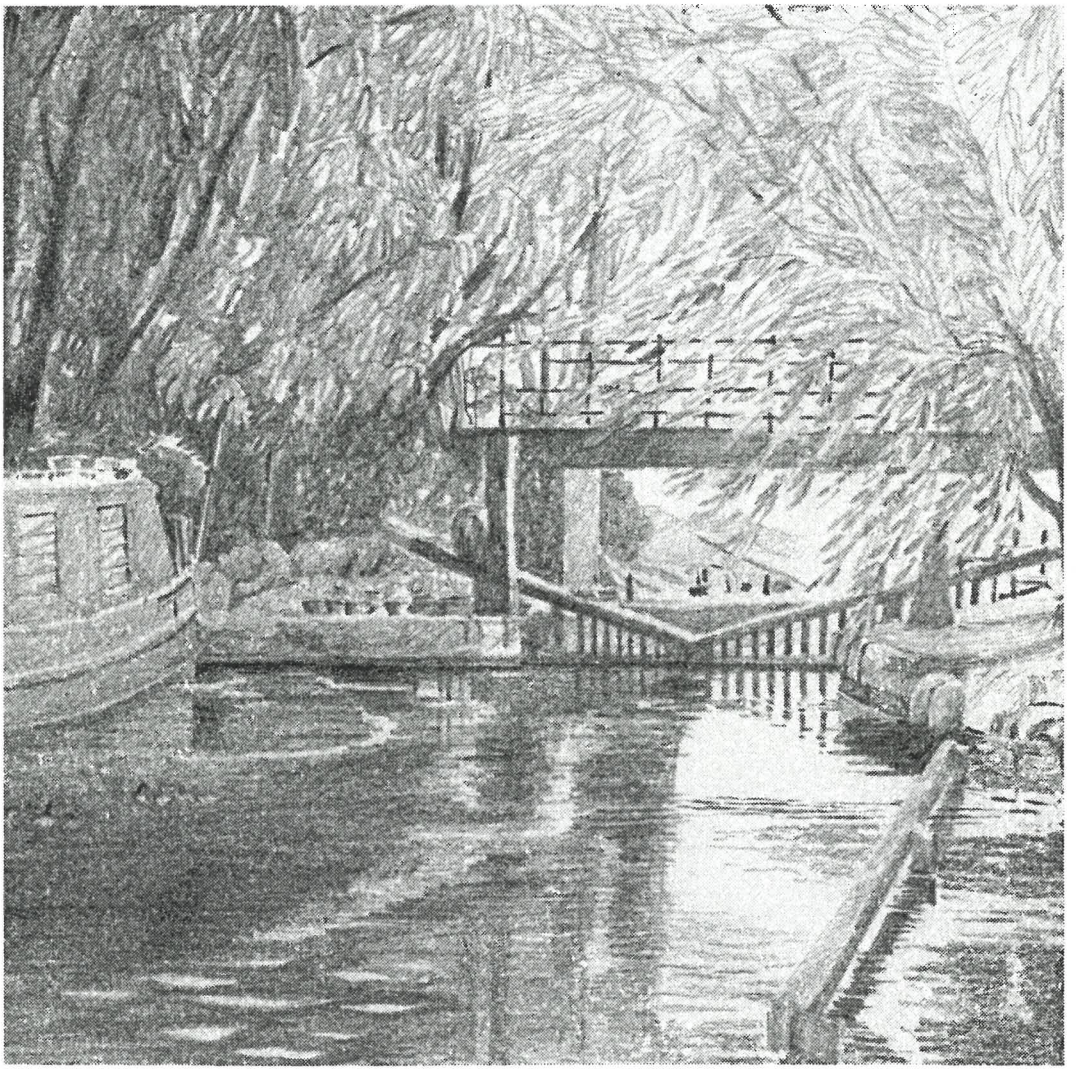
OUTWRITE

Journal of the Cambridge Society for Psychotherapy



Number 5 *December 2002*

Acknowledgments

The cover illustration and drawings in the journal are by Dorn Parkinson.

Many thanks to Jenny Corrigall, Carole Robinson and Jill Shields for help in proof reading.

Many thanks to Andy Brown, Rosemary Randall and Richard Dyball for technical help.

Editorial

OUTWRITE first appeared in August, 1999. Although the idea of a Journal for the Cambridge Society had been around for several years before that, it was solely due to the dedication, commitment and sheer hard work of the first editors, Michael Evans and Rosemary Randall, that the idea became reality. It is both an honour and a challenge for us to be following them as editors of such a stimulating and enjoyable addition to the life of the Outfit.

The pleasure involved in taking on this enterprise is tempered by a great sense of responsibility. The high standards established in the previous four issues present a challenge, if they are to be maintained. We quickly realised that there was no need to worry about the source of material – articles were presented with little prompting, evidence of the ongoing energy, talent and creativity in the Outfit – and we look forward to this continuing. The business of editing and production has been both worrying and interesting to us. We hope you enjoy the result.

We are delighted with the diversity of the articles in this issue. As we continue to celebrate 21 years as a psychotherapy training organisation, it is fitting to have Liebe Klug's memoir, in which she so engagingly describes some aspects of the Outfit's early days. At the other end of the time scale, we have a paper by one of the most recent graduates, Hilary Taylor, who has written a fascinating piece on the concept of triangulation in her work. Mike Bell, also a recent graduate, shares his understanding, based on many years' experience, of some of the issues involved in working with those who use drugs. Michael Evans' review of the new edition of Peter Lomas' *The Limits of Interpretation* challenges us to look deeply at our practice of psychotherapy; Michael has also contributed a thought-provoking short story. Barbara Tregear's stimulating account of the theory and practice of psychodrama will broaden our ideas of creative working, and Nick Hay draws on his experience as a group therapist in a psychiatric setting to review a recent television programme about a troubled adolescent boy. We are fortunate to have Kalu Singh's characteristically provocative article involving some new kinds of scenarios in practice, which all of us are probably encountering. Lastly, and perhaps of particular interest to those who have doubts about writing, Peter Lomas explores some of the difficulties (and drives) involved in his own writing.

Recently, one of us (PT) spent some time in the USA, always a culture shock, in the sense that one looks with a stranger's eyes. There, every historical site, every place of interest or beauty had its own 'Interpretive Centre', which described, explained or gave the history or theory of the place/event. Bearing in mind the limits of interpretation, might each one of us be working in a consulting room which is an 'Interpretive Centre'? At the least, each of the papers in this volume is an Interpretive Centre from which, we hope, outgoing ripples will lead us to wider thought and new juxtapositions of ideas.

Carol Dasgupta and Pat Tate

Mike Bell

Psychotherapy and drug use: in the drug clinic and in the consulting room

Introduction

Over a number of years, I have worked as a specialist Drug and Alcohol Nurse in the National Health Service, and at the same time I have been a student psychotherapist. I have found that my developing understanding of psychoanalytic thought has informed my work with clients of the Drug and Alcohol Service and, in particular, I have formed two ideas about the possible aetiology of problem drug use. Similarly, my experience as a Drug and Alcohol Nurse has influenced my work as a psychotherapist, in particular through an awareness of the importance of drugs in the lives of many people who do not have an identified drug problem.

In this paper, I will briefly outline the position of drugs in society as I see it, consider possible definitions of problem drug use and mention some psychoanalytic views on the subject, before going on to discuss my own ideas about aetiology. These are, firstly, that problem drug use may arise from inadequate experience of the good breast in infancy and, secondly, that it may be the result of invasion of personal boundaries at any stage of childhood. The second idea is illustrated by two brief case studies. I will then discuss to what extent it is possible to work psychotherapeutically with people experiencing such problems and how an understanding of psychoanalytic concepts may help the worker. Finally, I will briefly consider how any patient's relationship with drugs might helpfully be explored in therapy.

Background

The issue of drugs in society generates a great deal of interest and anxiety: any review of the media will quickly reveal stories containing evil pushers, drug-crazed addicts, innocent victims, worldwide cartels and so on. Yet the subject gives rise to hypocrisy in equal measure, since references to 'drugs' generally exclude alcohol. The headlines therefore obscure the reality that alcohol remains by far the most harmful drug in our society, in terms of overall cost to the Health Service, levels of violent crime and number of road traffic accidents, and that the problems arising out of drug use cannot fairly be reduced to good guy/bad guy or good drug/bad drug.

