a). Keeping things in mind. In: R. Anderson (Ed.), *Clinical Lectures on Klein and Bion*. London: Routledge.

Britton, R. (1992b). The Oedipus situation and the depressive position. In: R. Anderson (Ed.), *Clinical Lectures on Klein and Bion*. London: Routledge, 1992.

Britton, R. (1994a). The blindness of the seeing eye: inverse symmetry as a defense against reality. *Psychoanalytic Inquiry, 14* (3): 365–378.

Britton, R. (1994b). Review of "Guilt and Depression" by L. Grinberg. *International Journal of Psycho-Analysis, 75*: 621–622.

Britton, R. (1995). Psychic reality and unconscious belief. *International Journal of Psycho-Analysis, 76*: 19–24.

Britton, R. (1998). *Belief and Imagination*. London: Routledge.

Britton, R., Feldman, M., & O'Shaughnessy, E. (1989). *The Oedipus Complex Today* (ed. J. Steiner). London: Karnac Books.

Britton, R., & Steiner, J. (1994). Interpretation: selected fact or overvalued idea? *International Journal of Psycho-Analysis, 75*: 1069–1078.

Caper, R. (1999). *A Mind of One's Own*. London: Routledge.

Carpy, D. V. (1989). Tolerating the countertransference: a mutative process. *International Journal of Psycho-Analysis, 70*: 287–294.

Chasseguet-Smirgel, J. (1974). Perversion, idealization and sublimation. *International Journal of Psycho-Analysis, 55*: 349–358.

Chasseguet-Smirgel, J. (1978). Reflexions on the connexions between perversion and sadism. *International Journal of Psycho-Analysis, 59*: 27–36.

Chasseguet-Smirgel, J. (1985). *Creativity and Perversion*. London: Free Association.

Danbury, H. (1987). The real ending of a therapy—a problem of boundaries and separation. *Bulletin of The British Association of Psychotherapists, 18*: 103–110.

De Berenstein, S., & De Fondevila, D. (1989). Termination of analysis in the light of the evolution of a link. *International Review of Psycho-Analysis, 16*: 385-389.

De Simone Gaburri, G. (1985). On termination of the analysis. *International Review of Psycho-Analysis, 12*: 461–468.

Erikson, E. (1959). *Identity and the Life Cycle*. New York: International Universities Press. [Reprinted London: Karnac Books, 1994.]

Etchegoyen, R. H. (1978). Some thoughts on transference perversion. *International Journal of Psycho-Analysis, 59*: 45–53.

Fairbairn, W. (1958). On the nature and aims of psycho-analytical treatment. *International Journal of Psycho-Analysis, 39*: 374–385.

Feldman, M. (1997). Projective identification: the analyst's involvement. *International Journal of Psycho-Analysis, 78*: 227–241.

Ferenczi, S. (1927). The problem of the termination of the analysis. In: *Final Contributions to the Problems and Methods of Psycho-Analysis*. London: Hogarth Press, 1955. [Reprinted London: Karnac Books, 1994.]

Fisher, J. (1999). *The Uninvited Guest: Emerging from Narcissism towards Marriage*. London Karnac Books.

Freud, S. (1910h). A special type of choice of object made by men. In: J. Strachey (Ed.), *Standard Edition of the Complete Psychological Works of Sigmund Freud (S.E.), Vol. 11* (pp. 163–176). London: Hogarth Press, 1950–1974.

Freud, S. (1911b). Formulations on the two principles of mental functioning. In: *S.E., Vol. 12* (pp. 213–226).

Freud, S. (1911c). Psycho-analytical roots on an autoboagraphical account of a case of paranoia. In: *S.E., Vol. 12* (pp. 9–82).

Freud, S. (1914c). On narcissism: an introduction. In: *S.E., Vol. 14* (pp. 67–102).

Freud, S. (1914g). Remembering, repeating and working through. In: *S.E., Vol. 12*: (pp. 145–156).

Freud, S. (1917e). Mourning and melancholia. In: *S.E., Vol. 14* (pp. 237–260).

Freud, S. (1918b). From the history of an infantile neurosis. In: *S.E., Vol. 17* (pp. 7–122).

Freud, S. (1920g). *Beyond the Pleasure Principle.* In: *S.E., Vol. 18* (pp. 3–64).

Freud, S. (1921c). *Group Psychology and the Analysis of the Ego.* In: *S.E., Vol. 18* (pp. 67–143).

Freud, S. (1922b). Some neurotic mechanisms in jealousy, paranoia and homosexuality. In: *S.E., Vol. 18* (pp. 221–232).

Freud, S. (1927e). Fetishism. In: *S.E., Vol. 21* (pp. 149-157).

Freud, S. (1933a). *New Introductory Lectures on Psycho-Analysis.* In: *S.E., Vol. 22* (pp. 1–182).

Freud, S. (1937c). Analysis terminable and interminable. In: *S.E., Vol. 23* (pp. 211–253).

Freud, S. (1937d). Constructions in analysis. In: *S.E., Vol. 23* (pp. 256–269).

Gallwey, P. (1978). Symbolic dysfunction in the perversions: some related clinical problems. Unpublished paper.

Garland, C. (1998). *Understanding Trauma: A Psychoanalytical Approach.* London. Duckworth.

Glasser, M. (1978). The role of the superego in exhibitionism. *International Journal of Psychoanalytic Psychotherapy, 7*: 333–352.

Glasser, M. (1979). Some aspects of the role of aggression in the perversions. In: Isamond Rosen (Ed.), *Sexual Deviation* (second edition, pp. 278–305). Oxford: Oxford University Press.

Glasser, M. (1986). Identification and its vicissitudes as observed in the perversions. *International Journal of Psycho-Analysis, 67*: 9–17.

