OUTWRITE

Journal of the Cambridge Society for Psychotherapy

Volume 1 Number 1 August 1999

The cover illustration is by Michael Evans and shows the portrait sculpture of a seated scribe of Egypt, who lived about 2500 BC in the 4th Dynasty. The professional writer of this period had a high status and could afford to commission an exceptional artist to carve such a life like image for his tomb, so as to ensure his immortality. The writer is shown squatting with papyrus and brush as if calmly awaiting instructions from a client. The body was made of limestone and coloured naturalistically; the eyes were made with rock crystal. The sculpture is 52 cms high, about life size and is now in the Louvre, Paris.

Editorial

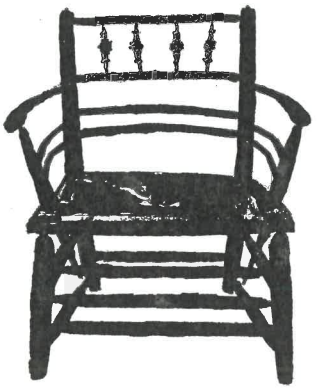
Welcome to the first issue of *Outwrite*. This is an in-house Journal and we hope that everyone, student, ordinary and associate members, will feel confident that they can offer their writings to it. There are many members who enjoy writing and we sense there are many more who would turn their hand to it if they felt that there was a space, encouragement and a readership. That opportunity has arrived. We want the Journal to be a place for the communication of imaginative thought and feeling and a forum for debate amongst everyone in the Outfit.

We are willing to discuss work with potential contributors at an early stage of their thinking and planning and when drafting their ideas. We wish to be active and encouraging. We welcome writings that address issues around the theory or practice of psychotherapy but we feel that the Journal should be open to almost any subject or genre – a poem, a short story, a book review, observations of life or meditations. Papers which deal with current affairs, language, the media, art, philosophy or literature would all be particularly welcome. Illustrations would also be welcome. However we think that news, comments on the development of the training or problems specific to the Outfit should remain within the covers of the Newsletter so that the two publications can co-exist with different functions.

In this first issue we have contributions on influence in psychotherapy, suicide, the concept of creativity, working with children, dreaming and note-taking and two book reviews. No theme has been looked for or has emerged but we welcome further papers on any of these topics or subjects related to them and certain themes may come to link different issues of the Journal. There is also the possibility of responses to these topics either in the form of letters or of further papers developing the same themes.

The need for an Outfit Journal has been felt for some years. The Society has always been productive but our efforts are not unsurprisingly largely intangible. The current quest for 'creative re-appraisal', through our conference of that title this summer, has intensified the need for us to be demonstrably creative. We hope the Journal will be a lively and enjoyable part of this.

Michael Evans and Rosemary Randall



Carol Dasgupta

Listening to children through play

This article first appeared in 'Time to listen to children' edited by Pat Milner and Birgit Carolin, published by Routledge, 1999.

Nuts and bolts

As a therapist, it is not enough to attend only to the words a child might use to describe their emotional responses to life; indeed, most young children do not yet have the appropriate vocabulary or verbal sophistication to be able to describe their world adequately. As with adults, a child's body language and relationship style will provide important and revealing clues and information. But by providing children with the opportunity to play, and by observing and interpreting their play, we can add another dimension to our understanding of what it is to listen to children.

As a play therapist in private practice, I work with children from the age of about 3 until that time when they no longer wish to express themselves through play, generally about the age of 10 or 11. The length of therapy varies, but unless I am trying to help with a very specific, well-defined problem, I would expect to work with a child on an open-ended basis, with sessions continuing for anything between a few months to several years. The sessions last fifty minutes and take place in the same room at the same time each week. I mention only two boundaries at the beginning of the work: neither of us is allowed to hurt the other, and neither of us is allowed intentionally to break or smash up the toys or equipment in the room. A child may, on occasion, decide to end a session before the fifty-minute limit, but I would usually make a verbal recognition of this. The room is equipped with standard play therapy equipment: a doll's house with dolls and furniture, a play house or corner with tables, chairs, pots, pans, cutlery, crockery, etc., puppets, toy animals, cars, dolls, paints, paper, pencils, hammer and peg set, two toy telephones, two sets of toy soldiers and army equipment, nursing bottles, bricks, Lego-type construction toys and a sand tray.

Referrals come through GPs, health visitors, social services, schools and parents. After the initial contact (usually by telephone), I generally arrange a consultation with one or preferably both parents before meeting the child. This enables me both to take a history of the child and to get a sense of how the parent(s) define or present their child. A child's difficulties can sometimes be the outward manifestation of a marital conflict or other parental issue, in which case some other intervention (such as family or couples therapy) might be more helpful. I would then arrange to have two meetings with the child alone, during which the following kinds of questions will be hovering in my mind:

- What kind of relationship style does this child come with?
- Does it seem likely that a therapeutic relationship will be possible?
- Does this child want to come here enough, or is it predominantly the parental need that is being satisfied?

These preliminary sessions would typically be somewhat more directive than ongoing therapy sessions, and I might engage a child in specific tasks such as drawing a picture of a person, or drawing everyone in their family doing something. I often use Winnicott's 'squiggle' game at this point. This game, in which therapist and child take it in turns to make a simple line-drawing and invite the other to turn it into something, can help to establish a therapeutic relationship in which play can occur. It is also used as a projective tool - what does the child make the squiggle into? After these two assessment sessions, I meet with the parent(s) again. If there is agreement on both sides that play therapy may be helpful, I spend some time explaining the nature of the work, the fact that the content of sessions will be confidential (apart from

any statutory obligations), and practical arrangements such as appointment times, payments, cancellations and holidays. It is my belief that therapy will be more helpful if such management issues have been discussed and agreed upon before the work commences. When working with children in a private practice, it is probably important to make some arrangement to meet with the parent(s) at regular intervals (maybe every four to six weeks) to discuss the therapy in general terms and within the bounds of confidentiality. These meetings help to 'hold' the parent(s) who may be experiencing feelings of anxiety, guilt, envy and ambivalence. (In a clinic setting, other workers can often provide this support for parents.) If, for whatever reason, it is decided not to proceed with therapy, I think it is important to encourage parent(s) to think about the reasons behind this and help them with a referral to another source of support if appropriate.

So the therapy starts. I am non-directive, waiting to observe, then follow and respond to, a child's play. In this, I am adhering not only to the principles behind Axline's (1996, 1969) theory of non-directive play therapy, but also to the basic tenets of psychodynamic therapy and counselling. As the sessions unfold, I try to be aware of the transference and counter-transference issues around - who is the child making me into? What is it in their internal or external world that is making them behave with me in their particular manner? What feelings is this child arousing in me that cannot be explained obviously or rationally? In order for these kinds of questions to be relevant and helpful, I have, of course, to be as consistent as possible in my behaviour and attitudes, aware of my personal strengths and weaknesses, and careful not to become too drawn into a child's world, although the temptation or desire to be so may be very strong. I believe the urge in adults to 'make things better' for children, to help them, and rescue them from pain is strong, but that has to be resisted here. The ability to stay with hurt, suffering and sadness is essential. It is the consistent offering of time, space, holding and attention that is helpful, rather than the premature offer of the release from pain, sadness or anger. This is sometimes terribly hard. I worked with one child over a period of several years. The individual sessions and the overall treatment were intense, and involved close attention to sad, painful, probably unresolvable issues. Session followed session; I wrote my notes, discussed the case with my supervisor, and generally proceeded in a professional manner. Very shortly after therapy ended, however, I found myself crying unexpectedly and uncontrollably. I believe I had managed to 'hold' the terrible pain and sadness during my professional involvement, only allowing myself to feel the sheer misery after therapy had finished. This emphasises the importance of adequate, ongoing supervision and support when working therapeutically with children. I make interpretations, always expressing them directly to the child through the toys being played with or through the relationship between the child and me. I try to establish a warm, positive relationship (but not cloyingly or smotheringly affectionate) with the child as quickly as possible.

What is play?

Definitions of 'play' are complex and varied. Erikson (1950) attributed great importance to play as a means of enabling a child to build up a sense of self-awareness and self-knowledge. Schaefer and O'Connor (1983) provide a useful review of the literature on play and identify certain aspects of it. Play is driven by pleasure and fun, rather than purpose or function, and it does not occur in new or frightening situations. A child's attention becomes increasingly focused on the action or fantasy and less on his or her own body state or situation. It is the unconscious aspect of a child's play that has induced therapists and counsellors to use play in their work. In the child-centred and psychodynamic models of working with children, play provides a communication function - the 'play cure' being somewhat analogous to Freud's talking cure. Play provides not only the means to communicate, but also the possibility of a relationship developing between child and counsellor, so that in the therapeutic context, the potential space between therapist and child may be provided through play. Donald Winnicott (1971) emphasises the importance of seeing play as therapeutic in its own right, as a creative experience, and as a basic component of a child's growth process.

A brief history of play therapy

Although Freud (1909) attempted psychotherapy with a child (conducted indirectly through the child's father), the first direct use of play in the therapy of children was undertaken in 1919 by a Viennese psychoanalyst, Hug-Hellmuth, who considered it to be an essential part of child analysis. Subsequently, both Anna Freud and Melanie Klein incorporated play into their otherwise traditional psychoanalytic sessions. Anna Freud used play as a way of encouraging children into analysis, by enabling the formation of the therapeutic alliance, or strong positive relationship between child and therapist. Klein (1961) believed that play was the child's natural medium of expression, and therefore a direct substitute for verbalisation. A child's verbal skills were, she thought, insufficiently developed to express the complicated thoughts and feelings they were experiencing, and she was of the opinion that any child, from the normal to the most disturbed,

could benefit from play analysis. Winnicott (1971) developed further ideas on the therapeutic use of play with children. A leading exponent of the developing object relations school, his ideas concentrated on the individual's very early relationships, typically with the mother. He saw the therapist/child relationship as echoing the earlier mother/child relationship, and he hoped the therapeutic relationship would be able to repair what was lacking, or wrong, in the earlier one. He argued that therapeutic work could occur in the space and relationship that develops when two people can play with each other:

> Psychotherapy takes place in the overlap of two areas of playing, that of the patient and that of the therapist. Psychotherapy has to do with two people playing together. The corollary of this is that where playing is not possible then the work done by the therapist is directed towards bringing the patient from a state of not being able to play into a state of being able to play.
> Winnicott (1971: 44)

Winnicott argued that playing is essential, as it is in playing that we are being creative, and it is only in being creative that we discover ourselves. To be really creative, a person needs an experience of a non-purposive or relaxed state, and relaxation is possible if 'the child patient among the toys on the floor be allowed to communicate a succession of ideas, thoughts, impulses, sensations that are not linked except in some way that is neurological or psychological and perhaps beyond detection.' There must be 'room for the idea of unrelated thought sequences which the analyst will do well to accept as such, not assuming the existence of a significant thread ' (Winnicott 1971: 65).

Margaret Lowenfeld (1979), also a paediatrician by training, recognised the significance of children's play, and the importance of non-verbal forms of thought and communication. In the 1920s she developed the World Technique, in which children used a sand tray to make worlds with small real-life and fantasy objects. This allowed for the exploration of a child's inner world, and the nature of the child's relationship to a particular social or environmental reality.

Virginia Axline's model of play therapy

Virginia Axline's (1969) model of client-centred, non-directive play therapy was made widely accessible through the moving description of her work in awakening the mute child, Dibs. Non-directive play therapy allows the child to be him or herself without facing evaluation or pressure to change. The child is the source of his or her own growth and therapeutic change: 'the therapist may leave responsibility and direction to the child' (Axline 1969: 9). During non-directive play therapy, a child can experience growth under the most favourable conditions: by playing out feelings, the child faces them, learns to control them or abandons them. The child 'begins to realize the power within himself to be an individual in his own right, to think for himself, to make his own decisions, to become psychologically more mature, and, by so doing, to realize selfhood ' (Axline 1969: 16). Children will experience being accepted as they are and will be given the empathic understanding, warmth and security they are unlikely to experience in other relationships. The role of the play therapist is to facilitate this growth, using an approach in which Axline identifies eight basic principles through which the therapist:

1. develops a warm, friendly relationship with a child, in which a good rapport is established as soon as possible;
2. accepts a child exactly as he or she is, in as non-judgemental a manner as possible;
3. establishes a feeling of permissiveness in the relationship so that a child feels free to express his or her feelings completely;
4. is alert to recognise the feelings a child is expressing and reflects back those feelings in order to help that child to gain insight into his or her own behaviour;
5. maintains a deep respect for a child's ability to solve his or her own problems if given an opportunity. The responsibility to make choices and to institute change is the individual child's;
6. does not attempt to direct a child's actions or conversation in any manner. The child leads the way. The therapist follows;
7. does not attempt to hurry the therapy along. It is a gradual process and is recognised as such by the therapist;
8. needs to find ways (such as time limitation, or the establishment of commonsensical boundaries) to anchor the therapy to the world of reality.