The notion of a drug takes many forms, but for the purpose of this paper I will use a definition developed by the World Health Organisation: a drug is 'any substance, other than those required for the maintenance of normal health, that, when taken into the living organism, may modify one or more of its functions' (Ghodse, 1995 pp.1-2). By this definition, virtually all of us use drugs, whether a cup of tea to perk us up, paracetamol for a headache or crack cocaine to 'blow our heads off' and we must all therefore have developed a relationship with them which suits us in some way.

For some of us, however, this relationship becomes problematic and it is therefore worth considering what distinguishes problem drug use from the rest. It is not simply the case that some drugs are harmful while others are not. Heroin, for example, which does so much well-publicised damage in some contexts is, in others, used for safe and effective pain relief. Conversely, medicinal drug use, even under medical supervision, can become problematic, for example when some tranquillisers are prescribed over a protracted period. Nor is it the case that drugs are necessarily harmful when used for non-medicinal purposes. A glass of wine can be enjoyable and possibly beneficial, yet alcohol in excess can destroy lives, both metaphorically and literally. Clearly context, quantity, frequency and motivation all play a part in determining whether or not drug use is a problem.

In his paper *'A psychoanalytical theory of Drug Addiction'*, Hopper (1995, pp.1123-1124) recognises five levels of drug taking:

a) Drug 'use': the benign use of a potentially addictive drug either in social situations or under medical supervision, which may not lead to the abuse of it, but warns of possible misuse, especially in a person with other emotional difficulties and within the context of a particular lifestyle.
b) Drug 'misuse': the use of a potentially addictive drug outside of medical supervision or inconsistent with medical advice, which may not lead to the abuse of it, but indicates a tendency to self-prescribe and to over-indulge, and warns of possible abuse.
c) Drug 'abuse': a maladaptive, recurrent pattern of drug use leading to a significant impairment or distress within a twelve-month period as indicated by: a failure to fulfil major role responsibilities at work, school or home; use in situations that are physically hazardous (for example, when driving); legal problems; and social and interpersonal problems.
d) Drug 'dependence': a chronic, progressive and often fatal illness that includes the following elements: the compulsive use or re-use of a drug involving the loss of control of it, and the continual use or re-use of it despite adverse consequences. The diagnosis of drug 'dependence' requires that during a twelve-month period of time at least three of the following occur simultaneously: the development of 'tolerance', involving either a need for increased amounts of the drug to achieve the same effect or a diminished effect from the same amount; 'withdrawal' symptoms, variations in them depending on the drug; taking larger amounts of the drug or using it over a longer period of time than intended; persistent desire or unsuccessful efforts to reduce or control the use of the drug; giving up 'important' social, occupational or recreational activities in order to use the drug; and continuing to use the drug despite knowledge of having persistent or recurrent physical or psychological problems that are likely to have been caused or made worse by the use of the drug.

   It is widely acknowledged that dependence on a drug involves two components: physiological dependence and psychological dependence:
   i) Physiological dependence refers to tissue dependence on the drug, and is evident in a tolerance for it and in the presence of withdrawal symptoms. Over a long period of time, metabolic tolerance develops, and a person needs the drug in order to feel that his body is 'normal' and in order to prevent withdrawal symptoms. Withdrawal symptoms include confusion, anxiety, insomnia and nausea, and tend to be opposite to the usual effects of the drug, e.g. withdrawal from depressants causes anxiety and withdrawal from amphetamines causes mental and physical fatigue. Tolerance and withdrawal can set up a vicious circle, in that as more and more of a drug is needed in order to produce the same effects, the stronger and stronger are the symptoms of withdrawal from it, and then more and more of the drug is needed, which may ultimately lead to overdose.
   ii) Psychological dependence refers to the fact that the perception of 'feeling normal' is subjective. Withdrawal from a drug on which a person has become psychologically dependent may produce a pattern of symptoms similar to those produced by withdrawal from a drug on which he has become physiologically dependent. In other words, a person may develop the belief or perhaps conviction that he cannot function without his drug. There are many variations on this theme. For example, some people abuse drugs daily, others go on 'binges' and 'benders', analogous to certain types of eating disorders and of alcoholism, and some abuse drugs only on specific occasions and in specific circumstances.
e) 'Addiction': a physiological and psychological dependence on a drug, also implying 'habitual' and 'severe'. The addict craves to use a drug in particular ways, amounts and frequencies that are harmful to himself and to those with whom he is in relationships.

Hopper's is a helpful and thorough overview of types of drug use. Nevertheless, I would take issue with the implication that drug misuse cannot occur while following medical advice and also with the suggestion, through the use of the word 'alcoholism', that alcohol is somehow qualitatively different from other drugs.

Another way of defining different patterns of drug use (after Tyler, 1989) also proposes categories which increase incrementally in terms of amounts taken and problems experienced. Tyler's classification starts with 'experimental' use, which is an isolated occurrence and with no particular drug of choice. Repeated use may go on to become 'recreational', where the user develops a drug or drugs of choice but experiences few negative consequences, which in any case are outweighed by the perceived benefits. Problems begin with the 'restrictive' category, where the user attempts to conceal his use and/or tries to cut down or stop. The final category in this model is 'dependent', where physiological and psychological features of dependence are present, where other health

problems are emerging and where other areas of the user's life are affected.

Hopper's criteria are, I think, more medically oriented than the framework put forward by Tyler but they share the idea of a progression of increasing use, which becomes problematic as tolerance and dependency take hold and as the user's need for the drug overrides important considerations regarding their physical and psychological well-being.

For the purposes of this paper I will refer to 'problem drug use', defined as any drug use, including use of alcohol, which has been recognised by the user, or by those with whom they come into contact, as a problem which affects their physical, psychological or social well-being.

I now want to consider some psychoanalytic views on drug use. The idea of viewing problem drug use as a symptom of deeper pain rather than as a disease is by no means new. As long ago as 1898, in *'Sexuality in the aetiology of the neuroses'*, Freud (1898 p.276) wrote:

> Not everyone who has the occasion to take morphia, cocaine, chloral hydrate, and so on, for a period, acquires in this way an 'addiction' to them. Closer enquiry usually shows that these narcotics are meant to serve – directly or indirectly – as a substitute for a lack of sexual satisfaction; and whenever normal sexual life can no longer be re-established, we can count with certainty on the patient's relapse.

Glover (1956) suggested that drug addiction arises out of an attempt to cope with or avoid psychosis and Khan (1979 p.153) saw addiction as having 'the unconscious significance of incorporating a good substance, which would neutralise (the addict's) bad inner substances'. Wurmser (1985 p.95) stated that, when considering the formation of addiction, 'far more attention should be paid to child abuse, especially to those forms involving physical and emotional cruelty'. More recently, Good (1995 p.150) has viewed addiction as a narcissistic defence in which 'the drug symbolically represents the object that cannot be experienced as separate, and ... the use of the drug means that the (user), in phantasy, gains control over the internal object...as well as his or her emotional state'.

Some personal thoughts about the aetiology of problem drug use

The first idea I wish to put forward is that the behaviour and experience of people with severe drug problems bear a striking resemblance to the behaviour and experience of infants. In particular, problem drug use may be seen as a doomed attempt to compensate for inadequate infantile experience of the good breast.

In terms of behaviour, one similarity between the drug user and the infant is their demand for immediate gratification. The stereotype of the 'junkie' who screams for his drug until he gets it can be quite accurate and certainly reminds one of the infant's 'I want it now' approach. Examples of this kind of behaviour are commonly exhibited by clients of the Drug and Alcohol Service who hope to receive prescribed drugs. They often find it hard to accept that a prescription will not be issued until they have completed an assessment process involving three distinct stages and taking at least two weeks. Despite this policy being made clear in the initial appointment letter and at each subsequent stage, at assessment interviews they will often insist 'I was told I would get a prescription today', become increasingly angry and, not uncommonly, storm out. And the problem does not end once a prescription is issued. Prescribed drugs are initially dispensed from the Drug and Alcohol Service's own pharmacy, which closes at 12.45pm. It is a common occurrence for a client to arrive after 12.45pm and literally to scream and shout, occasionally banging doors, because they cannot get their medication.