Glasser, M. (1988). Psychodynamic aspects of paedophilia. *Psychoanalytic Psychotherapy, 3*: 121–135.

Glover, E. (1955). Termination. In: *The Technique of Psycho-Analysis.* New York: International Universities Press, 1971.

Grinberg, L. (1990). *The Goals of Psychoanalysis.* London: Karnac Books.

Hardy, T. (1897). *The Well Beloved.* London: Macmillan, 1982 edition.

Heimann, P. (1950). On counter-transference. *International Journal of Psycho-Analysis, 31*: 81–84. [In: *About Children and Children No Longer, Collected Papers, 1942–80* (pp. 73–79), ed. by M. Tonnesmann. London: Tavistock/Routledge, 1989.]

Heimann, P. (1956). Dynamics of transference interpretations. *International Journal of Psycho-Analysis, 37*: 303–310. [In: *About Children*

and Children No Longer, Collected Papers, 1942–80 (pp. 108–121), ed. by M. Tonnesmann. London: Tavistock/Routledge, 1989.]

Hess, N. (1995). Cancer as a defence against depressive pain. *Psychoanalytic Psychotherapy, 9*: 175–184.

Hinshelwood, R. (1989). *A Dictionary of Kleinian Thought*. London: Free Association.

Hinshelwood, R. (1994). *Clinical Klein*. London: Free Association.

Hoffer, W. (1950). Three psychological criteria for the termination of treatment. *International Journal of Psycho-Analysis, 31*: 194–195.

Isaacs, S. (1948). On the nature and function of phantasy. *International Journal of Psycho-Analysis, 29: 73–79.*

Isaacs, S. (1952). The nature and function of phantasy. In: M. Klein, P. Heimann, S. Isaacs, & J. Riviere (Eds.), *Developments in Psychoanalysis* (pp. 67–121). London: Hogarth Press. [Reprinted London: Karnac Books, 1993.]

Jaques, E. (1965). Death and the mid-life crisis. *International Journal of Psycho-Analysis, 46*: 502–514.

Johns, M. (1998). Book Review of *Treating Survivors of Satanic Abuse*, ed. Valerie Sinason (London: Routledge 1994). *International Journal of Psycho-Analysis, 79*: 1255–1258.

Joseph, B. (1971). A clinical contribution to the analysis of a perversion. *International Journal of Psycho-Analysis, 52*: 441–449.

Joseph, B. (1975). The patient who is difficult to reach. In: *Psychic Equilibrium and Psychic Change: Selected Papers of Betty Joseph*. London: Routledge, 1989.

Joseph, B. (1982). Addiction to near death. In: *Psychic equilibrium and Psychic Change: Selected Papers of Betty Joseph*. London: Routledge, 1989.

Joseph, B. (1983). On understanding and not understanding some technical issues. *International Journal of Psycho-Analysis, 64*: 291–298.

Joseph, B. (1985). Transference: the total situation. *International Journal of Psycho-Analysis, 66*: 447–454.

Joseph, B. (1989a). Psychic change and the psychoanalytic process. In: *Psychic Equilibrium and Psychic Change: Selected Papers of Betty Joseph*. London: Routledge, 1989.

Joseph, B. (1989b). *Psychic Equilibrium and Psychic Change*. London: Routledge.

Kernberg, O. (1967). Borderline personality organization. *Journal of the American Psycho-Analytic Association, 15*: 641–685.

Kernberg, O. (1969). A contribution to the ego-psychological critique

of the Kleinian school. *International Journal of Psycho-Analysis, 50*: 317–333. [In: P. L. Giovacchini (Ed.), *Tactics and Technique in Psychoanalytic Therapy, Vol. 1* (Chap. 4). New York: Jason Aronson, 1972.]

Kernberg, O. (1974). Barriers to falling and remaining in love. *Journal of the American Psycho-Analytic Association, 22*: 486–511.

Khan, M. (1979). *Alienation in Perversions*. London: Hogarth Press.

Klein, M. (1926). The psychological principles of early analysis. In: *Love, Guilt and Reparation and Other Works: The Writings of Melanie Klein, Vol. 1* (pp. 128–138), 1975a.

Klein, M. (1935). A contribution to the psychogenesis of manic–depressive states. *International Journal of Psycho-Analysis, 16*: 145–174. In: *Love, Guilt and Reparation and Other Works: The Writings of Melanie Klein, Vol. 1* (pp. 262–289), 1975a.

Klein, M. (1940). Mourning and its relation to manic depressive states. *International Journal of Psycho-Analysis, 21*: 125–153. In: *Love, Guilt and Reparation and Other Works: The Writings of Melanie Klein, Vol. 1* (pp. 344–369), 1975a.

Klein, M. (1946). Notes on some schizoid mechanisms. *International Journal of Psycho-Analysis, 27*: 99–110. In: *Envy and Gratitude and Other Works. The Writings of Melanie Klein, Vol. 3* (pp. 1–24), 1975b.

Klein, M. (1950). On the criteria for the termination of a psycho-analysis. In: *Envy and Gratitude and Other Works. The Writings of Melanie Klein, Vol. 3* (pp. 43–47), 1975b.

Klein, M. (1952). The origins of transference. In: *Envy and Gratitude and Other Works: The Writings of Melanie Klein, Vol. 3.* (pp. 48–56), 1975b.

Klein, M. (1955). On identification. In: *Envy and Gratitude and Other Works: The Writings of Melanie Klein, Vol. 3* (pp. 141–175), 1975b.

Klein, M. (1957). Envy and gratitude. In: *Envy and Gratitude and Other Works: The Writings of Melanie Klein, Vol. 3* (pp. 176–235), 1975b.