Case material

(All identifying features have been changed or omitted.)

I worked once a week for seven months with Philip, a boy of 6 years. He was referred to me by his GP because teachers, health visitors and social workers were concerned about his out-of-control behaviour at school and in the neighbourhood. There was also concern over his mother's parenting skills. Philip's mother and father had separated shortly after his younger sister's birth four years earlier, after a stormy relationship, and contact between Philip and his father was minimal.

(In fact, Philip's father died suddenly and violently during the course of our therapy.) Both children were frequently found roaming the neighbourhood on their own, engaging in aggressive and threatening behaviour; they were badly clothed and often hungry. Philip in particular was felt to be in need of help: he appeared to have no sense of his personal safety, and he was already so disruptive and out of control at school that it was hard to contain him there. The therapy was to be jointly funded by social services and the health authority for twenty-two sessions. Some family therapy was set up at another agency, and Philip's mother was offered counselling to assist her to regain some measure of control over herself and her family. Early on in the course of Philip's treatment, it became clear that his mother had a serious drug addiction. Within a few months, her condition deteriorated so badly that she was unable to care for the family, and Philip and his sister were placed in foster care. Philip continued to attend his therapy sessions with me. Extracts from my ongoing notes are denoted by quotation marks.

1st session

Philip demonstrates an ease and independence in the playroom and in his relations with me - there is both a comfortable interaction with me, as well as an ability to play independently. He places his hand gently on my knee at one point, suggesting a need for some physical relationship. I noticed in this first session a wide variation in his moods - he ranges from a soft gentleness to expressions of intense anger.

2nd session

Philip arrives happily and goes immediately into the playhouse, which he calls 'my house.' He tells me I can do whatever I like in the sessions (an echo of my words to him last week), and it feels to me that he has taken charge of me and the sessions. In the house he cleans up the floor with the dustpan and brush, and he says he is going to do things his Mum doesn't allow. The session continues with some sand play and drawing. Philip plays with some puppets and makes the owl bang so hard on the walls of the playhouse that I have to remind him of our boundaries in the playroom. He buries another puppet in the sand, pours water around him, unburies him and announces that the puppet is messy. He washes the puppet, then hurls him onto the floor of the playhouse. At this point, I tell him that there are five minutes left until the end of the session. Philip shouts "I'm not leaving", then starts just smashing and throwing the contents of the playhouse, and pushes the walls over. He goes berserk, and seems really amazed that I am not stopping him. He is furious about leaving. I am left feeling exhausted and drained by the session, and also fed up, because it takes me so long to get the room ready again. But I am aware that I am already drawn to this child, and feel a strong commitment to him. I think I have begun to understand him, and am reminded that Freud wrote in 'Little Hans' that no moment of time was so favourable for the understanding of a case as its initial stage. Philip is concerned about the mess in his life, and indicates ambiguous feelings about clearing it up. He has, I think, already indicated a wish for attention and a maternal relationship, and is possessed by an anger when that attention is threatened (as it was at the end of the session). The strength of his wish for attention and relationship is suggested by the quickly established level of my commitment to, and strong maternal feelings for, him and by my feeling of being so drained by the intensity of the session.

3rd session

'Philip makes a terrible mess (of sand, water, and paint) ... he was aware of the mess he was making, and couldn't quite believe he was getting away with it.' He hurls the playhouse furniture around, 'systematically destroying what he had previously been so pleased to call my house.' Almost immediately afterwards, he picks up the feeding bottle, sits on my lap and sucks it with gusto. 'He says he's a baby, and I say that it seems he's a very hungry baby. He repeats this – "I'm a very hungry baby"- several times.' It feels to me that he is quite intensely in touch with his need for mothering here, and angry, also, with his lack of it. As we leave the room at the end of the session, he leaves the tap full on, and I let him do this, and he puts his hand marks all over the wall. Philip seems to me to be extremely needy, greedy for attention. He is very angry and hurt and shows signs of regression - the mess and the bottle. I am left exhausted, overwhelmed. It is an intense experience.

4th session

Again, Philip's chief activity is the smashing around of the playhouse and its contents, alongside periods of lying in my lap, drinking from the feeding bottle.

5th session

Aware of my growing frustration at the length of time it takes to clear up after his sessions, I tell Philip that when he makes a mess, it has to be within the sink and draining board area of the room. He can make as much mess as he likes there. He continues to want to be in my lap, being fed water through the bottle.

6th session

(Earlier in the week, Philip was told that his father had died.) Philip plays in the sand, and asks me to join in the play. He wants to add lots of water to the already wet sand. I set a limit of two bowls. He gets another bowl to put in the sand, and prepares to put it in. I remind him of the limits, so he puts

the bowl on the chair, and says it's to wash his hands in. Although he tries to stick to the limits as laid down last week and this week, the playroom is amazingly messy - there is sand all over the floor, on the walls, clothes buried in the sand, paint on the floor, in the sink, on the walls. It feels to me that he is showing me the whole mess in his life, and I reflect this by saying what a big mess he is showing me today. He shows me a hurt on his finger, covered by a plaster. He wonders if the hurt will be too much for me. I ask him if he thinks it will be too much for me, and he thinks it will. I feel it is important for me to tell him that I don't mind seeing things that are painful (for I think that was his concern - that I just would not be able to stand his pain). We play in the house. Philip climbs in and out over the top, which alarms me. We discuss how I should get in the house - he says I must climb in through the window, because all the doors are broken - his Dad has broken them all. He gets a doll and asks me if I like it. At this moment, I am uncertain how to respond, and I hesitate, and before I reply, he hurls the doll angrily onto the floor (I suspect he was wanting me to tell him how much I liked the doll [him]). Here, I was left feeling intensely inadequate, as if I could do nothing but fail him, however I responded. Again, I think that here I am reacting to his enormous, insatiable need for care, attention and love. He finds the toy stethoscope. I explain how delicate it is, and we take turns listening to each other's hearts, very gently, as well as the hearts of the toys to see if they're alive. He plays with a soft bee toy, then gets out the emergency vehicles (police car, fire-engine, ambulance: typically used by children when acting out concerns about traumas, safety, rescue). He puts no people in the emergency vehicles, but takes the vehicles to the scene of a bad accident. This seems to be a fire, and the vehicles enter the house. I suspected that he was playing out fantasies to do with his father's death and the fact that it seemed that no one could ultimately help him, and I responded by saying that sometimes the help that people can give is just not enough. At this point, it is time to warn about the end of the session. Philip becomes very angry about this, throws the vehicles around, with the intention of breaking them, and the session ends chaotically and violently, with me removing him physically from the room. My notes end: 'Philip seems a very frightened, sad, defended, vulnerable little boy.'

7th session

Philip makes a dreadful mess, with toys all over the playroom. He plays with playdough, mixes it up with paints, so it's all brown. He asks me what it reminds me of. I pick up the hint, and tell him it reminds me of poo. He looks relieved, as if he can now really enjoy it. He tells me that his mother never let him make a mess at home, and how he used to do poos all over her floor. I don't know whether this is real or fantasy, but it is real that he is talking about how far his mother could tolerate mess.

8th session

(After two-week gap) Constant testing of boundaries. Anger at end of session.

9th session

Testing of boundaries. Sits on my lap to drink from feeding bottle. At one point asks me how long it is till end of session. When I reply ten minutes, he responds by saying it's ten years – 'it feels as if he is aware of how much he needs.' He is agitated and angry at the end of the session, and he pushes the session beyond its time limit. I recognise that I seem to allow myself to get forced into inconsistent behaviour with Philip. 'I find I'm letting him get away with extending the period far too much.'

10th session

Philip seems stronger today. He removes furniture gently from the house, cleans and replaces it. Feeds himself from feeding bottle - says he's very big and strong.

11th session

Mess again. Hard for him to accept end of session, but no physical anger.

12th session

Philip expresses his desire to make a mess with sand, water, paint. I remind him of the limits involved with this - the mess has to be kept in one area, but it can be as messy as he likes there. He does make a terrible mess, but it is contained. Hard for him to end session. I make an interpretation now: I tell him that I've noticed how angry he gets when I tell him that a session is ending, and that maybe he wants to have me all the time, and is frightened that when a session ends, we might never have another one. He looks at me and listens, says nothing, but I feel he is grateful that at least I am *trying*.

13th session

Philip says he's very angry as he comes into the room, and he throws furniture out of the playhouse violently. He tests me on my boundaries incessantly, and I feel cruel as I maintain them. I remind him about the Christmas break (three weeks), and he tells me he'll be glad not to see me for three weeks. But he is furious at the end of the session and throws things around.

14th session

(After three-week break) A quiet session, which he starts off by telling me he wants to marry me. But terrible anger at end of session - smashes Lego and throws things.

15th session
Spends session making a globby mess with sand and water in a plastic bowl, which looks like faeces. He seems to be trying hard to contain his mess and (anger). It feels a bit as if he is frightened of his mess bursting out all over.

16th session
(Gap of one week - Philip is ill) Philip seems to be indicating that he wants lots of help. We spend much time in the playhouse, but several times he 'collapses' outside the house, and asks me to carry him in. He tells me I'm his mother. He fills sink with water, and spends about ten minutes slurping up/sucking water through the plastic piping. 'He makes loud panting/heaving/slurping sounds, and I'm left feeling very elemental - as if, somehow, I'm feeding him, allowing him to be nourished. He blows down the piping, it sounds like farting and he likes it. It feels very intense, elemental play. Philip tries to prolong the session by asking incessantly and in a hard-to-refuse way to play with one last thing. It's difficult to get him out of the room, and I think I just don't know how to get him out without destroying him. He feels very needy/greedy, and I'm aware that he is expressing his anger at not getting enough.'

17th session
Philip pours water onto the floor - more than I can reasonably be asked to allow. Then he starts to fill the wooden baby bed with water, says he wants it to overflow, so I say we can only do that over the sink (*always* trying to maintain boundaries with him). He spends much time filling the bed with water, and it upsets, so there is a mess, anyway! and I am not really surprised. I think to myself that he is indicating his great, overwhelming need for lots of attention and love. 'As always, an exhausting session - he is loving and terrible; wants to be nursed, then wants to smash things; always pushing to the limit.'

18th session
I am about two minutes late, and Philip is waiting for me - looking angry. He tries to shut me out of the room. He plays at the sink, but makes me sit on a chair at the other side of the room. I am being punished for my tardiness. He fills the sink with water, saying he wants to have just a little flood. Here, he seems to be expressing the continual dynamic between us - he has enormous, 'flooding' needs that might result in awful mess, but he also wants to please me, keep me happy, not frighten me away. This feels so difficult, perilous even, walking a tightrope between us drowning in an endless flood of water or mess, and me being judgmental, restricting, unaccepting. As it is, we settle for a rather unsteady, but just about maintainable, limit of water in the basin - just lapping over the top, but not a deluge. During this session, Philip makes probably the worst mess ever - paint, water, paper, sand, paper towels all churned up together, then smeared over his T-shirt. Terrible anger at end of session.

19th session
Again, Philip tries to shut me out of the room. I tell him we have four more sessions before we end. Philip denies this - says we have eighty-eight more sessions. I remind him that we have four more sessions, to which he replies that he has another friend called Carol, who looks just like me. I say that it sounds as if he is going to miss me, and that maybe he is going to feel very sad about our sessions ending. He plays in sand, in a way that feels very angry. When I tell him that I sense that he is angry, he tells me that he is angry. We talk about some of our previous sessions. He asks me to feed him from the bottle. Anger at the end of session.

20th session
I mention ending of sessions, and sense that Philip is in a rage about that. This session is characterised by a pretty systematic destruction of the room during the last ten minutes - almost everything movable is tipped out, thrown about, messed up. I make an interpretation: this anger is to do with the hurt he is feeling at the prospect of losing his time with me. I am angry as I tidy up the room - it takes me about thirty minutes. I know that I don't want to be angry during our last two sessions. I am aware of wanting the sessions to end well, so that Philip can leave the relationship without destroying it (I very nearly had to end this session) or me. I determine to define the boundaries again, at the beginning of the next two (last) sessions.