The similarity between this and an infant's tantrum is very striking. I believe that for many of these people, the desired effect of the drug is the illusion of omnipotence, and the disappointment they experience when they are thwarted in this is profound. The process of giving help therefore includes the aim of their becoming able at least to tolerate some delay in gratification and, after Milner (1987 p.105), 'to accept the symbolism of speech and talking about their wants rather than taking action to satisfy them directly'.

There are other striking similarities between the infant and the drug user. As the moment of taking the drug approaches, the user commonly experiences mounting excitement coupled with increasing anxiety that something will go wrong. In extreme cases, injectors will frantically stab away at their flesh trying to find a vein to connect them with their drug. This is reminiscent of the baby who, in the frenzy of an anticipated feed, will latch on to almost anything. Having satiated itself, the baby frequently nods off – just as the heroin user 'gauches out' (becomes extremely sedated) or the drinker falls into a drunken stupor. When no drug can be obtained, however, the user becomes increasingly uncomfortable and then ill. The physical symptoms are accompanied by a feeling of mounting rage: a sense that this is a matter of life or death. In the case of alcohol dependency, withdrawal may indeed lead to death as a result of a fit. Again there is a strong similarity with infancy – the infant needs feeding and will become increasingly distressed without it.

I wish to suggest, therefore, that the relationship of a user with their drug in some ways resembles that of an infant with the breast or, more precisely, with an unsatisfactory breast. In normal development, the baby gains enough comfort and nourishment from the breast for the memory of this experience to sustain it in the absence of the breast itself. In other words, the good breast is sufficiently predictable for the infant to be able to internalise it. Where experience of the good breast is inadequate, however, the craving for it may be heightened. Drugs might appear, like the breast, to offer comfort in the form of some desired effect, but actually the experience of drug taking is unpredictable and often involves effects other than the one desired. Furthermore, drugs provide no nourishment. In both these ways, therefore, they resemble a frustrating, bad breast.

The dependence on and craving for a drug is paradoxically heightened by the unpredictability of its effects. Anybody who has been a regular smoker of cigarettes may recall hoping for a 'good' cigarette – one that really 'hits the spot', gives that feeling of calm, well-being or even that 'buzz' – when in reality most cigarettes are ordinary, perhaps even a disappointment. In biological terms this can be explained by the level of the drug in the bloodstream: the first cigarette of the day may be the one that gives a good 'hit' because nicotine levels have fallen steadily during sleep. Thereafter, depending on the frequency of use, the effect will be less noticeable because the smoker is simply topping up the nicotine levels. If this example has little meaning for you, you might find the same applies to the first cup of tea or coffee of the day. With illicit drugs the effects are even less predictable: the concentration will be unknown and an injector may miss a vein and instead inject their drug just under the skin, causing a painful lump or abscess with little or none of the desired effect. In the worst cases the injector may accidentally hit an artery, causing calamitous loss of blood and requiring urgent hospital treatment.

I believe that this element of risk and the associated excitement is one of the reasons why people get drawn into problem drugtaking. Additionally, the uncertainty serves to reinforce dependency by increasing the extent to which the 'good hit' is idealised. According to Klein (1952 p.64), there is also a tendency for the very young infant to idealise the good breast. The 'perfect high' or 'good hit' may therefore be regarded as representing the 'ideal breast', which 'should fulfil the greedy desire for unlimited, immediate and everlasting gratification' (*ibid.*). Klein goes on to say that 'another factor which makes for the idealisation of the good breast is the strength of the infant's persecutory fear' (*ibid.*) and this fear can be seen as paralleling the anxiety and uncertainty associated with drug use.

For many people, unsatisfactory early experiences may be overcome, or their effects modified, by subsequent events. In some cases, however, where later experiences are less positive, we might hypothesise that inadequate experience of the good breast in infancy can lead eventually to drug problems: the user substitutes the drug for the breast they lacked. Yet at the same time their unconscious drives compel them to repeat the unsatisfactory experience of babyhood. For these people the drug can never be a good enough breast. They crave their drug to pick them up, to hold them, to soothe them, to stop them feeling ill. What they get is ambivalence, tyranny, frustration, disappointment and increasingly distant memories of bliss, ecstasy and omnipotence – especially as their tolerance to the drug increases, which it inevitably does. In the words of Klein (*ibid.*):

> Because the hallucinated breast is inexhaustible, greed is momentarily satisfied. (But sooner or later, the feeling of hunger turns the child back to the external world and then frustration, with all the emotions to which it gives rise, is again experienced).

Wurmser (1985) linked problem drug use with child abuse and my own experience also suggests that many of those who seek help from Drug and Alcohol agencies, like many who self-harm or who have eating disorders, have indeed experienced early transgression of their personal boundaries, commonly in the form of physical or sexual abuse. I would therefore like to explore the idea that this group of people later re-enact these transgressions by allowing themselves to be invaded in a wide variety of ways. They may also be unable to recognise or respect the boundaries of others.

The first and most obvious invasion is the chemical invasion of the body by the drug itself. It is worth noting that almost any substance introduced into the body can reach toxic levels – including, for example, water. The dangers associated with the use of any drug vary with the amount taken, its concentration, what it is taken with, how it is taken and how frequently. Where people have difficulty maintaining boundaries, they have difficulty setting limits, including on their use of drugs. Those who are injecting street drugs, particularly if they are sharing injecting equipment and are in an unhygienic environment, run the greatest risk: their illicit substance may be adulterated with far more dangerous substances than the one they seek; it may be in greater concentration than they expected, increasing the risk of overdose; their injecting equipment may carry infections; the other equipment (spoons, filters etc) and the water they use may also carry infections and, since they are puncturing their veins, they leave themselves vulnerable to many air-borne pathogens which are

given access to what nature intended to be a closed system. The self-abuse involved is reflected in the violent and/or sexual slang used to describe the activity and its effects, for example to 'have a hit' or to 'bang it up' for injecting and to get 'stoned', 'fucked', 'slaughtered' or 'shit-faced' for intoxicated.

In addition to the invasive nature of the drug-taking itself, further breaches of their bodies and personal space often arise as a result of these clients' lifestyles. In terms of their sexual activity they commonly report promiscuity, involvement in prostitution, and difficulty in maintaining relationships. Many also practise unsafe sex, which provides further opportunity for the transmission of disease. To these problems can be added the fact that this group of people are far more likely than the general population to be the victims of crime, including physical and sexual assault and intimidation as well as robbery, theft, verbal abuse and other less serious crimes.

Finally, I have noticed that these clients frequently have difficulties finding and maintaining accommodation. Those who are homeless and sleeping rough will clearly have the greatest difficulty protecting themselves from the elements, crime, police action, illness and pressure to use more drugs. Those in hostel accommodation will be out of the elements but the other risks may still apply. Those who manage to secure a tenancy often find themselves unable to maintain their space: they may fail to look after it materially, to pay the rent, to keep intruders out or to regulate guests and their behaviour when they visit. As a consequence, some tenants quickly find themselves evicted. Others find that they cannot cope, that they have no privacy and that the tenancy is more trouble to them than it is worth: they abandon it.

Along with this vulnerability to invasion comes an incapacity to respect boundaries in general, so that these people are often not only the victims but also the perpetrators of intrusive acts against others. These range from antisocial behaviour, such as the abuse of hospitality, to criminal offences, such as theft or soliciting to fund an illegal drug habit, or assault while under the influence of alcohol. Involvement in crime can lead to arrest, detention and ultimately imprisonment, in the course of which they may experience further verbal, physical or sexual abuse and a culture of illicit drug use.

People with the worst of all these problems tend to report the most severe difficulties in their childhood. There is a high prevalence of abuse, where their lives were characterised by serious transgressions of their boundaries, most notably penetrative sexual abuse or severe violence, often coupled with a denial of this reality by their carers. The point I wish to make here is that the greater the childhood experience of abuse, or intrusion into their bodies, the greater their difficulties in keeping themselves safe from repeated intrusion or, put another way, the greater their need to find some way of re-enacting the trauma. Those most severely affected struggle to keep anything out: people, drugs, infections.