Klein, M. (1958). On the development of mental functioning. *International Journal of Psycho-Analysis*, 39: 84–90. In: *Envy and Gratitude and Other Works: The Writings of Melanie Klein, Vol. 3* (pp. 236–246), 1975b.

Klein, M. (1975a). *Love, Guilt and Reparation and Other Works: The Writings of Melanie Klein, Vol. 1.* London: Hogarth Press. [Reprinted London: Karnac Books, 1992.]

Klein, M. (1975b). *Envy and Gratitude and Other Works: The Writings of Melanie Klein, Vol. 3.* London: Hogarth Press. [Reprinted London: Karnac Books, 1993.]

Kogan, I. (1996). Termination and the problem of analytic goals: patient and analyst, different perspectives. *International Journal of Psycho-Analysis, 77*: 1013–1029.

Laplanche, J., & Pontalis, J. (1973). *The Language of Psycho-Analysis.* London: Hogarth Press, 1985. [Reprinted London: Karnac Books, 1988.]

Lucas, R. (1992). The psychotic personality: a psychoanalytic theory and its applications in clinical practice. *Psychoanalytic Psychotherapy, 6*: 73–79.

McDougall, J. (1972). Primal scene and sexual perversion. *International Journal of Psycho-Analysis, 53*: 371–384.

McDougall, J. (1986). *Theatres of the Mind.* London: Free Association.

Meltzer, D. (1967). *The Psycho-Analytic Process.* London: Heinemann.

Meltzer, D. (1968). Terror, persecution and dread. *International Journal of Psycho-Analysis, 49*: 396–400.

Meltzer, D. (1971). Sincerity. In: *Sincerity and Other Works: Collected Papers of Donald Meltzer* (pp. 185–285), ed. A. Hahn. London: Karnac Books, 1994.

Meltzer, D. (1973). *Sexual States of Mind.* Perthshire: Clunie Press.

Meltzer, D. (1981). The Kleinian expansion of Freudian metapsychology. *International Journal of Psycho-Analysis, 62*: 177–185.

Meltzer, D. (1992). *The Claustrum: An Investigation of Claustrophobic Phenomena.* Perthshire: Clunie Press.

Miller, I. (1965). On the return of symptoms in the terminal phase of psychoanalysis. *International Journal of Psycho-Analysis, 46*: 487–501.

Money-Kyrle, R. (1968). Cognitive development. *International Journal of Psycho-Analysis, 49*: 691–698. [In: *The Collected Papers of Roger Money-Kyrle* (pp. 416–433). Perthshire: Clunie Press, 1978.]

Money-Kyrle, R. (1971). The aim of psycho-analysis. *International Journal of Psycho-Analysis, 52*: 103–106. [In: *The Collected Papers of Roger Money-Kyrle* (pp. 442–449). Perthshire: Clunie Press, 1978.]

Morgan, M. (1995). The projective gridlock: a form of projective identification in couple relationships. In: S. Ruszczynski & J. Fisher (Eds.), *Intrusiveness and Intimacy in the Couple* (pp. 33–48). London. Karnac Books. 1995.

Novick, J. (1988). The timing of termination. *International Review of Psycho-Analysis, 15*: 307–318.

Ogden, T. (1992). The dialectically constituted/decentred subject of psychoanalysis. II: The contributions of Klein and Winnicott. *International Journal of Psycho-Analysis, 73*: 613–626.

O'Shaughnessy, E. (1981). A clinical study of a defensive organization. *International Journal of Psycho-Analysis, 62*: 359–369.

O'Shaughnessy, E. (1988). W. R. Bion's theory of thinking of new techniques in child analysis. In: E. B. Spillius (Ed.), *Melanie Klein Today. Vol. 2: Mainly Practice* (pp. 177–190). London: Routledge.

O'Shaughnessy, E. (1992). Enclaves and excursions. *International Journal of Psycho-Analysis, 73*: 603-612.

O'Shaughnessy, E. (1997). Unpublished lecture.

Payne, S. (1950). Short communication on criteria for terminating analysis. *International Journal of Psycho-Analysis, 31*: 205.

Pedder, J. (1988). Termination reconsidered. *International Journal of Psycho-Analysis, 69*: 495–505.

Ponsi, M. (1997). Interaction and transference. *International Journal of Psycho-Analysis, 78*: 248–263.

Quinodoz, J. (1993). *The Taming of Solitude*. London: Routledge.

Raeburn, S. (1996). Reconstructing infancy—some contemporary Freudian contributions. In: *Reconstructing Infancy* (Monograph Number 7). London: British Association of Psychotherapists.

Reich, A. (1950). On the termination of analysis. In: *Psychoanalytic Contributions*. New York: International Universities Press.

Rey, H. (1979). Schizoid phenomena in the borderline. In: E. B. Spillius (Ed.), *Melanie Klein Today. Volume 1: Mainly Theory*. London. Routledge, 1988.

Rey, H. (1988). That which patients bring to analysis. *International Journal of Psycho-Analysis, 69*: 457–470.

Rey, H. (1994). *Universals of Psychoanalysis in the Treatment of Psychotic and Borderline States*. London. Free Association.

Rickman, J. (1950). On the criteria for the termination of an analysis. *International Journal of Psycho-Analysis, 31*: 200–201.

Riesenberg-Malcolm, R. (1999). *On Bearing Unbearable States of Mind*. London: Routledge.

Riviere, J. (1936). A contribution to the analysis of the negative therapeutic reaction. *International Journal of Psycho-Analysis, 17*: 304–320. [In: A. Hughes (Ed.), *The Inner World and Joan Riviere: Collected Papers 1920–1958* (pp. 134–153). London: Karnac Books, 1991.]

Rosenfeld, H. (1964). On the psychopathology of narcissism: a clinical approach. *International Journal of Psycho-Analysis, 45*: 332–337.