21st session
I start the session by reminding Philip of the two boundaries. He immediately upset the toy dresser in the playhouse, but then we played that it was due to a burglary. We talk about our last session next week, and I tell him that he can choose what we do. He asks if we can have a cake - just for us two. We play we are married and take turns sleeping and working. Then, a theme of being equal develops - we have the same number of toy cars, we do the same things in the sand. At five minutes before the end, I ask him if he wants to end the session himself. He says he does, and does actually manage to decide when to leave the room, having walked to the sink to wash his hands. He walks out of the room confidently, having kissed me first.

22nd (last) session
Philip talks about the cake as we walk to the room, and it feels tense until he sees there is actually a cake. He is delighted, grinning from ear to ear. He

wants to eat it straight away, and I think he may devour it, totally, on the spot. He cuts two pieces - a large piece for him, a small one for me. He eats cake ravenously, and I tell him that it is his cake, and he doesn't need to have it all now. We play in the playhouse, and he starts a game with me whereby he climbs over the wall, then hangs, upside down, as if falling, and asks me to save him. I catch him, lower him to the floor, and tell him I've 'saved' him. We repeat this three times, and I tell him that it must feel good to be 'saved', and that if he played the game again, there would be other people to play the saving game with him. We play with water in the sink, testing which things float and sink. No flooding today - Philip seems to be withdrawing from our intense relationship. I sense that he wants to say goodbye calmly. At the five-minute warning, he sits on my lap, and we hug each other. I tell him I shall miss our sessions, and he says he will, as well. We calmly leave the tidy room. I think this fairly short-term work helped Philip to feel that his 'mess' had been listened to, and was containable and acceptable, and this acceptance facilitated some ego development.

Longer-term therapy would have to wait until Philip's circumstances settled down - a situation not uncommonly encountered, and of necessity tolerated, by play therapists.

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Rosemary Randall

Dreaming and taking notes

Why do psychotherapists take notes? In a culture which values recording and monitoring it might seem self-evident: notes are a record of what has happened and a means of remembering it. Although medical notes, lecture notes and minutes of meetings may fall happily into such a category, a moment's thought makes it clear that psychotherapy notes do not. The meanings of 'what happened', of 'memory' and 'forgetting' are put in question by psychotherapy. 'What happened' is a matter of perspective, attention and selection while memory and forgetting are constructed as much by unconscious desire and fantasy as by observational re-call. So notes - if they are taken at all - must have some other function to be true to the work of psychotherapy.

Good notes can feel similar to the brief record of a dream, made on waking. They provide signposts to something that will otherwise vanish. If they are not soon worked on and integrated they will become meaningless curiosities, relics of a distant and disconnected life. The dreamer, turning through old notebooks comes across a long-forgotten, in-articulated dream. The date at the top of the page places it temporally and its symbols and characters feel vaguely familiar but its meaning has become inaccessible. 'Did I really dream that?' asks the dreamer and shrugs and turns the page. So it is with the notes of a session. They need to be made use of, the mnemic jottings associated to and elaborated or they too will vanish into the archaic underworld of the unconscious.

Not all dreams need to be remembered and consciously worked through and not all sessions need to be written down and thought about. Dreams may heal the trauma of everyday life without ever being brought to consciousness. The sensation that a good night's sleep has rendered a problem soluble may be due to the creative activity of the un-remembered dream. Other dreams, transparent and perhaps humorous, open the door to expression of contradictory or painful feeling. Two days before his exam results a boy dreamt that he woke as if it were Christmas and reached to the end of his bed for his stocking, knowing it would contain the results. The dream spoke concisely of his fears and wishes and he remembered its imaginative solution with affection. Other dreams clamour for attention. Often they are nightmares that disturb sleep and trace the day with mournful feeling. Sometimes they print themselves indelibly in the mind, unwelcome visitors from another world. Sometimes the dreamer struggles to record their images, caught between the desire to forget and the hope that remembrance and analysis may bring relief from the wretchedness that drags through the day. Occasionally therapist and patient determine ruthlessly to use the dream in pursuit of resisted truth. The patient, conscientiously records her dreams and the therapist listens responsively until at some point the intense need of the dream gives way to an easier elaboration of the unconscious and dreams can once more be brought spontaneously, according to the rhythms of need and relationship.

In the same way, not all sessions need to be written about and those which are will not all be recorded in a similar style or fashion. I tend to take notes only at particular times: always at the beginning, often when I'm stuck or puzzled, sometimes for pleasure and occasionally without quite knowing why or when something feels about to escape. Some sessions stay comfortably in remembrance. Some ask to be written down. Some positively demand silence and a kind of creative forgetting. Some I examine easily for a time while others I feel compelled to write about, battling against a wish to let them slide into repression. Some notes are a joyful, literary pleasure and dance their way onto the page. Others are poignant mementoes of a hard-won moment or tributes to courage or honesty. The notes are various and born of a variety of emotions - anxiety, delight, respect or many other feelings.

I often write extensively when I first meet someone: factual, family history jumbles with meditative

reflections on mood and feeling; anecdote rubs shoulders with observation and the whole is peppered with the question marks of uncertainty. My notebook quietens down as I get to know someone and by about the sixth session is usually silent. As the relationship becomes more comfortable and the work takes root, my need of the written word diminishes and it may be months before I write about that person again.

Often I write mere fragments of a session. These are usually easily or pleasantly remembered moments, the equivalents of the Christmas stocking/exam dream recounted earlier. Although their content may be painful they usually prompt an uncomplicated kind of reverie, a comfortable musing which holds the person in mind, connecting up the work of this session with others, consolidating a picture and making sense of something that was previously confused. Sometimes I record a moment because it seems special. Something feels like a gift and the writing seems a way of receiving and respecting it. The recounting of a dream can feel like this as can the telling of a secret. Sometimes I record it from a sense of achievement or of something changing. A young man I had worked with for three years gradually became able to identify and describe to me the way he protected himself by destroying his mind. We had spent session after session in which 50 minutes distorted into a tense eternity and I could barely piece a thought together, knowing that the torture I experienced must surely be the reflection of something he constantly did to himself. As narrative and a sense of time gradually entered the relationship he became able to speak of this strange self-destruction and came up with his own words for it – 'protective decomposition'. I thought this a wonderful phrase and wrote about it briefly in my notebook. Writing was a way of holding and using the phrase's explanatory power, allowing it to resonate and connect so that I thought and felt about this patient differently. In the reverie I found myself more clearly in touch with both anger and forgiveness for his helpless, destructive attacks and with a deeper imaginative sense of the cruel experience that had given rise to them.

In all such moments the notes are not important in themselves. They are a route to a state of mind that is important in psychotherapy, sharing some of those characteristics of attentiveness and quietude that may be found in moments of reverie with a patient, but different because the patient is absent. The focus is the therapist's on herself and on the patient as held in the therapist's mind. It allows the processing and connecting of the therapist's feelings and understanding. Every therapist needs to arrive at this state for herself. For me, the quiet room, the distant tick of the clock and the white page on which little is written are conducive to such a mood. They offer a structure in which my thoughts about the people I work with can be held freely without invading the rest of my life. One therapist I spoke to found walking her dogs allowed this kind of thought and another achieved it while doing odd jobs meditatively in the garden. However it is gained it is part of the characteristic movement in psychotherapy between different modes of being and different types of thought.

At other times I take up my pen again because I am troubled or anxious. Somebody stays uncomfortably in my mind. I am perplexed or exasperated or bored. They are discontented or angry, irredeemably sad or perhaps placidly self-content. On these occasions I write from a more active wish to understand and change something. I try to write these notes as soon as I can after the session, to re-call on paper what is most immediate and to order it chronologically. These accounts are always different. Sometimes they are quickly recognisable as belonging to a particular patient. The characteristics of that person and their relationship to me insert themselves into the language and structure of my writing. Sometimes the patient seems remote or anonymous. Sometimes the account is fluid and coherent. Sometimes the margins are filled with asterisks and arrows - 'No, this came first', 'Something missing here - why?', 'Why did I say that?' In one the first minute may be rendered in Proustian detail and the rest of the session skimmed over. In another I find I have concentrated on the shifts in the patient's moods, recorded their actual words, or noted a series of 'off the record' gestures and remarks. I might have recorded my own changing feelings and inward associations, noted down nothing but the interpretations I made and their responses, or launched straight into a diatribe of angry, counter-transference feeling.

This is my equivalent of a dream born of nightmare flung onto the page in the disquiet of waking. These notes are always individual, often puzzling, their meaning as yet unknown. My preferred means of elaboration is to continue to write in spontaneous association. I do not aim at reverie, although it may sometimes eventually arrive. I write to see what happens. I do not consciously choose a framework although retrospectively I can see that there are a number of strategies I adopt. I might write what I feel, working out a sense of disturbance or shock. I might reflect on what the notes reveal as absent. I might try to imagine what the patient was feeling as she arrived and after she left. What had she hoped for? What was she taking away? How had her feelings changed during the session? How had she experienced and imagined me at different points? I might pick up a phrase that had been rushed past in the session. For example, yesterday a patient angrily told me "This was your idea," and it felt inappropriate in

the heat of the moment to reflect with her on what this meant. Alone, as I wrote, I found the connections of temptation and the criminal act, complicity and disavowed responsibility, accompanied by the sense that something new had arrived in the work.

These are my particular ways of thinking about those familiar categories of transference and counter-transference, anxiety and defence and desire. I do not think it is important to deal with such categories systematically. If notes are to be useful they are necessarily personal and idiosyncratic. The point is to write towards some point of greater resolution where it feels easier to meet the patient again, perhaps calmer, more sympathetic, more excited or less confused. At the end there may be particular thoughts to be held in mind, checked in the relationship and discarded if they turn out to be mistaken, unhelpful or untrue. Or there may be no particular thoughts, just a readiness to work again, a sense of peacefulness, clarity or comfort. The writing that works towards these states can never be formulaic. It has to be individual and there must be many ways of achieving it, personal to each therapist and marked by each patient.

The notes are thus an organic part of the therapy, arising out of the relationship and sharing in its changing moods and experiences. They are not a mirror of therapy. They are not a summary. They are not a resource for somebody else. In a creatively developing therapy, the therapist will range across multiple moods and feelings - from the humorous to the thoughtful, from the analytic to the maternal, from the careful to the impulsive, solemn, emotional, empathic, absurd, joyous, confrontational...and so on and so on. Note-taking and its reflective counter-part need to be integrated into this spontaneous, collaborative process. Used sensitively and authentically, notes can form part of the therapist's contribution to the developing therapeutic relationship.

Unfortunately, notes are not always used in this way. Just as dreams may be treated carelessly, mechanically or arrogantly so there are many inhibiting, conventional and destructive ways of taking notes. The therapist can allow her own needs to dominate them, writing only from her own curiosity, pursuing only her own interests. Worse, the notes can be used defensively or be abused, written for self-justification, to support a theoretical or ideological assumption or to attack the patient. Note-taking can be adapted, crudely or subtly to the demands of others. These may be actual others in the form of teachers, supervisors, managers or institutions. Or they may be imagined others in the form of the conventions and received wisdom of a dominant culture. Timidity or conformity may be reinforced by the idea of a correct way of writing and using notes. Personal anxiety may be relieved by recourse to the comfort of exacting schemas or theoretical formulae. Self-aggrandisement may be encouraged by the routine application of categories and assumptions. These negative uses of note-taking can compound each other and have a cumulative, damaging effect on the therapy. When the therapist returns from such note-taking to the patient, her imagination may be restricted and her freedom of thought undermined.

Least harmful perhaps are notes consciously taken for a particular purpose, where the therapist is aware they have more to do with her own needs than those of the patient. For example I often write down people's dreams. This stems from a personal weakness - I find it hard to remember their detail. I may remember the mood, the atmosphere, some of the associations and interpretations but the actual narrative of the dream frequently vanishes. I have a similar difficulty in remembering poetry and the plots of novels and plays. I experience the same frustrating sense of hearing a rhythm or shape in my mind but being unable to capture the words. Sometimes this doesn't matter but there have been occasions when it has and so I usually record dreams. I am aware that this often has more to do with my own difficulty than with the needs of the patient and that it can place a false emphasis on the dream.

More disturbing to the work are notes deliberately taken for a purpose outside it. Recently, while working on a paper on phobia, I spent about six weeks making detailed notes on any references to phobia that came up in sessions. Sometimes this was illuminating and directed our attention to something previously missed. It was also distorting however because the pre-occupation was mine, not the patient's, and I sometimes felt a disorientating sense of being pushed off course by something external, although of course the impetus actually came from me. Notes taken for a supervision or case presentation may create a similar distortion. There may be the same awkward balance between the possibilities of new insight and the dangers of inauthenticity.