This re-enactment of the boundary breaches of childhood abuse is possible because of a split between body and mind. The problem drug user is repeating the attacks made on their body by those who abused them; in order to survive the original attacks it was necessary for them to separate their mind from their body, which they handed over to the abuser in order to cut themselves off from the pain. The body is thus disowned and attacked, and becomes used as a thing. In later life the victim may go on to deal with anger towards their abusers by maintaining the same split: they are angry with their abusers and attack their own body, from which they remain cut-off, to express the feeling and so relieve the associated tension. It may also be that the victim despises the weak body and identifies with the aggressor.

In addition, the split between body and mind distorts the sense of self so that the individual has difficulty maintaining a space between themself and others. Those most seriously affected may allow themselves to become addicted to repeated attacks from other people or from themselves, including of course by repeated and dangerous administration of near toxic levels of drugs. Their body, like their house, is disowned, handed over to others and ultimately destroyed. They are not at home with themselves. I will illustrate some of these ideas with two case studies.

Case study 1

The first case study is of a forty two year old woman, whose health at the time of writing is so poor that she spends as much time in hospital as out.

She was one of five siblings and was regularly sexually abused by an older brother from the age of four. When she tried to talk to her mother about this, the mother refused to believe her and was reportedly so angry with her that she never looked at her daughter again. The abusing brother went on to have six children of his own; he abused them all and one of his sons hanged himself when he was ten years old.
The client's drug use began in early adolescence and quickly involved injecting. By the time she became a client of our Drug and Alcohol service she was homeless and worked as a prostitute,

travelling from Cambridge to Kings Cross each day to earn money for drugs. Her physical health was poor and, as well as other infections, she had a severe skin complaint which needed daily dressing to clear away decaying skin and clean up the sores.

With her partner, the client moved into hostel accommodation and eventually into a council flat. Within six months, however, the couple had abandoned the tenancy at a time when they were in arrears with their bills and, more critically, were wanted by the police: the flip side of her vulnerability to intrusion was her tendency to intrude on others with prolific criminal activity, mostly theft. For example, whilst a patient in general hospital, she would frequently wander from ward to ward, sometimes wearing a surgeon's gown, taking money, valuables, drugs, injecting equipment – in short, having no regard for accepted boundaries of behaviour.

It may come as no surprise that this woman was difficult to help. The interventions of the Drug and Alcohol service consisted of providing oral methadone to help her stabilise her drug use, making arrangements to have her physical health needs met and liaising with accommodation agencies. Because of the chaos she brought with her, these measures were of limited success: she would regularly miss appointments, fail to collect her methadone or to have her skin dressed, she was frequently in police custody and was refused statutory services because of her extreme verbal abuse towards those who tried to help.

The breakdown of this client's skin can be seen as a reflection of her general breakdown of boundaries and it is interesting in this context to consider the ideas developed by Bick (1968) and by Anzieu (1989). Bick (*ibid.* p.484) explains that:

> in its most primitive form the parts of the personality are felt to have no binding force amongst themselves and must therefore be held together in a way that is experienced by them passively, by the skin functioning as a boundary.

But initially, the baby has no sense of its own skin and is therefore dependent on an external object to fulfil this function, the 'optimal object' being 'the nipple in the mouth, together with the holding and talking and familiar smelling mother' (*ibid.*). Where this experience of containment is inadequate, the baby's sense of its own internal space is impaired and this may later manifest itself in confusions of identity, for example in an inability to differentiate adequately between the self and others so as to have poorly defined personal boundaries. In these terms, we might therefore hypothesise that the origin of this woman's drug problems predates the onset of overt abuse and their intractable nature may be seen as a reflection of their primitive origin.

Anzieu (1989 p.32) points out that 'skin ailments are closely related to stress, to emotional upheavals and ... to narcissistic flaws and inadequate structuring of the Ego'. This woman's skin required daily attention and yet she so upset the District Nurses sent to give the care she needed that they ultimately refused to treat her. There was also a suspicion that she might deliberately have been exacerbating the condition. Anzieu (*ibid.* p.33) describes several factors that could be at work here, including:

> a way of calling attention to oneself and more particularly to the skin which, since early infancy, has not received from the maternal and familial environment the gentle, warm, firm, reassuring and ... meaningful contact outlined above.

We might postulate, therefore, that this woman not only experienced violation of her personal space through childhood abuse but, as a result of inadequate holding in early infancy, never in fact developed an adequate sense of it in the first place. Furthermore, her failure to derive benefit from treatment may be seen as a way of tyrannising those responsible for treating her: a way of exercising at least some control in a world otherwise characterised by confusion and chaos.

Case study 2

The second client was less damaged by her experiences. She was thirty eight years old when she came for help and had had a heavy drinking problem since the age of nineteen: half her life. However, by the time she reached our Drug and Alcohol service, she had already managed to cut down and stop her drinking altogether. She asked for weekly appointments for support and quickly came to rely on them.

Initially she talked about the difficulty of adjusting to life without alcohol. She had a number of friendships with people who would phone her up and talk at length about their problems and her habit had been to sit listening while drinking a bottle of wine. Without the wineglass in her hand she found she no longer had the patience for this or the desire to take on other people's problems. In social gatherings she found she was no longer the life and soul of the party and in fact she felt rather shy and awkward. She also talked about difficulties with her small business – how her staff constantly complained about their colleagues, their customers, their rates of pay and their lives outside work. Without alcohol to soften the blows, these problems were getting under her skin.
As the sessions continued she spoke more about

her earlier life, beginning with her first husband, who had become interested in making pornographic films and had wanted her to join in. After several oblique references to sexual abuse as a child and difficulties with her parents, she finally spoke more explicitly about sexual abuse by her grandfather, which had started when she was eight years old. She had managed to put a stop to this by the time she was twelve, but when she had spoken to her parents about it, aged nineteen, they had told her she was wrong, that it could not have happened - and it was then that she had begun to drink heavily.

She had become the kind of person who listens to and to some extent takes on other people's problems – everybody's agony aunt. This persona was not sustainable without alcohol and she had to begin learning to set boundaries with people, e.g. discouraging late night phone calls and repeated lengthy chats about personal problems. Our work moved towards its conclusion after about six months, when she reported a dream in which her parents were sitting on her front lawn, on indoor furniture. In the context of our work together, this seemed to suggest she had succeeded in, or at least come to appreciate the value of, putting her parents outside her 'house'.

Clearly the outcome for this woman was much more positive than for the client in the first case study and this may be partly attributed to the later start of her abuse and problem drug use. In addition, however, the second client was able to recognise that her drinking represented an attempt to suppress memories of abuse and to realise that she needed to stop drinking in order to let go of the trauma and move on. In other words, she demonstrated a capacity to mourn, both in relation to her experiences of abuse and for the loss of alcohol and her associated lifestyle. Klein (1940 p.314) states that 'The increase of love and trust, and the diminishing of fears through happy experiences, help the baby step by step to overcome his depression and feeling of loss (of the breast)'. If we accept that this early process of mourning is necessary for development of the ability to grieve successfully in later life, then we may surmise that this woman had had enough good early experiences for this process to take place.

Clinical considerations

I want to spend a little time considering the merits or otherwise of working psychotherapeutically in a drug and alcohol clinic with people who have or have had a significant drug problem. The important indicator of course is the extent of the drug problem: Is the person normally or frequently intoxicated? Do they show symptoms of dependence and, if so, do they require medical intervention to break it? Are drugs the most salient feature of their lives? Are they able to attend therapy sessions without being intoxicated?

Where the person is more concerned with consuming drugs and becoming intoxicated than with relating to other people, then I think their chances of being able to make use of any psychotherapeutic approach are limited. Above all else they need to have their drug use very much under control: ideally to have stopped taking the drug completely but at the most to be using, for example, moderate amounts of alcohol two or three times a week or small daily amounts of methadone. This is essential because psychoactive drugs affect the psyche so that material is either unavailable because of sedation or excessively available as a result of disinhibition. However, what is required for effective psychotherapy is that over a period of time the patient gradually feels able to lower their defences in a way that they, rather than the drug, are in control of.