Rosenfeld, H. (1971a). A clinical approach to the psycho-analytic theory of the life and death instincts: an investigation into the aggressive aspects of narcissism. *International Journal of Psycho-Analysis, 52*: 169–178.

Rosenfeld, H. (1971b). Contribution to the psychopathology of psychotic states: the importance of projective identification in the ego structure and object relations of the psychotic patient. In: E. B. Spillius (Ed.), *Melanie Klein Today: Vol. 1, Mainly Theory*. London: Routledge, 1988.

Rosenfeld, H. (1978). Notes on the psychopathology and psychoanalytic treatment of some borderline patients. *International Journal of Psycho-Analysis, 59*: 215-221.

Rosenfeld, H. (1986). Transference and countertransference distortions and problems in the analysis of traumatised patients. Unpublished talk.

Rosenfeld, H. (1987). *Impasse and Interpretation*. London. Routledge.

Ruszczynski, S. (1994). Enactment as countertransference. *Journal of the British Association of Psychotherapists, 27* (Summer): 41–60.

Ruszczynski, S. (1997). The "marital triangle": towards "triangular space" in the intimate couple relationship. *Journal of the British Association of Psychotherapists, 3* (34, Part 1): 33–47.

Ruszczynski, S., & Fisher, J. (Eds.) (1995). *Intrusiveness and Intimacy in the Couple*. London: Karnac Books.

Sacret, J. (1998). Omnipotent mechanisms in destructive processes: some theoretical and technical considerations. *Journal of the British Association of Psychotherapists, 3* (35, Part 2): 37–51.

Schachter, J. (1992). Concepts of termination and post-termination. Patient–analyst contact. *International Journal of Psycho-Analysis, 73*: 137–154.

Segal, H. (1957). Notes on symbol formation. *International Journal of Psycho-Analysis, 38*: 391–397.

Segal, H. (1964). *Introduction to the Work of Melanie Klein*. London: Hogarth Press.

Segal, H. (1972). A delusional system as a defence against the reemergence of a catastrophic situation. *International Journal of Psycho-Analysis, 53*: 393-403.

Segal, H. (1988). Termination: sweating it out. In: *Psychoanalysis, Literature and War*. London: Routledge, 1997.

Segal, H. (1989). Introduction. In: J. Steiner (Ed.), *The Oedipus Complex Today*. London: Karnac Books.

Segal, H. (1991). *Dream, Phantasy and Art*. London: Routledge.

Segal, H. (1993). The clinical usefulness of the death instinct. *International Journal of Psycho-Analysis, 74*: 55-62.

Segal, H. (1997). Psychic structure and psychic change: an introduction. Unpublished presentation to conference held by the

Psychoanalysis Unit, University College London (London, 15–16 February).

Sinason, V. (Ed.) (1994). *Treating Survivors of Satanic Abuse.* London: Routledge.

Sohn, L. (1985). Narcissistic organisation, projective identification and the formation of the identificate. *International Journal of Psycho-Analysis, 66*: 201-213.

Spillius, E. B. (Ed.) (1988). *Melanie Klein Today: Volume l, Mainly Theory. Volume 2, Mainly Practice.* London: Routledge.

Spillius, E. B. (1993). Varieties of envious experience. *International Journal of Psychoanalysis, 74*: 1199-1212.

Spillius, E. B. (1994). Developments in Kleinian thought: overview and personal view. *Psychoanalytic Inquiry, 14* (3): 324–364.

Steiner, J. (1982). Perverse relationships between parts of the self: a clinical illustration. *International Journal of Psycho-Analysis, 63*: 241–252.

Steiner, J. (1985). Turning a blind eye: the cover-up for Oedipus. *International Review of Psycho-Analysis, 12*: 161–172.

Steiner, J. (1987). The interplay between pathological organisations and the paranoid–schizoid and depressive positions. *International Journal of Psycho-Analysis, 68*: 69–80.

Steiner, J. (1990). Pathological organisations as obstacles to mourning: the role of unbearable guilt. *International Journal of Psycho-Analysis, 71*: 87–94.

Steiner, J. (1992). The equilibrium between the paranoid–schizoid and the depressive positions. In: R. Anderson (Ed.), *Clinical Lectures on Klein and Bion* (pp. 46–58). London: Routledge.

Steiner, J. (1993). *Psychic Retreats.* London: Routledge.

Steiner, J. (1996a). Revenge and resentment in the "Oedipus situation". *International Journal of Psycho-Analysis, 77*: 433–444.

Steiner, J. (1996b). The aim of psychoanalysis in theory and practice. *International Journal of Psycho-Analysis, 77*: 1073–1083.

Stewart, H. (1985). Changes in inner space. *International Journal of Psycho-Analysis, 66*: 255–264.

Stoller, R. (1976). *Perversion. The Erotic Form of Hatred.* Brighton: Harvester Press. [Reprinted London: Karnac Books, 1986.]

Symington, J., & Symington, N. (1996). *The Clinical Thinking of Wilfred Bion.* London: Routledge.

Tonnesmann, M. (Ed.) (1989). *About Children and Children-No-Longer. Collected Papers 1942–80 of Paula Heimann.* London: Routledge.

Tuckett, D. (1995). "Mutual Enactment in the Psychoanalytic Situa-

tion." In: A. Richards et al. (Eds.), *The Perverse Transference*. Northvale, NJ: Jason Aronson.

Waddell, M. (1998). *Inside Lives: Psychoanalysis and the Growth of Personality*. London: Duckworth.

Welldon, E. (1996). Perversions in men and women. *British Journal of Psychotherapy, 12* (4): 480–486.