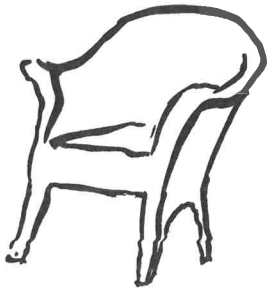
Both dreams and note-taking can be used in a more actively defensive way in psychotherapy. I have occasionally seen people who bring dreams incessantly, long notebooks full of indigestible material that take the whole session to recount, mesmerise with their obscurity and tantalise with their unexplored allusions. They are dumped in the consulting room. There is never time to examine them. The therapist shifts uneasily in her chair, waiting to catch the moment when she may intervene or shift the mood towards reverie or reflection. It never comes. Time expires and the dreams lie unexamined in the exhaustion of the session. There is something obsessional and death-

dealing in this relentless outpouring. It stifles thought, hi-jacks creativity and presents a parody of psychotherapeutic process. The conscientious therapist who uncritically records every session may unwittingly perform a similar function. Early on in my career I felt I ought to take notes on every session of every patient I saw. Notebooks full of indigestible material accumulated. The entries became repetitious, factual or superficial and the notebook remained closed from one session's end to the next. These notes were a monument to my anxiety and a memento-mori of the therapy. They gave the appearance of thinking but actually prevented thought. I abandoned them with relief.

At other times the defensive use of dreams or notes shades into abuse. A therapist can impose a dream interpretation on a patient, either by wandering off in personal associations and falsely assuming their relevance or by seeking out confirmation of their own or other's theories in the material presented. A personal symbol may be mistaken for a universal one or a cue to the past mis-read. In a fit of enthusiasm the therapist may steal the dream. The notes of a session can be even more vulnerable to such abuse. The written word has a seductive magic. It can assume power beyond the thought that forms it. It can acquire a spurious truth, demanding attention in an authoritative way not justified by its origins. As the therapist meditates and elaborates on her notes alone, without even the check of the patient's presence, she may become vulnerable to the lure of intellectual conceit or defensive self-justification. Although the intention may be one of careful reverie the opportunities for speculation, fantasy and neat theorising may not always be resisted. What is brought back to the patient may then be a strengthened distortion or a created fiction that confuses the patient and ultimately the therapist too.

These personal lapses and vulnerabilities increasingly take place in a culture of caution and defensiveness which, instead of challenging, may encourage them. It is a culture built on the belief that monitoring, checking and evaluation are inherently worthwhile. Psychotherapists are increasingly told they ought to be able to justify what they are doing/monitor progress/evaluate effectiveness/explain their treatment strategy/ modify their objectives and so on. If note-taking becomes seen as a routine part of this process there may be little challenge to the kind of individual defences I have described. If mechanical formulae are suggested for the form of the notes, inhibition will be encouraged. If crude assumptions are made about the truth and meaning of what is recorded, abusive interpretations may be left unquestioned. This culture is built around the anxiety of 'in case'. People are encouraged to keep notes in case they forget/need to check/are challenged/are sued/ appear before the ethics panel/have to give evidence in court, etc. In some fields of work this is crudely and cynically known as 'bum-covering'. People keep records and write letters not to develop the work but in order not be blamed if something goes wrong. Increasingly this culture is institutionalised in charters, regulations and inspections and its influence ripples out through management, education and the health service into areas of work previously untouched. It is an anxious culture, that anticipates the worst and is afraid of causing harm. Its regulations and injunctions often feel more like the magic rituals of the obsessional than a real attempt to deal with destructive and damaging behaviour. Note-taking that springs from such a culture is likely to interrupt the process of therapy, interfering with a more fluidly connected movement between different ways of being with and thinking about the patient. It has little of the dream in it. It may contribute to inhibition in the therapist and confusion in the patient.

Remembering the experience of the dream and its many uses may encourage a gentler and more dynamic appreciation of the part note-taking might play in psychotherapy. The dream marks both the gulf and the connection between conscious and unconscious experience. As a metaphor it calls attention to the unacceptable and the forbidden rather than the conventional and the correct. It speaks of subversion rather than conformity. It emphasises the escaping, elusive and uncertain aspects of the work rather than the obvious, definite and graspable ones. From the perspective of this metaphor, notes are not about recording, documenting or freezing the past but about understanding the present and keeping moving in it.



Leila Gordon

Inner death and the wish to die

This is the edited text of a talk given at the Annual Conference of the Association of University and College Counsellors (AUCC) in March 1999 at Fitzwilliam College, Cambridge. The talk was followed by a discussion on the topics:

- *Why is the wish to die more prevalent amongst young men than it used to be?*
- *Why is it that some young people can use help, whereas others find it impossible?*
- *What are the difficulties in working with someone who may be suicidal?*

The nature of an attempt

I have worked at Addenbrooke's and Fulbourn Hospitals in Cambridge for over ten years with patients who have attempted suicide or who have harmed themselves. Over the years I have assessed well over a thousand patients. I am on call in the mornings to assess patients who have been admitted overnight to the A. & E. Observation Unit. In the majority of cases I will be talking to someone who has taken an overdose, and I usually begin with detailed questions such as:

- What medication was taken, and how much?
- What was the time gap between taking the tablets and the admission?
- Was the patient aware of the lethality of the medication? (The most common overdose is Paracetamol, yet it seems that many young people do not know how very dangerous it can be.)
- Was the attempt well concealed from family and friends? Was it an impulsive decision?
- How was the patient found and by whom?
- What were the circumstances leading to and around the time of the overdose?
- Has the patient taken an overdose before?
- Does the patient have a psychiatric history?
- How does he/she feel about the suicide attempt now?

My task is to establish whether this was a serious suicide attempt or rather an impulsive act to break an intolerable feeling. I consider the individual's whole situation and draw in appropriate professional help. I may decide to refer the patient to a psychiatrist for possible admission to a psychiatric ward or I may recommend therapy with myself or other agencies. The majority of the people I interview accept the help offered and those who stay with me continue to work through their depression and suicidal feelings, usually over a period of three to six months. However, some come with a complex combination of problems, which can take much longer to resolve. Most of the students whom I assess come before or around the time of their exams, and during their first year in Cambridge.

I have encountered despair beyond belief in these meetings. Women who not only feel black but whose faces actually look black in colour. Some are unable to stay in bed and walk around. Some weep, some sit still, some regret the incident and want to go home, some are angry, hostile, or drunk. The majority of incidents are not medically serious but this does not mean they should not be taken seriously. I sometimes hear these patients referred to as attention-seekers. To me this shows a lack of understanding of what may be going on in the mind of the suicidal person.

When I interview a patient who has attempted to commit suicide and I find despair, it makes sense and helps me to understand. When I don't witness this pain I have to struggle to understand. What I have learned over the last ten years is how very complicated the issue of suicide can be. Even if the patient appears to be giving clear reasons for their act, the underlying motives tend to be profoundly ambiguous.

A month ago I interviewed a student who told me how he took the overdose and then walked the streets of Cambridge through the night. He said,

with total lack of emotion, how he wanted to die because he had come to the conclusion that, contrary to his expectations, his life was never going to be perfect.

Six weeks ago I interviewed someone else who told me in detail how she had planned her suicide well in advance. She went to the library and selected her favourite books to read throughout the night with a torch, on the back seat of her car, in an isolated spot by the river. She took a massive overdose in the evening, wrote suicide letters to her family and friends and waited for the time to pass. By 6 o'clock in the morning she was violently sick and eventually decided to call to a man walking his dog. She was shaking with emotion and regret and very nearly died when two weeks later her liver and kidneys packed up. There was a time when I thought she would not make it. I watched her go green and yellow on the High Dependency Unit while she was unconscious. Eventually the family asked to see the suicide notes, which I handed over to them. She has recovered physically but it is too early to say how she will recover emotionally.

Some facts and figures

- Suicide figures for young men aged 15-24 in the UK and Europe have increased by 75% since the mid nineteen eighties. Adolescent suicides constitute the largest cause of death in this age group after accidents.
- There were approx. 5933 suicides in the U.K. in 1997.
- Suicides by men outnumber those by women by a ratio of 2:1. In adolescents this rate is even higher at 3:1.
- Young women aged between 15 – 19 years are most likely to attempt suicide.
- There are 19,000 suicide attempts by adolescents every year – more than one every 30 minutes.
- Two-thirds of suicides communicated their intentions to others; one third had a history of attempts.
- Seasonal variation: the suicide rate rises in February and March and reaches a peak in May and June. It is also more common at weekends, birthdays, Anniversaries and Christmas.
- Gender differences: women are more likely to take overdoses. Men are more likely to make serious, often aggressive attempts, such as carbon monoxide poisoning, jumping off bridges or hanging.

Sources: Anderson and Dartington (1998), Hawton and Fagg (1992) The Samaritans (1999)

Although I rarely work with the family, I often come across members of the family at Addenbrooke's fairly soon after the attempt. The suicidal person has usually suffered from emotional problems and stress for some time which have already strained and sometimes exhausted relationships with people close to them. Even in suicide attempts the family are left with a mixture of strong feelings to cope with. They feel very angry and guilty, helpless and worthless. They were not seen to be able to help, they were not worth living with or for. They feel rejected and annihilated. It seems as if they were left with the patient's projected emotions, and where are they going to go from here?

One of the things that can be difficult to understand is why two people who find themselves in a similar situation, that they describe in similar terms, can react so differently. One person feels able to live with the situation while the other feels that the only way forward is suicide.

Let us begin with some questions. What do we understand by suicide? Is it an attack on oneself or is it an attack on someone else? Is it a self-punishment or a return to the inanimate state? Could it be a paradoxical act - an act of self-preservation, or of preserving someone else? Who is being killed and who is being saved? What are the pay-offs and what could make it appear to be worth doing?

The subject of suicide has not been written about at length in the analytic literature and tends to be something discussed only in passing. The topic is not one you jump on with joy and some of the people who know most about it will be those who have personally experienced loss through suicide. Another reason is the complicated nature of the act. In one case of a suicide attempt Freud (1920)) noted that 'several quite different motives, all of great strength, must have co-operated to make such a deed possible' (p.163). He observes that this coming together of different motives 'is only in accordance with what we should expect'.

There is another difficulty in either working on, or studying suicidal feelings. This has to do with our own inner worlds and the traumas and fears, which are likely to be stirred up in the course of close involvement with the subject. Suicidal behaviour is often accompanied by feelings of revenge, triumph and rage and can have narcissistic and hateful overtones. All can be experienced as extremely disturbing.

Loss and depression

In my experience, the significant factors connected with suicide attempts are social and emotional

deprivation, family stresses, drug and alcohol problems, unemployment and a history of physical and sexual abuse. However it is usually relationship problems that bring about the suicide attempt and give us some clue to the personal tragedy. I find that I work for much of the time with issues of loss and guilt.

This does not necessarily mean loss by death but could mean loss by abandonment, rejection, or the emotional absence of a parent, as in depression. I also believe that with a suicidal patient the most recent loss triggers off emotions associated with a much earlier loss in life. This helps us to understand why the ending of a brief relationship can produce such devastating emotion. There is usually another story to be heard, something that took place nearer the beginning of the individual's life. In some cases I find that as a young child the patient was 'wished dead' by the parent.

Working with these very early experiences of life I draw strongly on the work of Freud, Winnicott and Klein. I find them particularly helpful in understanding the sense of loss, depression and guilt in a suicidal individual. It is not my intention to present a theory of suicide but rather to help us understand some aspects of it using analytical theory. I would like to emphasise that this is one way to try to understand suicide. Undoubtedly there are other ways. I shall not be discussing those individuals for whom the suicide attempt and depression are part of a mental illness or where these signal the beginning of mental illness. This is an area where I call for help from psychiatrists whom I work with.

Whether we like Freud or not, he offers us a foundation for understanding the disposition to suicide. In *Mourning and Melancholia,* Freud (1917) explores the differences between the grieving process in mourning and the pathological condition that he calls melancholia, something that some of us might nowadays call clinical depression. In such a melancholia or depression, what we usually find is a profoundly painful rejection. There is a loss of interest in the outside world, a loss of the capacity to love and an inhibition of all activity. Self-regard is lowered; there is self-reproach, little sense of self-worth and a need for punishment.

Freud observes that in both profound mourning and in melancholia the reaction to the loss of someone who is loved contains the same painful frame of mind. There is the same loss of interest in the outside world, the same loss of capacity to adopt any new object of love (which would mean replacing the beloved) and the same turning away from any activity that is not connected with thoughts of the beloved. Mourning is essentially a healthy process. What distinguishes melancholia or depression is the disturbance to the sense of self-worth. Furthermore, in depression it is not always clear just what has been lost. The depressed person may know who has been lost but not what has been lost with them. The sense of what is lost is unconscious, unlike in mourning, where it is known.