Clients often delude themselves by saying, for example, 'If only I knew why I was using, then I could stop.' However, this is a smokescreen - a defence against confronting the reality of the overriding need to stop using the drug. In fact they have to stop first in order to be able to begin making sense of the origin of their problems. I think Alcoholics Anonymous, the self-help organisation, sums this problem up well: members are challenged to 'walk the walk' rather than 'talk the talk'. It is striking that after withdrawing from the drug many users no longer feel a need to explore the reasons behind their difficulties. The function of their quest for answers is to postpone the difficult business of real change, so that once the change is achieved their need for answers evaporates.

Nevertheless, working with people who have artificially altered states of mind has its attractions. Freud, for example, tried working with patients under hypnosis and others have administered LSD and even ecstasy in an attempt to expedite the therapeutic process. In such circumstances people's defences are lowered and their problems may therefore seem more accessible. I have occasionally been seduced into short sessions with clients who are intoxicated and they have disclosed very significant fragments of information, for example about sexual abuse. However, in subsequent sessions, when they are no longer intoxicated, the defences have been re-erected and the material is no longer available to work with.

Unfortunately, those who are most damaged are the least likely to benefit from psychotherapy. Because they are unable to control their drug use

sufficiently, they may have other more pressing needs regarding their physical health or accommodation, and in any case struggle to engage constructively with anybody who attempts to help them. Where attachments were unsatisfactory during the early years the difficulties remain. Clients are frequently angry, mistrustful, contemptuous and feel compelled to demand more.

However, there is hope. Over time, often years, clients who start by being very challenging and chaotic can come to see a Drug and Alcohol service as sufficiently caring, nurturing, predictable and constant for them to be able to achieve some stability in their lives. In other words, they find in the agency a good enough object to tolerate their rage and distress.

In the case of people who are opiate dependent, this stability may simply be a shift from injecting heroin to taking prescribed oral methadone, a much less exciting drug. Some may then go on to stay in a residential rehabilitation centre for six months or so: here they live drug free and have the opportunity to begin to address the issues behind their drug use. If they stay the course they may go on to do well, though relapse is always a possibility, especially when they leave the containing environment of the centre.

Clients with less serious drug problems find it easier to cut down and stop. Unfortunately, they tend to sever connections with the Drug and Alcohol service immediately after stopping, when they are at their most vulnerable, choosing not to attend follow-up appointments for support. In other words, their interest in the service is simply in managing their drug problem rather than in forming a nurturing relationship. The risk of relapse is then high: their repertoire of coping skills for life's ups and downs is likely to be severely restricted and, in addition, their original reasons for using may re-surface, compounded by the often traumatic life events that have not been adequately dealt with during their years of intoxication.

What seems to work best is where clients move into a stage of dependency on the service or their worker, address their basic needs in relation, for example, to housing, finance, benefits, court proceedings and general health problems and then reduce and control or preferably stop their drug use. Only once this has been achieved, can working more psychotherapeutically be considered: Does the client have an interest in connecting their drug problems with any other areas of their life? Do they seem committed to and capable of examining this connection in a constructive manner? If so, then psychotherapy may be appropriate with a view to addressing issues underlying and related to their drug use, developing new coping skills and, crucially, finding a way of getting in touch with and satisfying their creative urges. Where this latter stage is not achieved, clients can seem to be left in limbo: they have let go of one way of life but have nothing with which to replace it. Instead of their life revolving around drug taking it now revolves around avoiding drug taking. In other words, they have stopped using but have not been able to grieve and move on, and the risk of relapse is very high.

Although the scope for effective psychotherapeutic interventions with these groups is therefore limited, I have nevertheless found psychoanalytic concepts very sustaining in my work. Having a theoretical framework to help me understand how people's difficulties may have come about helps me cope with the disappointments involved in trying to help them.

When we consider the practice of psychotherapy in general, my assertion that effective psychotherapy cannot take place if the patient's psyche is under the influence of drugs has interesting implications since, as explained at the beginning of this paper, most of us use drugs to some extent. People who do not see themselves as having a drug problem may nevertheless be using a variety of drugs on a regular basis, for example nicotine, alcohol, cannabis or sleeping tablets. Even caffeine can affect people's lives problematically, creating dependence and leading to anxiety, agitation, poor sleep and paranoia.

There will be some patients for whom drug use is a major feature of their lives and yet who disclose little or no information about it in therapy. For example, some people who are successful in terms of keeping out of trouble and paying their way (including bills for psychotherapy), may drink or smoke cannabis quite heavily each day when they get in from work until bedtime, so that significant areas of their psyche are chemically closed off. What they notice and seek help for, however, is that their relationships fail, they feel unfulfilled or they sleep poorly and feel agitated.

Some patients may drink or use other drugs shortly before their session, which may either strengthen their defences or remove them. Either way, the relationship with the therapist is impaired, where what is required for the work to have on-going meaning is that psychic defences are not affected by drugs but are lowered by the patient when they are ready. Of course the matter should be addressed, but this may not always happen. Some years ago, before I had worked in specialist drug problem services, I was a member

of an analytic psychotherapy group. Two other group members routinely attended smelling of alcohol and even talked about stopping for a drink on the way to the group. Perhaps because they did not appear to be intoxicated, the matter was not pursued. With hindsight, however, I think it was significant and should certainly have been explored more fully.

In general, I think it is likely to be useful to be as curious about a patient's relationship with drugs as with anything else in their lives: Do they use drugs often? Which ones? Who with? What effect are they seeking? What effect do they get? How do they feel when the drug is not available? The therapist may feel reluctant to ask these questions, particularly when unfamiliar slang terms are being used about illicit drugs, from a fear of appearing ignorant. However, from the patient's point of view, I think that if their therapist is prepared to take a chance and reveal their ignorance it is more likely to be received as humility and genuine concern than as incompetence. In the few cases where it emerges that someone may be physiologically or psychologically dependent on a drug then, to avoid the risk of distressing withdrawal symptoms or even psychosis, they should reduce their intake gradually or consider getting specialist help.

During my time as a student psychotherapist, I have worked psychoanalytically with several people whose reasons for seeking help have had nothing to do with drugs, but who have nevertheless talked at considerable length about their use of a whole range of substances. I hope that by opening the subject up a little I may inspire others to dig a bit deeper in their own clinical work: an individual's relationship with drugs can, I believe, reveal a lot about their unconscious processes.

Discussion

In this paper, I have suggested that problem drug use may be viewed either as an attempt to replicate the good breast, which was lacking in infancy, or as a repetition of early transgressions of boundaries through childhood abuse. However, these two factors should not be regarded as mutually exclusive, nor as exclusive of other explanations. On the contrary, many problem drug users are likely to have experienced both a lack of nurture in infancy and subsequent childhood abuse. It may be that the most intractable and harmful drug problems reflect the earliest psychic damage.
In this context, Anzieu's (1989) work is particularly interesting, since the many boundary breaches associated with problem drug use may be seen to reflect an inadequacy in formation of the skin ego, particularly where drug use involves actual damage to the skin. This applies most obviously to those who inject street drugs, who not only pierce the skin with needles but also commonly have infections on or just under the skin around their injection sites so that the normal containment afforded by it is under attack. Some are able either to stop injecting or to improve their technique so as to minimise harm; others, however, continue to inject in a way that exacerbates chronic problems and creates new ones to the extent that the self-abuse appears almost as significant as the effect of the drug itself. Similar considerations apply to some heavy drinkers who, apart from the chronic internal damage to their bodies, will frequently injure themselves accidentally and possibly also in fights while under the influence of alcohol. They thus develop skin injuries which, because of their general poor health and malnutrition, never quite heal. Chronic cocaine use also inflicts damage on the 'skin', specifically on the mucous membranes of the nose, to the extent that the nasal septum may be ulcerated or even perforated. This in turn leads to bleeding and consequent transmission of infections such as hepatitis through the sharing of snorting equipment. These groups, who continue to use drugs excessively and compulsively while their health deteriorates, and whose problems may be viewed as having the very earliest psychic origins, are unfortunately the most difficult to help.