Werman, O. S., & Jacobs, T. J. (1983). Thomas Hardy's "The Well-Beloved" and the nature of infatuation. *International Journal of Psycho-Analysis, 10*: 447–457.

Williams, A. Hyatt (1998). *Cruelty, Violence, and Murder*. London: Karnac Books.

Williams, S. (1997). Psychotherapeutic ends and endings. *British Journal of Psychotherapy, 13*: 337–349.

INDEX

"abnormal ego" [Freud], 3
acting out of pseudo-mature
  patient [Meltzer], 85
Adams, M., xi, 5, 75–92
aggression:
  and death instinct [Klein], 57
  innate, 136, 137
  in perversion, 7, 137, 147, 149, 150
    and splitting of ego, 150
  self-preservative, 137
ambivalence, 5, 110
anal stage, 12
anger, 67
annihilation:
  fear of, 60
  inner, 5
anxiety(ies):
  capacity to tolerate, 158
  castration, 137
  claustro–agoraphobic, 120
  depressive, 16, 22, 30, 43, 120, 157
  and mourning, 40
  narcissistic, 149
  paranoid, 22, 120
  persecutory, 43, 136, 157
  primitive, 14, 21, 37, 45
  psychotic, 149
  separation, 157
  termination, 157
  unmanageable, 63
Arundale, J., xi, 7, 135–151
attacks on linking, 59, 149

Balint, E., 99, 131
Baranger, M., 62, 63
Baranger, W., 62
Bell, D., 56, 57, 63, 64
beta elements [Bion], 61
Bion, W. R., 1, 2, 4, 19, 67, 98–105, 127, 135
  on attack on linking, 149
  container/contained,
    conceptualization of, 3, 20, 57, 98, 99, 101, 104, 114

on containment, 56, 61
inadequate, 62, 67
maternal, 4
on crucial role of environment, 101
on emotional growth, 98
on knowledge, 8
K, 8, 103–104
minus-K, 103, 104, 109
no-K, 103, 110, 113
on negative capability, 93
on Oedipus complex, 97, 98
on projective identification, 101
as communication, 19, 45
and introjective identification, 100
on "selected fact", 94
birth, denial of, 88–91
Bleandonu, G., 98
Bleichmar, H., 118
bodily fusion states, 136
borderline personality(ies), 2, 65, 120, 135
and depression, 118
Brenman, E., 59
Brenman-Pick, I., 93
British Psychoanalytical Society, 156
Britton, R., 1, 6, 16, 17, 61, 62, 83, 84, 99, 101–105, 110, 114
on attacks on thinking, 105, 110
on depressed patients, 124
on link between parents, ability to tolerate, 103
on minus-K, 103, 104, 109
on movement between paranoid–schizoid and depressive positions, 62, 97
on oedipal situation:
centrality of, 1, 6
triangular nature of, 99, 101, 102
on parental containment, 61, 62
on "selected fact" vs. "overvalued idea", 94
on triangular space, 104, 105

Caper, R., 101, 115
Carpy, D. V., 31, 93
case studies:
"Emily" [dynamics of depression and work of mourning], 121–134
"Mr A" [recovery of historical past], 25–36
"Mr D" [unresolved mourning], 47–48, 53
"Mr H" [misrepresentation and denial of life events], 75–92
"Mr L" [paedophilia], 138–151
"Mr N" [terror of disintegration and inadequate early containment], 68–73
"Mrs E" [later effects of crippling loss at arrival of sibling], 40–42, 53
"Mrs F" [movement into depressive position], 95–97, 106–109
"Mrs G" [re-creation of old circumstances], 42–43, 53
"Mrs M" [termination], 162–176
"Ms B" [attacks on thinking], 109–114
"Ruth" [role of play], 11
Thomas Hardy's *The Well Beloved*, 40, 48–54
castration anxiety, 137
Chasseguet-Smirgel, J., 86, 87, 103, 147
claustro–agoraphobic anxieties, 120
"collated internal object" [Khan], 136
communication, 30
child's private world of, 45
infant's, 61
non-verbal, 23
in perversions, 136
primitive, 23
projective identification as, 3, 19

repetition compulsion as, 39
concern, capacity for, 99
concrete thinking, 136
conflict, capacity to tolerate, 158
container–contained, theory of [Bion], 1, 3, 20, 57, 98–102, 104, 105, 114
containing function, of mother, 4
containment, 6, 98, 104, 105
capacity for, 6, 103
concept of, 101
by environment, 43
failure of, trauma of, 64, 65, 67, 69, 71
good-enough, 66
wish for, 66
inadequate, 62, 64, 65, 72, 73
introjected, 100
process of, 104
theory of, 58
[Bion], 56, 61, 62
countertransference, 20–21, 29–36, 83, 93
dullness in, 149
Heimann on, 100
reconstruction in, 65
and termination, 160
countertransferentially based knowledge, role of in therapy, 101
coupling, attack on, self-adulation as, 79
creativity, 45, 136

death, 59
denial of, 88–91, 154
fear of, 136
inevitability of, 6, 44, 77, 134
acceptance of, 158
instinct:
and attacks on linking, 59
Kleinian concept of, 56–61, 67, 73
and termination, 159
defence(s):
manic, 16
omnipotent, 60, 65, 66
paranoid, 16
primitive, 16, 21, 29, 37
delusional retreat, 84–86
denial, 40, 46, 76, 80
of birth and death, 88–91
dependency, 5, 36
depression, 6, 7
chronic, psychoanalytic psychotherapy for, 117–134
clinical entity of, 119
infantile, 44
types of, 118
depressive emptiness, vs. schizoid emptiness, 120
depressive functioning, 8
depressive position, 1, 3, 4, 8, 12, 15–17, 22, 24, 30, 31, 36, 37, 44, 46, 60, 62, 97, 99, 104, 105, 130, 151, 158. *See also* paranoid–schizoid position
and concern for lost object, 130
and creativity, 45
functioning, capacity for, 158
and mourning, 2, 119
working through, 16, 157
De Simone Gaburri, G., 157
destructive narcissism [Rosenfeld], 55, 58
destructiveness, 57, 59, 61, 63, 64, 73
and death instinct, 59
innate, 57, 61
Kleinian concept of, 56
primitive, 61, 63
development, early, 55–73
disintegration, fear of, 73
dream(s), 42–43, 69, 78, 87, 111–114, 131–133, 141–146, 148, 150, 165, 168–170, 172–174
analysis, 161