In mourning it is the world that has become poor and empty. In depression it is the self, the worthless, weak, powerless individual, emotionally impoverished and lacking in self-confidence. This is the self-description I most often hear from patients at interview and I believe it is a correct description of their psychological condition at the time. If, in addition, there is a deep sense of guilt and hopelessness and if reduced sleep and lack of appetite are also reported, then we are almost certainly listening to someone in whom the desire to live is in question.

Self-reproach is often a most important element. Freud (1917) notes that:

> If one listens patiently to a melancholic's many and various self accusations, one cannot in the end avoid the impression that often the most violent of them are hardly at all applicable to the patient himself but that with insignificant modifications they do fit someone else, someone whom the patient loves or has loved or should love... So we find the key to the clinical picture: we perceive that the self-reproaches are reproaches against a loved object which has been shifted away from it...

In other words, what underlies the self-accusations is an accusation about somebody else. A woman whom I saw last week blamed herself for failing in marriage through not being strong enough. I felt she might really be saying that she had to be strong for her weak husband and that the marriage broke up the moment she lost her strength. Where we discover self-blame taking the place of blaming someone else, usually loved, then we recognise ambivalence. This is one of the most frequently encountered components of suicidal feelings. The opposed feelings of love and hate cause a conflict, which can make the grieving process an overwhelmingly tortuous task. Simultaneous intense feelings of love and the wish to die become an uncontainable combination and may lead to suicide or to attempted suicide.

The depressed individual is unable to separate from the ambivalently loved, lost person. Instead, he identifies with them; they become part of himself, live with him forever and can be attacked as part of himself. Suicide can be seen as the ultimate act of hatred or punishment against this person. Alternatively it can be seen as a way of

rescuing the good parent by killing the bad one, thereby preserving the self.

The patients I work with often report ambivalent feelings towards their parents. Sooner or later many speak about their early life and about some loss that happened to them. That loss was not necessarily experienced at the time because of their very young age but was repressed.

A young woman I saw yesterday took an overdose in response to a rejection by her boyfriend, after a three-month relationship. She realised this did not make sense and that it may somehow be tied up with a feeling that she had lost someone whom she loved most of all a long time ago. She spent her childhood with both her parents and has never understood where this feeling comes from. She says that she has rejected many people in her life from fear of being rejected herself.

If the loss at this early age is particularly severe, the child can be so completely unequipped to deal with it that some part of him or her dies, becomes annihilated. This may help to explain why some individuals become more suicidal than others later on in life. For example how does a very young child experience his mother's depression? If she removes her attention from the child and becomes emotionally unavailable and the father is unable to replace this attention, how will the child experience this sudden and inexplicable detachment? One way to survive would be through identification with the depressed mother. Through incorporating the loss it is the child who becomes lost and depressed. What would happen to the emotions that the child felt towards the mother before her depression? Maybe in such a case they could be described as becoming split off, annihilated, or as André Green describes it in *The Dead Mother* (Green 1972) frozen, yet continuing to exist in some form of hibernation. In therapy the ice begins to thaw and the thawing process can be as painful as entering a warm room after being out in freezing cold weather. As our fingers thaw, the feeling returns and it hurts.

Sue has recently been abandoned by her boyfriend and she swears never to fall in love again. She feels deadened and suicidal. When we first met I was struck by her coldness and emotionally starved presence. When she was twelve she decided not to have anything to do with feelings but instead to get on with her life. She has been very successful professionally despite her young age and she had managed to keep out of relationships. Then the thing she most dreaded happened: she fell in love and was rejected by the man. After years the frozen emotions of pain and love are returning to life in therapy and she finds this almost unbearable. She recalls how she turned away from people at the age of 4 when her parents split up in a most acrimonious way. She believes that people cannot be trusted and that they will inevitably abandon her sooner or later. Love is simply too painful for her.

I often find that people who are suicidal have strong fears of death, breakdown or annihilation. Winnicott (1974) explains this as a fear of something that has already happened but which the patient was not mature enough to make sense of. What remains is a pre-occupation with an unnameable catastrophe. Suicide can be seen as a desperate attempt to return to this earlier death in the hope of bringing the lost, annihilated self back to life. This striving has to be replaced by the returns and rememberings of therapy where the 'unremembered' can become 'remembered' in the transference and be experienced for the first time.

Anne had spoken in the previous session of her fear of a dark room which she had mentioned frequently before. She thought that the only way to overcome this fear was by returning to this dark room, maybe with the help of hypnotherapy, as all other therapeutic efforts had failed. She thought the room belonged to the house where she lived as a little girl before she was three. The house was a large hotel, which her parents ran and the room was at the top of the stairs. The darkness felt frightening and suffocating. In a dream, which has repeated itself since childhood again and again, a man arrives at this same house wearing a 'long heavy coat, and a hat'. Anne is standing at the top of the stairs. The man does not speak and Anne is terrified. She does not let him in. After this scene, she finds all the curtains closed in the house. Anne's mother died when she was just three years old. The only memories she has from this period are to do with playing with jelly fish across the road in the sea, and later being taken to live with an aunt she had never met before. When Anne came to her session the following day she was very upset. She said she did not want to live any longer. She had tried everything, and nothing could bring her out of her despair (Anne had been coming to see me for several years). The way she felt was impossible for her to articulate. The best way she could describe it was to say it felt like being suffocated.

I believe Anne may have reached her dark room, the part of her that died or was annihilated at the time of her mother's death. She felt alone in her confusing despair, unable to make sense of it, just as I imagine she may have felt at the time. It was not yet a feeling of sadness but rather one of fear and anxiety. The grieving for the loss of her mother is still to come. This is the stage when all that has been still and frozen begins to thaw and the feeling begins to return. Anne has in a way

'remembered' her own emotional part-death around the time her mother died in reality. It is possible, although it requires long-term work and regression, to reach this stage with the help of therapy, without actually having to die.

Guilt

A strong sense of guilt is another significant characteristic of a person who feels suicidal. He or she may not know why they feel guilty but there will be a tendency to believe that they were responsible for whatever went wrong. In my experience, most people report the ending of a relationship, brief or long-term, as the main reason for their wish to end life. They also believe that they themselves are the cause of the relationship's failure. Where they have lost their partner to somebody else, this reinforces their already strong feelings of lack of self-worth, their sense of abandonment, and their sense of being (for want of a better word) bad.

Becky is an attractive young woman. She is in a violent relationship, which she feels unable to end. She says she loves and fears the man who beats her. Becky thinks that somehow she is to blame for the abuse, because she is weak. She says she should be able to help her boyfriend instead of rejecting him. The reasons for her self-blame are quite unreal, as is her ability to help the boyfriend. I am extremely concerned about her, as I believe she is suicidal and could kill herself at any time.

Suicide attempts after the break-up of a relationship may sound very like a punishment, not only to the subject, but also to the rejecting party who would be forced to learn about the depth of the patient's suffering and its intolerable nature.

This level of guilt cannot be explained by the recent rejection alone and we need to explore the original guilt situation. Between the ages of about 3 and 5 the young child becomes aware of his parents' relationship with each other and his place in this triangular, Oedipal situation. He can become overwhelmed by powerful, contradictory and rivalrous feelings of love and hate for both parents. If these feelings cannot be managed within the family the child may be left with an excessive burden of anxiety and guilt for his desires and hates.

Jane believed that she had killed her mother who died accidentally falling downstairs when the patient was three years old. In adult life she had a number of relationships that involved three parties, relationships that she knew would end in defeat. She suffered from excessive guilt over her mother's death and repeatedly got herself into situations where she was forced to withdraw and leave her partner to his wife. She was unable to overcome the guilt caused by her wish come tragically true: namely that her mother died in reality because she had wished her dead and she got what she wanted, her father.

In a similar way, the parental separation and potential further separations with the parents' new partners place today's young people in situations where such Oedipal conflicts may have come true, again tragically, several times over. These are multiple Oedipal situations where the emotional turmoil between loss, love, hate, and guilt raises the question of how containable such a situation can be in the first place for a young adult.

Ideally in health the child would be able to contain both love and hate towards its parents and the guilt that this produces. In my work the guilt that I come across is by no means healthy. On the contrary it is oppressive.

Melanie Klein (1953) is very good in helping us understand the deeply persecutory experiences of people who are suicidal and who remain locked in a persecutory world where good has been destroyed and there is nothing they can do about it. They are left in despair. Good, for such a person, is only experienced in an idealised and unattainable way. It only happens to other people. I could again mention Sue here, who had lost her trust in people and for whom love was too painful. She could only feel safe in a world of no emotions. Klein saw the conflicts of love and hate as being more powerful and more significant earlier in the child's development. Her ideas about splitting, projection, the depressive position and reparation can be helpful in understanding some aspects of suicidal feelings.

Klein symbolises the infant's good and bad experiences as the 'good' and the 'bad breast'. She does this because she sees that the infant at this stage relates primarily through the physical feeling and holding in the relationship with mother. The world is now split into a warm, good physical experience, and a bad, terrifying, persecutory one.

In normal development, at about the age of six months, the child is able to bring these experiences together. This is Klein's depressive position. The child realises that the person he loves and hates is one and the same and feels guilt and remorse for his attacks. Winnicott calls this the stage of the child's capacity for concern. The successful negotiation of the depressive position is dependent on the predominance of good experiences over bad and on a containing environment in which difficult feelings can be tolerated.

People who are suicidal may not have had enough good experiences to securely attain the depressive

position. They may be returning under situations of stress and breakdown to earlier more persecutory ways of relating. This is particularly common in the re-negotiations of adolescence, when first-love relations re-awaken memories of the past. This is a complex question. It is not a matter of blaming the mother or the family but of understanding how and why defences have broken down leaving the person so vulnerable to this persecutory world.

Sue struggles with fear of her own destructiveness and love. She feels cold and she looks as if she were always cold. While with her, I wish I could hold her, wrap her up with blankets and comfort her in an ordinary physical manner, as you do with babies. Words seem to have little effect and I feel helpless with her despair. There seems to be no sign of her beginning to believe that good may exist and be part of her.

Working with suicidal feelings

University students are scarcely past the enormous changes of adolescence. They are hardly well adjusted to their new size and shape or settled in sexual relationships. Now they have to face the separation from home. This is welcome to some, frightening to others. Once again, as therapists, we are face to face with the lost child, afraid and vulnerable, rejecting and angry or chaotic and disturbed.

Because of their fear of rejection and abandonment, troubled young people often threaten to break off contact with any professional worker who is trying to help them, in order to avoid being left themselves. Some of them believe that suicide allows them to go on living without pain in a world that is safe from the threat of rejection. Death is a fantasy to many who have attempted suicide. Few have actually thought of being dead.

At the time of the suicide attempt I believe that most people are not thinking of death itself nor of the fact that they will not be here to witness the outcome of their death and what they may have gained from it. Instead they are thinking of how to stop the suffering now that they can take no more. There may be the hope of saving face in a shameful or embarrassing situation, a wish to punish someone, or a gesture of despair. A wish to die does not often mean a wish to be dead. More often than not patients tell me after a serious attempt when they nearly died that they are glad they survived. Their original hypothesis about having to die to be able to live fully does not work in reality, and the pay-offs are never realised. Sometimes the suicide attempt itself, with follow-on therapy, can be experienced as the breaking point in an intolerable sequence of events and emotions which had to be stopped, at least temporarily, for the patient to reassess his or her life.

What is it like to be in the room with a suicidal young person? What are the signs of suicidal ideation? How do we know how serious the situation is? Some signs to look out for are:

- A withdrawn, unconnected individual for whom the world has become meaningless.
- The inability to contain conflicting emotions, a lack of hope and the sense that the whole emotional system is at a point of collapse.
- Narcissistic superiority, detachment, lack of emotion, contempt, hate, anger and often a refusal to co-operate.

The first thing to do when faced with such states is not to panic but to encourage the person to speak and describe how it feels to be suicidal. In his despair he will take you into his world but only part of you enters with him. The rest of you remains connected with the real world. This may become his only connection to reality and he may hold onto it as his only or last line. It may represent hope for him. Stay calm and listen, and while he talks he may find another connection from his own past which will make him curious and could lead to new discoveries about himself and his history. It is helpful to remain open to patients' feelings, to be affected by them but not overwhelmed by them. If we can manage to contain their fears and our own, this will be communicated to them and will help them feel safer. With greater integration, they will be able to contain their own destructiveness. Silence in the room can be a difficult experience for a suicidal person who may be struggling to stay alive. Unresponsiveness by the therapist is not helpful and may even increase the feeling of deadness.