There are similarities between problem drug use and other addictions and compulsive behaviours such as gambling and self-harm. They all involve ritual and anticipatory excitement and we may surmise that similar psychic mechanisms are at work. How significant a role does physiology really play in maintaining problem drug use? The subjective effect of opiates, such as heroin, is that they insulate or cushion the user against the world and may thus be regarded as mimicking the barrier function of the skin, separating 'inside' from 'outside'. In withdrawal, the barrier breaks down and the inside spills out through sweating, diarrhoea, spontaneous orgasm and vomiting. It is worth considering whether this experience of containment may be a specific gain for some problem drug users, as an attempt to compensate either for lack of holding in very early infancy (inadequacies in development of a skin ego) or for the disembodiment experienced by the abused (splitting).

I have suggested that, before they can benefit from psychotherapeutic interventions, people with drug problems first need to stop using or bring their drug use very much under control. They may need initially to experience a helping agency as a containing and nurturing object which can tolerate their rage and upon which they can become dependent in a benign relationship. In order to

move on in the long term they will require a creative vehicle for expressing themselves. Many, however, are unable to make use of any help and this may reflect both an inability to mourn, rooted in unsatisfactory experiences in infancy, and the fact of having missed, through continual intoxication, the normal experiences of adolescence so that the personality is frozen in an immature state. It may also be that, in the most intractable cases, the user derives some sense of control, or even of triumph, from not getting better.

It is relevant here to consider the relationship between clients and staff of statutory Drug Clinics and, for that matter, between the client group and the staff of other statutory agencies such as Benefit Offices. To what extent is the institutions' inflexibility a result of collective hostility in the countertransference – a desire to reject the client group, whose needs are endless – rather than of necessary organisational restrictions? Do individual members of staff hide behind the rules in order to attack or further abuse their clients, thus gratifying the clients' unconscious need for the abuse to continue? The clients certainly push the boundaries, but how do staff respond? With sadistic, unbending, retaliatory harshness? Or with patience and firmness, which succeeds in rejecting the behaviour but not the person? These ideal actions of a parent figure may be even more difficult to achieve in relation to an angry, physically threatening adult than in relation to a child.

Finally, I have discussed implications for psychotherapy in general and have suggested that work with people in the consulting room can be enriched by taking a lively and probing interest in their relationship with drugs. When working with the general population it should be remembered that drug use is extremely widespread – indeed normal. I hope, therefore, that my ideas might stimulate any reader who provides therapy into exploring more fully this pattern of human behaviour which has always been with us and which appears, if anything, to be increasing in prevalence.

References

Anzieu, D. transl. Turner, C. (1989). *The Skin Ego.* New Haven and London: Yale University Press.

Bick, E. (1968). 'The experience of the skin in early object relations'. *International Journal of Psychoanalysis,* 49.

Freud, S. (1898). 'Sexuality in the aetiology of the neuroses'. In *The Standard Edition of the Complete Psychological Works of Sigmund Freud,* Vol. III pp. 259-285, ed. J. Strachey. London: Hogarth Press.

Ghodse, H. (1995). *Drugs and Addictive Behaviour.* Oxford: Blackwell.

Glover, E. (1956). *On the Early Development of the Mind.* London: Imago.

Good, L. (1995). 'Addiction as a narcissistic defence: the importance of control over the object'. In *Narcissistic Wounds: Clinical Perspectives* pp. 148-158, ed. J. Cooper and N. Maxwell. London: Whurr.

Hopper, E. (1995). 'A psychoanalytic theory of 'Drug Addiction'. *International Journal of Psychoanalysis,* 76.

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

Klein, M. (1940) 'Mourning and its relation to manic-depressive states'. In *Contributions to Psycho-Analysis 1921-1945* pp. 311-338. New York: McGraw-Hill, 1964.

Klein, M. (1952). 'Some theoretical conclusions regarding the emotional life of the infant'. In *Envy and Gratitude* pp. 61-93. London: Virago, 1988.

Milner, M. (1987). *The Suppressed Madness of Sane Men.* London: Tavistock Publications.

Tyler, P. (1989). Unpublished training materials developed for groups in substance misuse services.

Wurmser, L. (1985). 'Denial and split identity: turning issues in the psychoanalytic psychotherapy of compulsive drug users'. *Journal of Substance Abuse Treatment,* 2.

Acknowledgement

My thanks for all their help to Dr Shankarnarayan Srinath, Sian Morgan, Melanie Bell and my colleagues in the Cambridge Society for Psychotherapy.

Liebe Klug

Accidental therapist

In 1949, South Africa was a very different country from today. Apartheid, with its attendant repressions, was severely in place. We had the opportunity to come and study in England, so, aged 20 and 23, my husband Aaron and myself left Cape Town for the great adventure.

In 1949, England also was a rather different country than it is now. The country was very much still showing the scars of war, and everything from clothes to potatoes was rationed. Houses were barely heated in the winter, because of the shortage of fuel, and there were few cars on the road. But, despite the contrast with South Africa, the land of plenty, England felt vaguely familiar, with the colonial connections and tied history and culture. A small example: my birthday is on 24th May. Queen Victoria's birthday was also on the 24th May, and in South Africa this was celebrated by a public holiday called Empire Day. Though neither the Empire nor the holiday now exist!

Cambridge, too, was a different place in 1949. Like England generally, the spirit, the style and the culture held tightly to the pre-war mores. My husband had come to the Cavendish Laboratory, and I was to study Modern Dance in London. I spent a year at this rather well thought of school, based on the ideas and techniques of the choreographer Kurt Joos. The system was analytical, rather rigid, I thought; in its own way as constraining as the classical ballet from which I wished to escape. So, after a year, I left the school, and instead found teachers and classes here and there that enlivened, informed or educated me. Anyway, no one really wanted to look at new ideas in the Arts, and particularly in Dance. Eventually I began to work with a small West Indian dance company, where I felt comfortable. That dancing reminded me of home, and of the plans I had if we returned there, to work with the ethnic dance of South Africa and with multiracial groups. I had had a taste of this while a student in Cape Town, teaching evening classes at a club called the Evening Star Club, for children in an area known as District Six.

After three years in England, we went back on a visit to see our families. It was clear then that we would never live there again; we wouldn't have lasted two minutes in that political regime. So in 1953 we returned to England. No jobs on the horizon, nowhere to live, but we felt we wanted to have a child, nevertheless. My husband found a job in London at Birkbeck College, we found a flat at the top of a crumbling Victorian house in Swiss Cottage, and I gave birth to a beautiful son, Adam.

Eight years later, we were back in Cambridge, which I hated. There was nothing here that I felt in tune with, no sense of belonging, and no role outside the family. There was one great compensation: after several disasters, and a nine-year gap, I gave birth to our second son, David. Then, in 1965 I was asked to do voluntary work at Fulbourn Hospital. For a few years I led an informal exercise and dance session in the short-stay unit, and also a Saturday evening dance and social club in the hall at the hospital, to which many long-stay patients came. I also kept in touch with the young children at the new ACE Nursery school in Station Road, working voluntarily, doing music and movement sessions and story telling.

My mother died unexpectedly, and following that I became severely depressed. This depression was a stroke of good fortune. I decided that I couldn't live like this, and was referred to one of the only two psychotherapists in Cambridge; by chance, it was a therapist with whom I had immediate rapport. She was a woman from the Southern States of America, sent after the war to work with displaced children in Europe, and trained by Anna Freud. She was black, and I think that was important to me. Also like me, she was a

transplant and, without ever saying it, had an instinct for the dilemmas that loss of country and family presented. Marie Singer was a wonderful therapist for me; she said very little, she could have been asleep from time to time for all I knew, but the important part for me was that she valued individuality, accepted difference, and did not pathologise or over-analyse. My therapy, three times a week for a few years, changed my life, and although I did not know it at the time, I think one of the models of a therapist was my time with Marie Singer. By the way, she charged £2 a session, and apologised when she had to raise it to £3!!!