ego, primitive [Klein], 12
enactment, 21, 31
of infatuation, in Hardy's *The Well Beloved*, 51

enclaves [O'Shaughnessy], 82
environment:
  crucial role of, 101
  failure of, 45, 57, 63
envy, 58, 59, 61, 64, 66
  constitutional, 57
  infant's [Klein], 45
  innate, 136
  Kleinian concept of, 56
Erikson, E., 43
"erotic form of hatred", sexual perversions as [Stoller], 7
Etchegoyen, R. H., 149, 150
evacuation, violent, 64
excursions [O'Shaughnessy], 82
experience, subjective and objective awareness of [Britton], 6
external world, relevance of in Kleinian thought, 14–15

Fairbairn, W. R. D., 19
Feldman, M., 1, 21
Ferenczi, S., 156
fetishism, 137
Fisher, J., 77, 103
fragmentation, 62
  fear of, 64
free association, 11
free-floating attention [Freud], 93
free-floating responsiveness [Sandler], 93
Freud, S., 1, 4, 7–9, 12, 17, 18, 22, 42, 46, 57, 59, 66, 80, 148, 155
  "abnormal ego", 3
  on conditions for termination of analysis, 156
  on free-floating attention, 93
  on insight, 98
  on knowledge, 8
  on love and choice of love object, 40
  on memory, 9
  on mourning and depression, 119
  on Oedipus complex, 102
  on psychoanalytic cure, 156
  "psychotic part", 3
  on reality principle, 65
  on repetition compulsion, 39–40

Gallwey, P., 136, 149
Garland, C., 56, 63, 65
genital stage, 12
Glasser, M., 135, 136, 137, 149
Glover, E., 156
good breast, 57, 58
"gridlock" [Morgan], 3
Grinberg, L., 155, 157, 160, 162
guilt, 36, 119
  depressive, 127
    vs. persecutory guilt, 127
  in depressive position, 16
  oedipal, 75
  unconscious, 147

Hardy, T., *The Well Beloved*, 40, 45, 48–54
hate (H) [Bion], 103
Heimann, P., 18, 20, 25, 100
Hess, N., xi, 6, 7, 117–134
Hinshelwood, R., 1, 2, 10, 11, 16, 17, 57, 62, 130, 154
historical reconstruction:
  Kleinian technique in, 9, 22–36
  vs. recollection, 9–37
homosexuality, 81, 137

id, 155
identification, role of, 119
identity confusion, 148
incest, 137
infant development, Kleinian understanding of, 3, 36
infantile amnesia, 156
infantile omnipotence, 160
intercourse, misrepresentation of, 81–84
internal saboteur, 8
internal world, concept of, 11
interruption, of therapy, due to therapeutic impasse, 153

introjection, 20, 101
  of analyst's capacity for self-analysis, 157
  and projection, cycles of, 14
introjective identification, 100
Isaacs, S., 1, 11, 63

Jacobs, T. J., 51
Jaques, E., 44, 45, 47, 117
jealousies, oedipal, 86
Johns, M., 64, 65
Johnson, S., xii
Joseph, B., 1, 2, 21, 30, 44, 45, 55, 56, 60, 86, 93, 149

Katz, E., xii, 7, 153–176
Kernberg, O., 51, 58
Khan, M., 136
Klein, M., 1–5, 7, 12, 13, 16, 36, 43, 45, 51, 52, 56–59, 62, 91, 93, 98–102, 157, 158
  on concern and reparation, 130
  on death instinct, 57, 59
  on envy, 45, 58
  on importance of child's early experiences, 5
  on importance of internal world, 119–121
  on infant mind, development of, 5
  on internal world, 10
    child's, 46
  on loss:
    of good internal mother, 120
    of loved person, 46
  on melancholia, 7
  on memories, rejection of, 40
  on mourning, 7, 40, 52
  on paranoid–schizoid and depressive positions, 1, 3
  play technique of, 11–12
  on projective identification, 1, 45, 100
  on termination, 157
  on unconscious phantasy, 1
    present from birth, 57
  unconscious phantasy
  on working through depressive position, 126
Kleinian theory:
  on centrality of oedipal situation, 1
  container/contained theory in, 1
  on death instinct, 56, 58
  of depressive position, 99
  on destructiveness, 56
  on early development, 55–73
  on envy, 56
  on historical reconstruction, 9
  on infantile development, 3
  on paranoid–schizoid and depressive positions, 1, 3
  on pathological organization, 60–61
  on projective identification, 1, 2
  on role of parental couple, 57
  on trauma, 56
  on unconscious phantasy, 1
knowledge, 98, 100
  K [Bion], 103–104
    as third factor of psychic life, 8
  minus-K [Bion], 103, 104, 109
  no-K [Bion], 103, 110, 113
  of other, 103
  of self, capacity for, 103