While working with someone who feels suicidal or who has already attempted suicide it can be useful to help them to remember the feelings associated with situations of loss in their life and what personal meaning that loss has. Apart from sadness we may encounter anger and rejection from a patient and this can sometimes feel dangerous. With much time this anger often turns into a sense of helplessness which we may be able to connect with the similar feelings of powerlessness and feeling lost in the past.

Emily attempted suicide a year ago and has been feeling very much better recently. She is now pregnant and expecting her first baby in three month's time. Towards the end of her pregnancy she has become suicidal again and overwhelmed with fear that her husband will leave her after the baby is born. She has no rational explanation for

this fear as her marriage is happy and she has been looking forward to having a baby for years. Emily's father left her mother soon after Emily's birth and she has been told that her mother became very depressed at the time. In this way she lost both of her parents when she was only a few months old. Emily is unable to remember how it felt at the time, yet the fear of abandonment and confusion which she is unable to express in words (because words did not exist for her at the time of the trauma) feels to me, in the transference, like the helplessness and fear of a very young child. She experiences the feelings now in connection with her unborn baby through identification with her depressed mother and herself as the baby. Were she able to work with these emotions now she might gain an insight into her suicidal feelings; an understanding of how her wish to die is connected with her early emotional 'part-death' through self protection, out of a fear of abandonment while struggling to survive.

In order for the unremembered to become remembered in therapy and for the annihilated part to return to life, we need to allow the patient to express and work through their ambivalence and the guilt about the ambivalence and loss. This can be a long and slow process. It involves careful listening to the patient's innermost experiences of fear and pain, tolerating angry transference attacks at times of the therapist's breaks from work and putting up with rejection as revenge. If we can connect the anger with the earlier situation where it really belongs, we may find the anger turning into helplessness. The earlier situation may be an early loss (before the age of 11) when there was nothing the child could do to prevent a loved parent from leaving or detaching themselves. It may refer to a parent's attempt to 'suffocate' the child or emotionally to wish the child dead. The child who was wished dead by the parent is someone who often reports their childhood as a lonely one in which they felt generally ignored and unwanted and in which they were left to find their own way of emotional survival. The recent rejection in a relationship has brought back this familiar feeling of being at loss (helplessness) and now the person feels a mixture of anger, guilt, and helplessness.

If we are successful in helping the patient to work through these different psychological areas he may find the courage to expose the hidden or annihilated part that reveals the vulnerability and neediness of the young child. This is not necessarily different from working with someone who is feeling depressed yet you may find that in a suicidal individual the sense of guilt, suffering and worthlessness are persistent and strong features that are hard to break.

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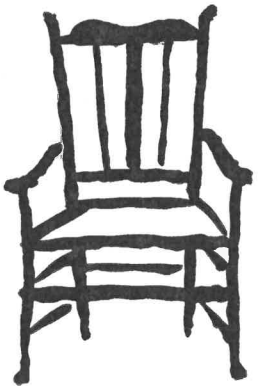

Peter Lomas

Some reflections on influence in psychotherapy

It is notoriously difficult to distinguish between aggression that is based on greed and that which is a defensive reaction to a fear of being invaded. Attack, it is said, is the best form of defence. Psychotherapeutic theories vary as to the prime mover in this drama. Freud feasted on our greedy desires, and, in the context of generational conflict, on the child's wish for exclusive possession of the chosen parent and hate of his or her rival. Most of us, I imagine, can see the truth of Freud's thesis when we look into ourselves or when we observe children. However, in both cases, I find myself no less impressed by the child's ferocious attempt to hang onto her perception and sense of identity in the face of influence.

It is not so much the content of the influence that is a threat but its power. Indeed, an influence that is in tune with the child's own perceptions and feelings can be particularly undermining. If the parent pre-empts the child's spontaneous reactions she may come to doubt whether her own reactions are authentic. The desperate search for identity in this kind of situation has been described by Eric Erikson (1968) in formulations that have never been surpassed.

To put the matter in another way. A child may turn away from the influence of the parents for various reasons many of which are well explored in the psychoanalytic literature including, for example, jealousy, envy, rivalry and disappointment, which often dominate the scene. These emotions result in alienation but are not based on the matter I discuss, namely a primary fear of the power of the parents to influence one's perception of the world.

These considerations have, I believe, a bearing on intellectual influence and are worth looking at in relation to how we gather our views on psychotherapeutic theory. The literary critic Harold Bloom proposed the term 'creative misreading' to describe how a writer may find his own voice against that of the most dominant of the age. Although heavily influenced by the genius to whom he is most indebted he confronts him and manages to transform the work into something of his own. If the fear is too great (if, for example, other factors, such as oedipal rivalry, play too large a part) the younger writer or thinker is deprived of a valuable influence. We cannot create ourselves out of nothing (a doomed undertaking comparable to what Rycroft describes as 'ablation' of parental images). (Rycroft 1985)

In our line of work the giant we have to deal with is of course Freud. Yet there can be nearer figures, sometimes those with whom we have had personal contact or whose ideas are closer to our individual philosophy. In my case the two thinkers who give me most trouble when I attempt to find my own voice are Rycroft and Winnicott. Rycroft because he was my training analyst and because I am indebted to him in many ways, including intellectual help. Winnicott, not only because he charmed the pants off me from the day I first met him and I found his philosophy so close to my own, but because I think him the most creative thinker in psychoanalysis of the last fifty years. I cannot afford to do without Winnicott but I have had to struggle hard to understand the difference between the way I work and think and the way I imagined he worked and thought.

Another factor which can have a deleterious effect on our ability to use what is handed down to us – another 'enemy of promise' – is simplification. Gestalt theory has shown us that the brain organises the chaotic stimuli on the retina into coherent or manageable form. It ties up loose ends and discards bits that are irrelevant to its purpose of protecting us from confusion. It simplifies. And this process of simplification extends to all our faculties; we do not take kindly to cognitive dissonance. The discipline of intellectual history is no exception to this phenomenon. It is easier to write for example 'As Melanie Klein says' or 'As Winnicott says', using their exact phraseology to

describe an idea, than to tease out the various ways in which the same idea has been formulated in other ways by their predecessors. The big fish eat the little fish. For example, Paul Roazen notes in his forthcoming book *Oedipus in Britain: Edward Glover and the Struggle over Kleinianism* (which I have had the privilege of reading in manuscript) that:

> It is now heralded as an implication of Lacan's admitted genius to question the requirement of training analyses, but no-one seems to remember that Glover was calling attention to this issue over fifty years ago.

And Glover was hardly a little fish.

The phenomenon of selective influence in the psychoanalytic movement has been explored at great depth by Roazen, whose writings on the history of psychoanalysis are uniquely insightful and backed up by rigorous documentation. (Roazen 1975) His concern, as a historian, is to establish the truth, insofar as that can be done, in the face of received opinion. What emerges is a sorry story. That the movement has been marked by warring factions is well known but the extent of the intrigue – the manipulation, both crude and subtle, in order to achieve influence – is so pervasive that one has serious doubts as to how much of our theoretical beliefs have lodged in our minds as a consequence of influence rather than because of their intrinsic value.

The Freud-Klein controversy was a notable example of this phenomenon. It was this debate which brought to the fore the degree to which training analyses were being used in order to cultivate proselytes and exploit them to swell the ranks of initiates – a nefarious activity which led Glover to make his plea for the abandonment of such analyses. Once can easily understand the temptation to stray from therapeutic integrity; moreover the dividing line between benevolent influence and manipulation for ulterior motives is a narrow one.

The word benevolent, in the context I have used it, is open to all kinds of questions. The psychotherapist's wish to influence her patient is not of course confined to a situation in which training is involved. Indeed, without influence there would not be therapy. Benevolent influence implies a genuine and innocent aim to help the patient lead a more fruitful life. In pursuing this aim the therapist will unwittingly judge what is more fruitful according to her own value system. The idea that our purpose, as therapists, should be to help the patient find his own voice is a sound one and helps us to restrain urges to preach or dominate, but such a process is not achieved in a vacuum. However much the fact may be painful to accept, we are not and cannot be neutral. Nor should we attempt to attain this ideal. We can only hope that we are, in the consulting room, sufficiently sane, sufficiently good, and sufficiently free from ulterior motives to provide the kind of relationship in which the patient can find a way to grow. The history of psychotherapy – the accounts of what really goes on rather than what is said to go on – shows us just how difficult it is to do.

I have, up to this point, dwelt on the ways in which we (as patients, students, practitioners or commentators) can easily allow ourselves – whether by oversimplification or surrender to charisma and manipulation – to accept too facile a picture of therapy. But, if we are victims, we still have to take responsibility for our conceptual errors. Why do we so easily fail to discriminate?

The capacity to discriminate has, I believe, been neglected by psychotherapy. Failures to discriminate, noted by therapists in their daily work, tend to be quickly accounted for by linking them to concepts which are more familiar, such as denial or dearth of intelligence. The relative lack of interest in discrimination shows itself in many areas of psychotherapy. Much is written about love, hate, trust and so on, without due emphasis on whether those who adopt these attitudes of mind are justified in doing so. For example, someone may be inhibited from taking a positive, forceful, aggressive stance towards intrusion because they simply lack the capacity to judge whether such action is justified. To consider this phenomenon brings us to the knotty problem of where the sense of justice come from. At this point we enter areas of morality which are far too complex to be approached in this short note.

The patient in therapy has very little chance of knowing what he is letting himself in for. He will, of course, bring all the defences he has erected against the precariousness of living, but much of his caution may be attributable to a realistic fear that he is being asked to trust, and let himself be influenced by, someone about whom he knows very little and who may let him down. A too ready trust is as much an incapacitating error of adaptation as paralysing suspicion. As for the therapist, she has the almost impossible task, based on her knowledge of her limitation and her understanding of the patient, of estimating what would be justifiable trust. If she gets this wrong her interpretation of defences is likely to be wrong also.

We will never eliminate failures of judgement but I think it advisable, when we consider

psychotherapeutic concepts, to be aware of the oversimplification that results from limiting them to the influential ideas of key figures. There is a price to be paid for this. We become stuck with certain concepts into which our minds slide easily. We have certain books on our shelves, just as do the various branches of W.H. Smith's and we do not readily stray from the safe haven of our intellectual homes. We live in a society that is progressively concerned with caution – and that comes at a price too.

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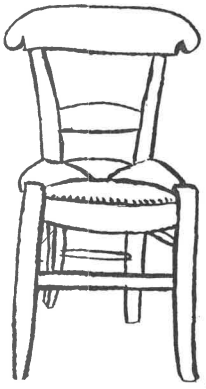

Michael Evans

Creativity: a sketch of an idea

This is not a paper about creativity in itself and no light is going to be shed here on what is often called the 'creative process'. Because I find creativity such a confusing subject and because of my feeling of uncertainty as to ever knowing what it might be, and because of my doubt about it ever meaning any one thing, I am going to explore where I think the concept came from, how it evolved and its present day significance. It is particularly interesting that the term creativity, in the general sense of a human faculty or ability, only became widely used in the twentieth century. I hope to clarify some semantic confusions around creativity and by showing the impossibility of defining the topic suggest that we are sometimes talking of different things under the one heading.

A short history of the concept

In *Keywords: a vocabulary of culture and society* Raymond Williams (1983) is concerned with the history of our language, showing how concepts which are of key importance today have evolved and changed. Williams defines the term creative in the modern English sense as the production of something innovative and original. He points out that in classical times and into the Renaissance the world and all its creatures were regarded as the product of a divine force. It was only God who could create, and it was only because of their Divine Right that Kings could create social rank and exercise judgement. Art and the productivity of artists was considered to be an imitation of God's creation, but creation in the Renaissance period could also be used in a negative sense as the creation of counterfeit and falseness. And of course art has for long been associated with mimesis, lies and illusion and was therefore ruled out by Plato from his Utopian Republic.

By the 16th century the concept of creation had become strongly associated with artistic production but still retained its sense of having its source in the divine. Torquato Tasso (1544 –95) wrote: 'There are two creators, God and the poet.' (Williams (1983) P.82) Philip Sydney saw God as having made nature but having also made man in his own likeness, giving him the capacity 'with the force of a divine breath to imagine and make things beyond nature.' (ibid.) Williams omits to mention that for Shakespeare, nature rather than God, or perhaps nature as a divinity, could be regarded as the author of all creation. In *The Winter's Tale* he has Polixenes ingeniously argue that man's creations are an attempt to improve on nature, but that the art he makes is still no more than a product of nature, since man is but a product of nature himself. Whether from nature or divinity, the point is that, historically, creation was regarded as coming from an impersonal source, rather than being an expression of individuality as it is today.