At some point in my therapy, I was asked to teach a one-off class to a student contemporary dance group at Homerton College. The group and I seemed to be on the same wavelength, and gradually, once a week expanded to regular classes, performances, weekend workshops, summer schools, and eventually, a base at Parkside Community College, as part of the adult education programme. There was no structure to start with; we all grew in response to the needs of the group. Except for the teachers who came from London, no one was paid; all the work was done voluntarily and collaboratively. The Cambridge Contemporary Dance Group functioned from 1969 until 1982. Importantly, it was a place where the people of Cambridge could meet and communicate non-verbally, to join in activities they all loved and became committed to. We all worked (how we worked!) evenings, weekends, holidays, and all day every day, in my case.

There was a fly in the ointment, though. From time to time, feelings that I could not understand, and dealt with badly, erupted in the group. As an only child, I could not fathom feelings of envy and sibling rivalry; indeed, I could hardly see them. So I decided to do something about it, and joined the first introduction to group work course, about 1980. Towards the end of the course, Jeanette Josse told me of the new training in psychotherapy that was starting in Cambridge, and wondered whether I would want to join. To be honest, I was by that time getting rather tired and my joints were starting to complain. It felt like a possible new start (I am always attracted to new starts, having attended 8 different schools) and I applied.

All this preamble is really relevant to what comes next. After an initial interview with Peter Lomas, a meeting was arranged with Lucy King, David Ingleby, and one other applicant. We met one evening at the top of Lucy's house and sat around on mattresses, drinking coffee and chatting. At one point Lucy's baby joined us, crawling around and being friendly. The other applicant decided not to join; I was accepted. I have sometimes thought that it must have seemed a step forward to have a student! Here I was, already over 50 years old, no paper qualifications, no academic connections, but in a way I think that answered to the early dreams of the Outfit. What I did show was long-term work with people, nursery age to old age.

The Outfit met once a month in Peter's consulting rooms. We were always welcomed with a cup of coffee. The meetings were freely associative, with no particular topic, and enjoyable. After a year, our first administrative decision was to meet twice a month; our second administrative decision was to make a contribution to the coffee. The money was kept in a tin moneybox. From time to time applicants joined, and left or stayed. In this way, numbers very gradually grew. I think it was about two years into the life of the group that the students decided to meet alone on alternate Mondays, in one house or another.

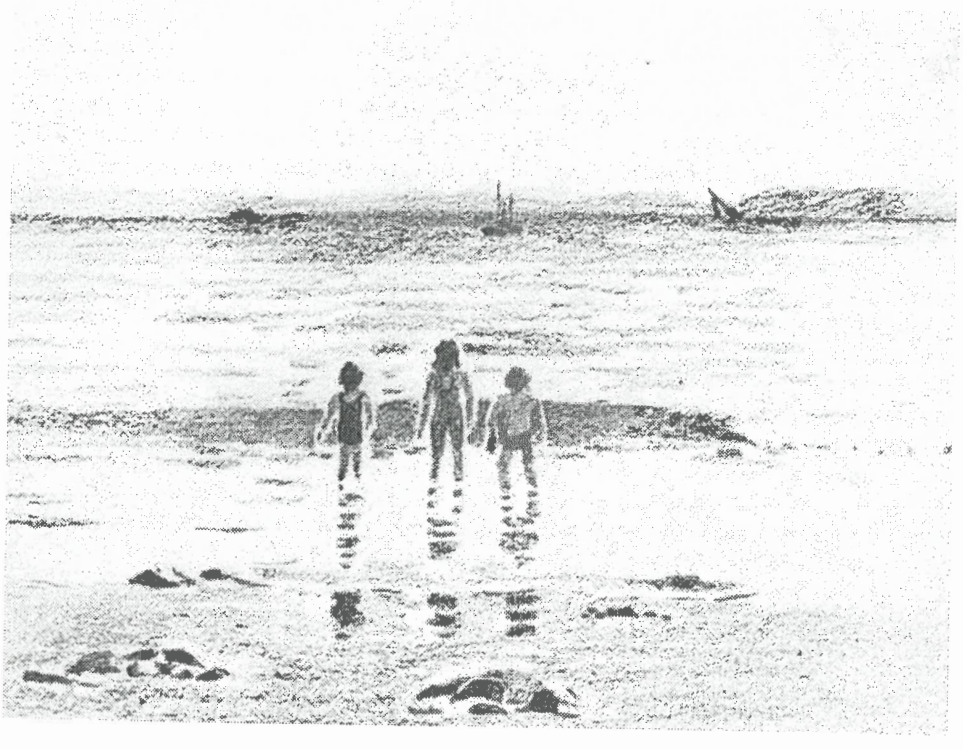
The simple structure suited me, the lack of definite curriculum suited me, the whole set up or lack of set up gave me a sense of freedom to find my way. I am not suggesting that it was easy; this was not an easy option of how to become a therapist. In the student group I always felt an outsider, maybe because everyone else seemed to be, or have been in therapy with Peter. Deliberately, I chose a different therapist.

The patterns changed when the full group became too big for Peter's rooms, and we moved to Peterhouse and made our own coffee. So, the structure was set: first Monday for the whole group, other Mondays for the students. Three of us (Judy, Vivienne, and myself) started a reading group; there was also a reading group at Newnham Road. As I try to recapture those days, what comes to me is a sense of communality, of the warm generosity of the non-students, and of a commitment to a way of learning. All decisions were taken together, and every change was discussed. There was a long discussion about 'the piece of paper', that is, the graduation 'diploma', or whatever one chose to call it. Eventually, it was decided that should anyone ask for one, it should be given. I wonder whether anyone has?

The question could be asked, how did I learn to be a therapist, in this rather easy-going training? Firstly, and I think most importantly, it was and is a question of integrity and of commitment. The route was up to each individual to discover and put into practice. Reading the texts was, for me, not very useful. So often, reading seemed to be an exegesis on what went before, in many cases unnecessarily convoluted. I didn't and still don't subscribe to many theories, or the continual

grasping of metaphor. In the benign mode of the Outfit, it was possible to be different, and for this to be tolerated. I learnt in a sort of apprenticeship, in contact with those already seeing clients, and with supervisors, all of whom gave me a model as well as information and guidance. This gradually formed in me a way of working that is appropriate for me. Above all, I recall the warmth and generosity of those who shared this journey with me. Eventually, having forsaken family and country, and having been in many senses the outsider in both places, the Outfit, in trusting to accept me, so many years ago, recognised the value and usefulness of the non-conforming role.

South Africa and England have both changed. Cambridge has changed. The Outfit has changed. For the last five years or so, I have been out of touch, so I cannot really comment. Just one last word: when, encouraged by the group, I graduated after six years of being a student, we marked it by supper at my house. There was nothing else. I was told to choose the manner of graduation, and that was it.



Hilary Taylor

Triangulation – opening up a space to work

As a geometric figure, a triangle opens out a line between two points into a shape which links three points and encloses a space, making a one-dimensional figure into a two-dimensional one. In trigonometry, triangles can be used as a way of measuring the otherwise unmeasurable. Through the invention of the sextant, sailors were able to use triangulation to fix their position from the sun and stars in an ocean without landmarks. The principle here is that of using what is already known to expand knowledge into new areas. But true fixed points are rare; as the calculation is made the ship will already have moved on. In engineering, triangles have been used to strengthen a structure, from flying buttresses in medieval cathedrals to iron girders in bridge construction, but three is also a number associated with myth, mystery and magic. It moves beyond the binary boundary of one, two, yes, no, black, white to a place of wider possibilities, intermediate positions and the unknown. So triangulation can be seen both as establishing a fixed point in what was unknown and allowing for new possibilities.

The theoretical formulation which springs most readily to mind in connection with triangulation is of course the oedipal triangle, but Winnicott's notion of the transitional object is also concerned with triangulation in that it introduces the idea of a third area which lies between 'me' and 'not me', and in doing so opens up a space for play and creativity. These constructs are concerned with the process by which we develop and negotiate the relationship between our inner world and the world which we find around us, and attempting to understand this process is, as I see it, the central task of psychotherapy. The concept of mirroring is also relevant here, as are the perspectives of intersubjectivity and the ideas of Bion and Lacan about the development and nature of thought and language. Bion's ideas about containers are important too; triangulation, like any theoretical construct, is a kind of container, a way of holding the chaos of raw experience as if in a crucible so that it can be worked with.