Laplanche, J., 154
libidinal stages, 12
life instinct, 59
Lipshitz-Phillips, S., xii, 4, 7, 39–54
loss, 8
  capacity to tolerate, 158
  catastrophic, effect of, 52
  centrality of experience of, 4, 7
  coming to terms with reality of, 80
  and depression, 120
  early, 39–54
  of internal mother, 7
  and termination, 159
  working through, 153

love (L) [Bion], 103
Lucas, R., 67, 68

masochism, 77
masturbation, 88
maternal containment, failure of, 5
maternal figure, primary, loss of, 7
maternal reverie [Bion], 20, 56, 61, 98, 100
maturity, 39
  psychological, 103
McDougall, J., 136, 147, 149
melancholia, 7
Meltzer, D., 10, 59, 85, 88, 89, 135, 136, 149, 151, 161
mental paralysis, 149
Miller, I., 162
mind, pathological organization of, 2, 55, 60, 64, 68
"minus-K" [Bion], 103, 104, 109
"misrepresentation", 90
  of intercourse, 81–84
  Money-Kyrle on, 77
  as psychic retreat, 79–81
Mom, J. R., 62
Money-Kyrle, R., 6, 77, 103, 133
  on "misrepresentation", 77
Morgan, M., on "gridlock", 3
mother:
  containing function of, 4, 136
  and father, relationship between, relevance of, 99
  internal, loss of, 7
  premature loss of, 4
  See also maternal containment; maternal figure; maternal reverie; parents: link between
mourning, 2, 105, 120, 150, 159
  and depressive position, 119
  Freud on, 7
  Klein on, 7
  and loss, 7
  psychological work of, 126, 133
    stages of, 126–127
  and termination, 157, 159, 160
  unresolved, 39–54
  working through, 153

narcissism, 77
  destructive [Rosenfeld], 55, 58
  negative [Rosenfeld], 2
narcissistic features, and depression, 118
narcissistic personalities, 135
narcissistic states, 2
negative capability [Bion], 93
neurotic personalities, 135
no-K [Bion], 103, 110, 113

object:
  collated internal, 136
  omnipotent autistic domination of, 136
  primal, 136
  relationships, 4
  relations theory, 135
oedipal guilt, 75
oedipal phase of development, 99
oedipal reality, unbearable, 91–92
oedipal situation, 1, 6, 102, 106
  triangular nature of, 6, 8, 99, 102, 103, 107, 115
oedipal story, 98
Oedipus, 76
  complex, 40, 97–99, 102, 151
  situation, 17
Ogden, T., 151
older patient, termination process with, 7, 153–176
omnipotence, 86
  infantile, 160
  phantasies of, 65, 68
omnipotent denial, 21
omnipotent phantasy, projective identification as, 100
oral stage, 12
O'Shaughnessy, E., 1, 2, 20, 59, 60, 85
  "enclaves" and "excursions", 82
"overvalued idea" vs. "selected fact", 94

paedophilia, 6, 7, 135–151
ego-syntonic, 147
psychodynamics of, 137
panic attacks, 40
paranoid–schizoid position, 1–3, 8, 12–16, 21, 22, 24, 30, 31, 36, 105
and creativity, 45
and depressive position, movement between, 13, 60, 62, 97, 158, 174
working through, 157, 158
parents, link between:
ability to tolerate, 6, 102
role of, 102–104
pathological organization, 2, 55, 60, 64, 68
and death instinct, 60
delusional, 85
psychopathology of, 60, 61
Pedder, J., 156
personality, formation of, intra-psychic and external factors in, 55–73
perverse states of mind, and psychotic states, link betwen, 135–151
perversion(s), 6
characteristics of, 136
as psychosis, 150
psychoanalytic literature on, 136–137
transference, 149
phantasy(ies):
infant's, omnipotent, 11
omnipotent, 60, 65, 68
projective identification as, 100
unconscious, 1, 10–12, 17–19, 22
primitive, 36, 57
phobias, 137
play technique [Klein], 11
pleasure principle, 65
Ponsi, M., 17, 18
Pontalis, J.-B., 154
position, concept of, 12–13
primal object, devouring, castrating, 147
primal scene, 136, 147
primitive thought, 45
projection, 20, 64, 101
and introjection, cycles of, 14
parental, into infant, 64
projective identification, 2, 16, 19–21, 29, 31, 61, 88, 100–103, 136, 151, 158
as communication, 1, 3, 19
and countertransference, 20
between mother and infant, 45
as omnipotent phantasy, 100
role of, in therapy, 20
proto-mental elements [Bion], 61
Proust, M., 48
pseudo-mature patient, acting out of [Meltzer], 85
psychic equilibrium, 21
psychic retreat, 61, 64
[Steiner], 2, 55, 142
misrepresentation as, 79–81
psychic structures, 2
psychopathology, 135–151
psychosis, 2
"psychotic part" [Freud], 3

Quinodoz, J., 157

Raeburn, S., 18
rage, 136, 149
jealous, 77
libidinal, 66
psychotic, 67, 68, 73
realistic, 66, 68
use of in therapy, 66–67
reality:
emotional, 8
internal and external, 4
oedipal, unbearable, 91–92
principle [Freud], 65
and inevitability of death, 44
testing, 136
recollection vs. historical reconstruction, 9–37