To some extent this is so even into the romantic period, although of course the artist's subjectivity and struggle were becoming much more important. Wordsworth wrote to Benjamin Haydon in 1815 'High is our calling, friend, Creative Art.' (Williams (1983) P.83) This sentence has a feeling of divine attribution in the term 'a calling', a phrase still used by novitiates to explain their entry into the priesthood. But it is interesting to know that Haydon, the painter to whom Wordsworth wrote, later committed suicide in his studio because of his sense of having failed to become a great painter. For by this time, during the eighteenth century in England, France and Germany, the notion of genius had taken hold and according to Williams the concepts of genius and creation developed closely together. It was as if the Muse fell towards Earth and the artist or poet identified with her to save her from falling. To an extent it is still the case today that the idea of being creative has connotations of a high calling, reserved for the artist as genius, a Jackson Pollock or a Jacqueline du Pré. A recent Tate Gallery poster claims 'There's no mistaking a Pollock, it has genius splashed all over it.' Why does our culture need such myths which obfuscate truth and repress thought?

However this elitism began to lose some of its force even in the nineteenth century. In his widely read *Stones of Venice* Ruskin (1851) enthused over the craftsmanship of the basilica of St. Mark's as much as its architecture. He was contrasting hand made carving produced by the individual craftsman, which he felt had an essential humanity, with the mechanical quality of mass produced commodities whose hardness and exactitude had for him connotations of the exploitation of human labour. In 1890 William Morris, influenced by Ruskin, wrote *News from Nowhere*, an allegory of a twenty-first century Utopia that he envisaged as taking place after the socialist revolution which he and his friends were working for. In this narrative our hero (Morris himself) dreams that he awakes after a long Rip Van Winkel-like sleep and steps into a brave new world that exists sometime after the year 2000. Finding himself on the banks of the Thames on a bright June morning (the water of the Thames crystal clear with salmon swimming in it, since pollution has been cleared in the late 20th century) he takes a ferry across the river. He notices that the ferryman is a handsome, friendly man and that

> ...his dress was not like any modern work-a-day cloth I had seen, but would have served very well as a costume for a picture of 14th century life. It was of a dark blue cloth, simple enough, but of fine web, and without a stain on it. He had a brown leather belt round his waist and I noticed that its clasp was of damascened steel beautifully wrought. (P.183)

In the conversation that follows Morris discovers that his ferryman is knowledgeable about metal working, and considers the hand-chased coins of the period of Edward III far superior to the mass produced, mechanical images of Queen Victoria's time which he (and therefore Morris) describes as 'beastly ugly'. It then turns out that our twenty-first century ferryman, a working man, is an enthusiastic metal worker and has himself made the beautifully wrought buckle he is wearing.

In this Utopian vision there are two significant shifts from the romantic notion of creation which are distinctly modern. Creative ability was no longer just the preserve of the higher arts. Quite ordinary crafts using cloth or metal could be the product of human creation. Neither divine genius nor elite training was a prerequisite for creation. The ordinary person could turn his hand to making and could become a creative artist or craftsman.

Morris's Utopia amounted to a vision of and belief in the democratisation of creativity. It was exemplified by praxis in his life's work as a craftsman and not just in his writings. But earlier than Morris, Friedrich Froebel had opened the first kindergarten in 1841 where he had stressed the importance of pleasant surroundings, self-directed activities and play in the development of the child. In the 20th century his ideas were developed further by Maria Montessori, who introduced eurythmics, paint, clay, the crafts, music-making and creative writing into our educational system. She believed that pre-school children given an environment rich in manipulative materials would teach themselves. The notion of creativity as a specific human psychological faculty arrives.

Psychoanalysis and creativity

I may be wrong, but I do not detect much interest in creativity per se in Freud, although he developed the notion of sublimation of basic instincts to explain cultural activities in general and the higher and sublime achievement of symbol formation. Perhaps he was born a bit too soon to tackle creativity as a process? He was of course extremely interested in art and literature and frequently analysed their content, often in terms of biography. Jung certainly did write about creativity and the creative process in connection with art and the notion of creative living. Freud eventually rejected the idea that psychoanalysis had anything to contribute to aesthetics or the understanding of art. Jung was of the same opinion, and in fact took the traditional view that essentially art is not charged with personal qualities, believing that '...the personal is a limitation, yes, even a vice in art' (Jung 1953 P.177), although he did believe that psychology could look at the mental processes that lead to forming art.

Within the Freudian tradition it is the object relations analysts who developed theories to explain creativity. Melanie Klein regarded creativity as motivated by a need to make reparation to a damaged good object that had been previously attacked in phantasy. She understood that the excessive need to make reparation led to the compulsion, in certain cases, to make art – a sort of sublimation of anxiety rather than instinct. Klein also researched the play of infants which she regarded as involving a creative process, thereby giving the term a new dimension. The act of playing was a rehearsal in a symbolic way of the experience of pain in order to overcome it. Play therefore gave rise to symbol formation.

Donald Winnicott's view of creativity was I think quite different from that of his predecessors. For him it was a state of mind rather than a capacity to create objects. He was highly critical of Freud's biographical analysis of Leonardo da Vinci, saying that the direction of the inquiry was wrong. Winnicott was not interested in making a distinction between the production of a work of art and that of craft. For him an oil painting or a symphony equalled a garden or a hairstyle. These

are creations and should not be confused with creativity of the individual, which he defined as a state of being alive. Creativity was the opposite of compliance with the outside world and a feeling of deadness. Like Klein, Winnicott regarded play as the root of creativity and the origin of symbol formation. Unlike Klein he felt that play was an expression of joy and was a learning activity rather than having a reparative function. It was play with the transitional object (i.e. corner of a blanket or doll) that enabled the infant to make a connection between mother and the outside world, and to understand the difference between the 'me' and the 'not-me' and this creative play gave the infant the confidence to perceive that life in the environment was worth living and full of potential.

I find it impossible to adequately summarise Marion Milner's ideas about creativity. She describes the history of her own development towards creative living in her books, particularly in *A Life of One's Own* (Milner 1988). Her views are a development of Winnicott's. In her paper on him (Milner 1987) she writes of her ideas of creativity as:

> ...not simply perceiving, but as deliberately relating ourselves to our perceiving. It is perceiving that has an 'I AM' element in it. P.249

In his *Critical Dictionary of Psychoanalysis* Charles Rycroft (1972) has a section on creativity (there is none in Laplanche and Pontalis (1973)) where he points out that:

> ...the concept raises problems as to whether it is a general aptitude, in which case everyone could become creative if his inhibition were removed, or a special gift, in which case psychoanalysis has to admit exceptions to its categories. P.26

I think this is where most confusion lies when psychoanalysts and therapists talk of creativity. Do we mean creativity leading to Art, a special faculty of the Artist, or creativity common to all? If we mean only those designated great or geniuses then what happens when the canon of great writers, musicians and painters shifts about with time? In the past 100 years Piero della Francesca has moved from a minor position to become a great painter. Edwin Landseer, once great, is now regarded as second rate, no longer worthy of analysis. If we talk of creativity as a special aptitude of the artist then where do we draw the line? Can we include bad artists? Is the distinction between good artists and bad artists merely a matter of taste? What about minor artists, amateurs, popular artists, photographers, rock composers and performers? Are their creative processes special?

Rycroft's question asks us to think about whether or not the creativity we have in mind derives from the romantic notion of artistic genius. If so are we trying to understand the mental processes of people who, according to received wisdom, are essentially different from a norm that psychoanalytic theory works around? It follows that we need new theoretical equipment. Or, to take Rycroft's other option, are we trying to understand and facilitate the more prosaic making-processes potentially available to everybody and therefore universal, as promoted in different ways by William Morris and facilitated by Froebel, Montessori and Winnicott et al? In this case psychotherapy and psychoanalytic theory might have something to offer.

Rycroft's first definition of creativity is 'The capacity to arrive at novel but valid solutions to problems' (Rycroft 1972.P.25.) According to this definition there is a kind of creativity that has no obvious end product but is a mental process. Lateral thinking would be a good example. His second definition is 'The capacity to create imaginative products which are compelling, convincing, significant.' (P.25/6) A powerful advertisement for toothpaste or cigarettes would fit this definition very well. And oddly, most adverts are the product of a team, visualiser, photographer, copywriter and creative director, rather than any one individual. Perhaps the theories of group therapy are more applicable here if we wish to understand something about creative dynamics. Rycroft's two notions of creativity, as problem-solving and as the production of a significant object, lead us to the present day preoccupation with creativity in the world of work.

The rise and rise of creativity

Creativity is now being promoted by business, and research and development is being brought to bear on what creativity might be and what its benefits are. The received wisdom has been that:

> ...employees' satisfaction with their work and a positive view of the organisation, combined with relatively extensive and sophisticated people management practices, are the most important predictors of the future productivities of companies. (The Observer 1999)

Now under the auspices of the *Institute of Personnel and Development* (IPD), research shows that human playfulness in the workplace leads to an improvement in 'innovative activity and creativity.' (ibid.) The research also shows a negative correlation between high levels of stress and creativity. But a distinction as to the value of creativity is made between the kinds of industry where it is deemed useful and those where it is

destructive. In older traditional institutions like law and insurance, creativity can be disruptive and destabilising, whereas in certain entrepreneurial groups, in the financial sector and in services, creativity is found to be beneficial, even necessary to their survival. Research shows that creative thinking flourishes where there is an atmosphere of trust and can easily be blocked by the strangling of innovation by committee. It emphasises the importance of permitting play and an atmosphere of tolerance towards non-compliant behaviour.

Sooner or later capitalism appropriates everything. In the last century the Tate Gallery was financed by a sugar magnate. In our own century Sainsbury financed the National Gallery extension. The exhibitions of an Ingres at the National Gallery or a Monet at the Royal Academy become part of the corporate identity of their promoters. Now, just as the corporate institutions are financing the creative arts, the arts are reciprocating. The Royal Shakespeare Company, sponsored by Allied Domecq, has provided a programme to transfer to the world of business the creativity, dynamism, originality and team work that goes into its theatrical productions, specifically for the world of business, in order to promote their capacity for creativity. This course, called *Directing Creativity,* offers creative team building techniques as used by leading directors in the theatre. It offers analysis of working relationships and how groups can solve problems. It teaches managers how to develop the tools to direct the creativity of their staff. Business people who have done the course report very favourably.

If we contrast this concept of creativity, such as it is, with that of Winnicott or Milner we can see that there are few similarities. Such a management led approach could lead to compliance and alienation, particularly if it fortifies a power relation between the individual and the institution by the use of a coercive ideology. Some grass roots interest might need a voice in order to check that the balance between the collective good and the interests of the individual is not tipped too much towards management and mammon.

Creativity is a highly topical, almost fashionable subject. It has become a buzzword. These days we have creative writing, creative photography, creative advertising, creative accountancy and of course creative therapy. There are many individuals who long to be creative or to have creative faculties or are envious of those who apparently have them in excess. Creativity is now almost like fame, everyone should have a right to at least 15 minutes of it in the course of their life. Perhaps the concept describes the typical neurosis of the western world in the late twentieth century that has replaced the hysteria of the late 19th century as a focus of discontent and anxiety. Both Martin Buber and Winnicott recognised the preoccupation but each was using creativity in a different sense. Buber felt that the dominant delusion of our time was that artistic creativity is the criterion of human worth. In *Playing and Reality* Winnicott (1971) wrote:

> In a tantalising way many individuals have experienced just enough of creative living to recognise that for most of the time they are living uncreatively, as if caught up in the creativity of someone else, or of a machine. (P.65)

In a country or a time when people are desperately poor and struggle to survive, it would hardly be uppermost in people's minds as an aim or a problem. Perhaps the term creativity, as a faculty, was invented in our period, an age of mechanisation and de-skilling and conspicuous consumption, because we need a means to express our discontent. If only we could abandon the concept of creativity and get on with being creative, however we frame it. But there is an anxiety around the feeling that we need to make something out of our lives and that we do not always do so adequately, which is real enough in the western world as any therapist would testify. There is a difficulty because the concept has become closely associated with adjacent concepts of self-expression, free expression, play and genius which induce further feelings of inadequacy.

I prefer to associate creativity with the capacity to work, but this must involve more than mere drudgery and therefore means a kind of work which includes an element of imagination or fantasy. Rodin made a comment about sculpting being an activity involving 99% hard work and 1% inspiration. I like this, because it is down to earth and does not preclude baking a cake as having an inspirational element. A difficulty arises when the person making, feels that the thing made is not good enough. Hence the report about 'the madly anxious Matisse' made by one of his friends. A too unkind sense of self-judgement can inhibit the making process and be destructive. Matisse was evidently strong enough to live with whatever doubts he had.

The process of making, however one defines it, must involve a large measure of mental energy going outward, away from the self, towards not-self, a state of consciousness of otherness. That other may be another person or the sensation of a thing, or the solving of a problem, or the making of an object. It is the making of a 'not-self' out of one's self. For this reason I think that most of our production reveals very little about ourselves.

Creativity is a construct – a signifier. It is a way of talking about mental processes and is not a faculty with an essence. We have seen how many definitions there are, none definitively true or false. The difficulty is that we can go on endlessly extending its meaning until it comes to mean so many things that it is applicable to almost everything, and therefore means practically nothing. My own hunch is that creativity is a concept which is too overloaded, and has insufficient history to be of much use in the long run unless we learn to use it in a more disciplined or more specific way.

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Reviews

Committed Uncertainty in Psychotherapy: Essays in Honour of Peter Lomas. Lucy King (Ed). Whurr Publishers, 1999. Reviewed by Vivienne Seymour-Clarke

This book really is a joy to read. Each chapter, in its own unique way, communicates the ordinary humanity and honesty of the approach to therapy and its underlying ideas that Peter Lomas has both written about and practised, and for which he is so respected, valued and loved by those who have encountered him and his work.

As a whole the book is rich and diverse, containing many gems. It is impossible in just a few words to pay each contributor the honour they deserve for honouring Peter Lomas in this way and of course I am unable to write from a position of detachment; training as a psychotherapist with the Outfit remains one of my most valued experiences, both professionally and personally, and being supervised by Peter Lomas for three years was a very important part of that process.

There are twelve excellent chapters in which the writers speak 'from the heart' about being in therapy, imagination and metaphor, ethics and power and the concepts of ordinariness and humanity in the therapeutic relationship. Aspects of Freud's work are re-examined and a case is made for recognising the science in psychotherapy; while a compelling alternative argument for the central importance of the therapist as person is presented in another chapter.

I found the interview between Peter and Sian Morgan particularly moving, partly for the personal reason of my felt connection to each of them, but also for the way in which a shared anarchic spirit, humour, honesty and straightforwardness is portrayed through the congruence of their relationship. Their conversation unfolds in everyday language to reveal aspects of his early life, the evolution of his philosophy, his dislike of rigidity and fundamentalism in all its forms and his valuing of the ordinary in the therapeutic relationship.

The conversation with Sian in this second chapter (following a sensitive and illuminating first chapter by Michael Jacobs on Peter's life and work) takes us on a journey through his ideas about therapy, '...I would like to ask you what you think heals?' and on to training, raising some challenging questions for all therapists including our defensive reliance on technique and the central issue of power in the relationship. They also highlight the difficult but essential tasks which await the student therapist, such as gaining confidence, trusting intuition and integrating learning into a personal way of being helpful to people in distress. The reader feels invited in to hear their conversation and I was left with a sense of curiosity, engagement and desire to ask questions. The interview ends with Peter talking about the people and ideas he has drawn inspiration from and I was struck by the qualities he admires in those people, being brave, taking risks, having courage, honesty and being ordinary - the very qualities that we recognise in Peter himself.

Because of a personal interest in ideas from systemic and narrative therapy I particularly enjoyed Eia Asen's chapter, *The limits of technique in family therapy*, and his hope that both individual and systemic therapists will rediscover and learn from each other. 'Once therapists fall in love with their models and believe these to be true and universal, complexity is likely to be reduced to some banal principles, with 'invariate' prescriptions or other entirely predictable interventions levelled at anyone, irrespective of their personal characteristics or family circumstances. Whilst such a stance may be reassuring to the therapist it is probably of rather limited value to clients and their families' (p128).

For me this statement alludes to a common theme in the book; one of encouragement to therapists to be curious and sceptical, to develop their intuition, refine their integrity and ethical practice and not to run for cover to the received wisdom of solidified theories.

In an eloquent final chapter David Ingleby describes the key features of Peter's approach to the theory

and practice of psychotherapy, an approach he describes as containing, 'Not answers, but questions; not dogmas, but doubts.' With occasional wry humour as in, 'The role of God is so immensely rewarding that few can be trusted not to take advantage of it,' he contextualises and considers the key issue of power in the therapeutic relationship and Peter's vital contribution to this debate.

Everyone interested in therapy, whether client or therapist, would benefit from reading this book. Professional and personal passions are clearly articulated throughout and the very independence and individuality of the views expressed ensure that they combine into a fitting tribute to Peter Lomas which truly honours his approach to therapy.

Flow—the psychology of happiness. Mihaly Csikszentmihalyi. Random House, 1992. Reviewed by Margaret Farrell

This book was given to me recently when I was speculating on the subject of happiness, and wondering how little it is attended to by psychotherapists. Having read it, I also went back to the well-known book of the late sixties, *Joy*, by William Schutz, and to various Buddhist studies on happiness.

The American Declaration of Independence makes the powerful statement that man is endowed with an unalienable right to the pursuit of happiness! I started thinking of the various words we use to express this condition, moving from contentment, pleasure and happiness, to joy, excitement, ecstasy, and bliss. We wish for all of these states – but perhaps some of them are more permanent or even more desirable than others. Most people who come to see us as clients or patients are in some way saying that they suffer from a lack of these things. Sometimes it is a temporary lack: a person feels he/she is leading a reasonably good life, but is plagued by spasms of obsessional doubting, restricting phobias, or unsatisfactory relationships. But often it is because they feel that life is somehow grey, 'not real,' or that they are depressed or anxious too much of the time – they are 'unhappy.' On our side, we aim to use our training and knowledge to help them to review the narrative of their past, to make links where the links were repressed or broken, to experience a different way of relating through their relationship with us, through the 'corrective emotional experience.' Often, it seems to me, the patient or client is clear that he/she wants to be helped to be 'happy,' but we, gloomily or dutifully, refer in our minds to Freud's beautiful but discouraging essay on happiness in *Civilisation and its Discontents* and his pessimistic conclusions about the Death Instinct.

Therefore I wondered if Csikszentmihalyi could teach us, and through us, our clients, something new. His first chapter is called 'Happiness Revisited.' For the past thirty years, as a professor of Psychology at the University of Chicago, he has been researching happiness, which he also defines as 'optimal experience', or 'flow'. He says that it is 'a condition that must be prepared for, cultivated, and defended privately by each person. People who learn to control inner experience will be able to determine the quality of their lives, which is as close as any of us can come to being happy.' He says that 'the best moments usually occur when a person's body or mind is stretched to its limits.' He speaks of the difficulties inherent in finding solace in religion or culture, and says 'there is no way out except for an individual to take things in hand personally,' by which he means control over consciousness. He emphasises the importance of finding rewards in the events of each moment. Since reading the book, I have discovered that 'Flow' is extensively covered on the Internet, (complete with a photograph and aid to pronunciation of Mihaly Csikszentmihalyi) where it is defined more succinctly as 'a state of concentration so completely focused that it amounts to absolute absorption in an activity...everyday experience becomes a moment by moment opportunity for joy and self-fulfilment. Feelings of chaos, indecision and anxiety disappear.'

Through his studies (questionnaires and interviews taken from several thousand respondents), Csikszentmihalyi isolated a number of 'elements of enjoyment' (as opposed to evanescent pleasures). These included mainly: doing challenging activities requiring skills, the merging of action and awareness, setting clear goals, concentration, involvement, and the loss of self-consciousness. In all these, experience is an end in itself, which he terms the 'autotelic experience.' He quotes Bertrand Russell as typifying an autotelic personality, saying: 'I learned to be indifferent to myself and my deficiencies; I came to centre my attention increasingly upon external objects: the state of the world, various branches of knowledge, individuals for whom I felt affection.'

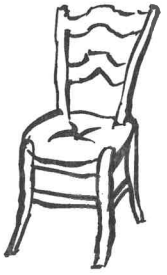
The final chapter is headed 'The Making of Meaning.' As he reaches his conclusions, he says: 'Purpose, resolution and harmony unify life and give it meaning by transforming it into a seamless flow experience... A person whose consciousness is so ordered need not fear unexpected events, or even death. Every living moment will make sense, and most of it will be enjoyable.' He acknowledges the necessity of drawing meaning from the past, and understanding better why we are as we are (perhaps a nod in the direction of psychotherapy!). The final sentence of the book speaks of the individual's purpose in merging with the universal flow.

I wondered whether Schutz said anything different. He comes from a different 'angle': while Csikszentmihalyi has done massive research. Schutz, although also from an academic background, is making a more personal statement. He arrived at his ideas whilst gazing at his baby son: 'when Ethan smiles, every cell of his body smiles, including his turned-up toes.' He also talks about total absorption, honesty and openness. I believe it was Schutz who was initially responsible for the 'human potential' movement, saying: 'Joy is the feeling that comes from the fulfilment of one's potential.' He specifically eschews too much talking or analysing: he feels that people get in touch with their potential through growth exercises, 'doing' rather than talking, through fantasy, dramatic, and non-verbal techniques. We, in the analytic tradition, can so often perhaps narrow-mindedly feel uncomfortable with this approach.

What of Buddhist teachings? In a sense they also advocate 'doing', although it is a very special form of 'doing.' All Buddhist sects advocate long and regular practice of meditation and the practice of mindful concentration in daily living. Thich Nhat Hanh, the Vietnamese Zen monk, says: 'To practice a life of deep observation according to the teachings of the Buddha is to have a life of peace, freedom, and joy, and to realise complete liberation.' The Dalai Lama said recently on the radio that the way to happiness is absolute compassion. Nina Coltart, in her essay on 'Buddhism and Psycho-analysis Revisited' (in *The Baby and The Bathwater*, Karnac, 1996) appears to agree with Schutz that the 'intellectual component...can get in the way ...it is the great sea of the unconscious that is the source of wisdom.' She emphasises the Buddhist aim of overcoming the 'Hindrances' (hatred, greed, anxiety, laziness, doubt and illusion) as the path to achieving happiness, equanimity and morality –which she sees as completely congruent with the goals of psychotherapy.

Why, in the end, was I disappointed with Csikszentmihalyi's book? There was no dearth of personal examples, and there was a refreshing lack of dogmatism. He includes ideas both from Buddhism, and from Schutz's *Joy*, as well as making a few respectful nods in the direction of Freud. He agrees with Freud and subsequent existential and phenomenological philosophers such as Heidegger, Sartre and Merleau-Ponty that the task of modern man is not simply to accept the rules of society, but to 'create harmony based on reason and choice' to choose the authentic rather than the inauthentic. But in the end I felt swamped by this compendium of worthy ideas and felt that I had lost the thread. I think that his most valuable idea remains that of 'flow' itself – the ability to concentrate intensely on the task and by so doing to lose consciousness of the self. I think that the Buddha had already put that more thoughtfully in 500 BC and had also emphasised Right Living and compassion – elements absent in Csikszentmihalyi's view of happiness. But what of the relevance for us, as psychotherapists and patients – indeed as people?

I think that we as therapists can get over-stretched, and over-stimulated by too many demands, too many ideas, and too much self-criticism. The danger of burnout may lie there. Perhaps by our attending more mindfully, or being more 'in flow' in relation to the immediate task in front of us we would reward both ourselves and those whom we are with. Buddhist (and even Christian) teachings on morality and kindness, taken not as super-ego precepts, but as guides to personal and interpersonal action may be much more important than many psychoanalytic writers have been willing to admit. And, outside the consulting room, more concentration, and more attention to the task in hand, rather than clocking in one more meeting, one more learned article, one more seminar, might keep us healthier – and happier.



Notes for contributors

We are planning to bring out the next issue of *Outwrite* in January 2000 and because it will be the Millenium we hope it will be an extra large number. As you can see from the editorial we welcome a wide range of writings, not only on psychotherapy. Please contact Michael or Rosemary if you have any ideas as it is important that we reflect the voices of the Outfit membership as widely as possible. We are glad to receive completed papers or to receive outlines or drafts if you would like comments at an early stage. It is helpful if you can put any references in the format of this issue and if you can send us the completed work on disc. Typed or hand-written contributions are also acceptable but are less convenient.

The deadline for contributions for the Millenium issue is December 1st 1999.

OUTWRITE

Journal of the Cambridge Society for Psychotherapy

Volume 1 Number 1 August 1999

CONTENTS

Published by The Cambridge Society for Psychotherapy, P.O. Box 240, Cambridge, CB1 7WA.