Reich, A., 154
reparation, 16, 68, 150
repetition, 40
  compulsion, 4, 18, 39
    infatuation as, 51
    and transference, 18
resistance, 46
retreat:
  delusional, 84–86
  perverse, 86–88
  psychic. *See* psychic retreat [Steiner]
reverie, maternal, 61, 100
  [Bion], 56, 98
Rey, H., 60, 62, 120
Rickman, J., 156
Riviere, J., 22, 78, 120
Rosenfeld, H., 1, 2, 59, 60, 66, 68, 85, 135, 149
  "destructive narcissism", 55, 58
  "negative narcissism", 2
Roys, P., xii, 3, 9–37
Ruszczynski, S., xiii, 1, 6, 93–115, 95, 103, 105

sabotaging phenomena, 59
Sacret, J., 4, 5, 55–73, 65
sadism, 75, 136
sado-masochistic narcissistic organization, 136
sado-masochistic relationship(s), 3
  with superego, 137
Sandler, J., 93
Schachter, J., 153, 157
schizoid emptiness vs. depressive emptiness, 120
schizoid features and depression, 118
schizoid mechanisms, 100
schizoid patients, 120
Segal, H., 1, 2, 11–13, 16, 57, 59, 60, 104, 105, 151, 158, 174
"selected fact", 94
  Bion on, 94
  vs. "overvalued idea", 94
self-adulation, 86
  as attack on coupling, 79
self-analysis, capacity for, 157
self-destructiveness, and death instinct, 59
self-reflection, capacity for, 103
separateness, 36, 105
  capacity to tolerate, 158, 159
    lack of, 31
separation, 68
  anxiety, 157
  and termination, 159, 160
  working through, 153
sexual abuse, 63, 64
  child, 135–151
sexual perversions, as "erotic form of hatred" [Stoller], 7
Sinason, V., 64
Sohn, L., 22, 59
Sophocles, 76
Spillius, E. B., 1, 21, 55, 57, 58, 60, 101
splitting, 16, 21, 41, 44–46, 61, 148, 151, 158
  defensive, 137
  of the ego, 158
    in perversion, 150
  internal, 156
  pathological, 67
Steiner, J., 1, 2, 13, 22, 59, 77, 81, 85, 91, 92, 106, 158, 175
  on containment, 105
  on destructiveness, 61, 63
  on Oedipus, 76
  on pathological organization, 56, 61
  on "psychic retreats", 2, 44, 55, 80, 142
    perverse, 86
  on role of mourning, 105, 120, 126, 159
  on "selected fact" vs. "overvalued idea", 94
Stewart, H., 120
Stoller, R., 7, 136

structural model of the mind, 155
superego, 155, 156
cruel and critical, 119, 127
and death instinct, 59
destructive, 59
ego-destructive, 62
sado-masochistic relationship with, 137
symbolic functioning, 136
Symington, J., 98
Symington, N., 98
symmetry, capacity for, 105

terminability/interminability of psychoanalysis, 155
termination, 133, 159
criteria for, 156
and older patient, 7
precipitate, premature, 153
process with older patient, 153–176
psychoanalytic literature on, 155–159
stages in process of [Meltzer], 161
timing of, 161
as weaning process [Meltzer], 161
thinking, 98, 100
concrete, 136
interference in, 136
time, inevitability of, 6, 77, 133
topographical model of the mind, 155
transference, 3, 17, 21, 36, 44
–countertransference relationship, 2, 4, 100
enactment of unconscious phantasies in, 29
neurosis, 149
perverse, 148
sadomasochistic, 149
reconstruction in, 65
repetition compulsion, 18
resolution of, 160
and termination, 160
total situation of, concept of, 93
unconscious phantasies in, 22–23
trauma, 56, 64
concept of, Kleinian, 62
early, 65
implications of for technique, 56
and maternal containment, 5
traumatic stress disorder, 63
triangular space, 104, 105
[Britton], 104
Tuckett, D., 21

unconscious phantasy, 1, 10–12, 57, 63

violence, 63

Welldon, E., 147
Werman, O. S., 51
Williams, H., 61
Winnicott, D. W., 99

PSYCHOANALYTIC PSYCHOTHERAPY IN THE KLEINIAN TRADITION

Edited by Stanley Ruszczynski and Sue Johnson

This set of papers from members of the British Association of Psychotherapists, demonstrates the vitality of the 'Kleinian tradition' in work with adult patients. It is a picture of work from outside the inner circle of Kleinians in London. And it thus indicates how the concepts have fared in their transport into everyday psychotherapy.
There is here a thorough immersion in contemporary Kleinian thought and practice; the communicative aspects of projective identification (containing), the conceptualisation of parts of the person and their structure as organisations of defence, the vicissitudes of knowledge especially in its Oedipal context, and a close attention to the texture of the transference-countertransference relationship. These faithfully reflect the developments of the Kleinian Group in the British Psycho-Analytical Society over the last 50 years. These papers demonstrate a serious use of them in clinical practice with a wide variety of patients commonly seen in contemporary psychotherapy.... The book represents a very accurate single source for the wide spectrum of Kleinian ideas that are currently in use. It is therefore an extremely useful single source for these ideas and examples of clinical practice, useful for teaching purposes and also for others seeking to know the fate of Melanie Klein's remarkable additions to Freudian theories.

Bob Hinshelwood

This collection of clinical essays by a group of psychotherapists who are firmly committed to a psychoanalytic approach in their work can be thoroughly recommended. The different authors show how particular psychoanalytic theories they personally value find a place in their clinical work. The editors have organised the book admirably so that the individual contributions collectively give an overview of Kleinian theory and the recent theoretical contributions of the so-called "Contemporary Kleinians of London."
What pleases me about these essays is the accuracy and clarity of the theoretical account and the vividness of the clinical understanding. Through the brief introduction and eight carefully integrated essays an interested psychotherapist learning the business and wanting to know what this "school of thought" is about will find in this book a clear, non-textbook account with real clinical relevance. Other more experienced psychotherapists will find the book helpful, stimulating and challenging. The authors all demonstrate that "thinking what you are doing" is the lifeblood of psychoanalysis and psychotherapy.

Ron Britton

Karnac Books,
58 Gloucester Road,
London, SW7 4QY

www.karnacbooks.com

Cover design by Malcolm Smith
Cover illustration: Upright Internal/External
Form (1953-54) by Henry Moore
reproduced by permission of
the Henry Moore Foundation
ISBN: 1 85575 175 5