Freud's construct of the oedipal triangle brings father into the mother-child dyad to make three, and is a metaphor for thinking about the conflict around desire, identification and difference which makes up human sexuality. It was a focal point of early psychoanalytic theory, and a starting point for those who sought, like the archaeologists that Freud so much admired, to excavate the earlier layers of experience and examine more closely how relationships begin to be made with external objects from earliest infancy, and how the inner world is formed. Freud, writing in a patriarchal age and as the golden child of his mother, focused on the father; Klein and the object relations school shifted the focus to mother. It is hard for both to remain in focus at once, and this is part of the oedipal dilemma.

Winnicott's writing hardly mentions the father; Adam Phillips observes that 'fathers tend to turn up in his writing in brackets or parentheses' (Phillips 1988, p6). But he deals with triangulation in that he identifies a transitional space between subjective inner experience and the objective outside world, 'a third area, that of play, which expands into creative living and into the whole cultural life of man' (Winnicott 1974, p121). It is not a fixed point; the existence of the transitional area depends on an acceptance of the paradox that it is neither inside nor outside, and it is impossible to know whether the transitional object has been discovered or created. Illusion can flourish in an atmosphere where trust is possible. It is a model which I find helpful in thinking about the complexities of early intersubjective experience, and in understanding what can be recreated, or rediscovered, in the therapeutic space.

Winnicott described the role of the mother as mirror, and how this mirroring function fails if the mother does not respond to the baby by reflecting back her experience of him in her face. The baby sees only the other, not himself in the other; 'perception takes the place of that which might

have been a significant exchange with the world' (Winnicott 1974 p 132). Another way of putting this is that triangulation has not occurred; the way into the third, transitional area of creative experience has been barred.

Malcom Pines, writing about mirroring in group analysis, similarly distinguishes between two different types of mirroring:

> one is primitive, confrontational and destructive, indicating a fixation to a dyadic mode of relationship, the other exploratory, negotiable and dialogical, where both persons, or more than two persons, can share the same psychological space, one in which different points of view are accepted and understood. (Pines 1984 p 128)

He describes the second type of mirroring as "triadic" and links it with Abelin's work on early triangulation and the role of the father. Abelin worked with Mahler to explore and describe the different stages in the separation-individuation process. His work is based on observation of young children with their parents, and draws on the work of Piaget. The psychologist works from the outside looking in rather than reconstructing past relationships from the inside out, which is the psychoanalytic viewpoint. The observational perspective on human emotional development enriches the schematic picture given by the theories developed through reconstruction of what adults bring to the consulting room. I have found the work of Daniel Stern particularly helpful in this respect as he approaches the interpersonal world of the infant from both the observational and the clinical point of view.

The shift of viewpoint from inside to outside is also central to what Abelin calls the 'Copernican revolution' in which the child learns to imagine himself as if he saw himself from the outside; the beginnings of a sense of self. Abelin argues that early triangulation is an essential part of this process; the child internalises the relationship between the parental couple, and through identification with father, recognises both his own desire and his exclusion: "There must be an I, like him, wanting her" (Abelin 1980 p 153).

The role of the father in triangulation can also be seen as opening a window on the world; Abelin refers to Mahler's description of the father as the 'knight in shining armour'. A similar view is expressed by Kenneth Wright in his exploration of how a sense of self is formed; "the father *is* the world, or stands *for* the world....the father exerts a positive pull on the child, drawing him out from the regressive undertow of maternal symbiosis" (Wright 1991 p 114).

Early triangulation is hypothesised as occurring at a pre-verbal stage, or at the very beginnings of language development, as a part of the emergence of awareness of a separate identity which can relate to others. Abelin saw it as a precursor of oedipal triangulation, though he discovered important gender differences in the children he observed. The development of language marks a new stage in relationship: there is a way of symbolising and communicating about experience that is not direct and in the present. So language itself becomes another point of triangulation; Stern refers to it as a double-edged sword and quotes Dore's suggestion that it is a form of transitional phenomenon (Stern 1985 p 172). Lacan links the emergence of language with the triangulation with the father, 'le nom du Pere' , and entry into the realm of the symbolic to take one's place in the world. Psychosis is connected to the inability to triangulate and to symbolise, a foreclosure on recognising the father. Bion's work shows how the psychosis of the paranoid-schizoid position is also characterised by an inability to think, and an attack on meaning and linking.

Ronald Britton's work on the Oedipus complex emphasises the importance of the child's recognition and internalisation of the parental relationship in 'the development of a space outside the self capable of being observed and thought about' (Britton 1993 p 84). He describes working with a patient who was unable to achieve this triangulation;

> we were to move along a single line and meet at a single point. There was to be no lateral movement.....What I felt I needed desperately was a place in my mind that I could step into sideways from which I could look at things. But when he attempts this she responds violently, first with wordless screaming and then, as she becomes able to use language, by shouting 'stop that fucking thinking' (Britton op cit p 86).

Along with acquisition of language, the acquisition of mobility helps the movement towards triangulation in a literal spatial sense as the baby is able to crawl away from mother to a new point of view from which familiar objects can be seen from a different angle. Turning towards my practice of psychotherapy, I think that what I am looking for when I am in the room with someone is a *point of view* which will give me a sense of perspective, and open up a space where both I and the person I am with can think about what we are experiencing and feeling. In the absence of this third point of triangulation the mirroring in the dyadic relationship may be confusing, and risks becoming destructive, with chaotic and overwhelming feedback, as when a microphone and a loudspeaker are placed too close to each other. Sometimes, though, it can be important to be able to tolerate staying together in the untriangulated,

merged, confused place, to have what Keats describes as negative capability, '..capable of being in uncertainties, mysteries, doubts, without any irritable reaching after fact and reason.' (Keats, ed.Page 1954, p 53)

There are many ways of thinking about this triangulation in relation to the practice of psychotherapy. The most obvious place to acquire a point of view is of course supervision, and this has been a fundamental triangular structure for supporting my learning and practice so far. My supervision has particularly helped me to see myself more clearly in the therapy relationship, and thus to think more about what is going on in the transference and counter-transference relationships. For example, I have often missed communications about the importance of breaks in therapy which have become clear in discussions in supervision.

Patrick Casement's idea of the internal supervisor conveys how the reflective process of discussion with a supervisor can become integrated into the internal world of the therapist. He describes this as a parallel process to Winnicott's view of how the father's role is to hold the mother who holds the baby:

> ....it is a function of the internal supervisor to hold the analyst (or therapist) who is learning to hold the patient. This provides the structure of an internal "nursing triad", which can help the therapist to find an inner play-space where the options can be explored.' (Casement 1985, p.27)

I am often aware of my internal supervisor in action as I process a session by writing notes afterwards, or sometimes in the moments after my patient has left the room – suddenly something becomes clear which I couldn't see when I was 'in' the relationship. Maybe there is an important difference here. The more conscious process of reflecting as I write notes might involve using theoretical frameworks and linking what I have just experienced to what I have read or discussed in the student group or in supervision. The realisation as the door closes has a different quality which has more to do with feeling than with thinking. With a patient I see who has an eating disorder I have on two occasions found myself bursting into tears just after she has left. There are huge losses in the family history, and a difficulty of separation between mother and daughter, and I think that what I felt was the grief which lies behind the anxiety that mother is warding off through holding onto her daughter and my patient is trying to control through her eating disorder. I have also found that as the door closes I will suddenly see another layer of meaning in a communication that has been made in the session, which is often about a negative transference. For example, a patient had recounted two dreams, both involving critical observers who were peripheral to the action, and I subsequently understood the reference to me as observer, and the patient's shame about this. These are the areas where I am not yet able to think about the experience while I'm having it in the room with the patient, though hopefully I can recognise it again in subsequent sessions, and bring it back into the room.

Casement's concept of the internal supervisor includes the role of theory and writings about psychotherapy, which can also help to open up a space for processing and thinking, though he distinguishes between internal supervisor and the internalised supervisor, where the student therapist has not yet found space for her individual voice and is over-reliant on a particular theoretical orientation. There is also the triangulation with one's own therapy. I know that, in the examples given above, what made awareness and reflection difficult for me while the patient was in the room was significantly due to the power of my own transference, and it is my therapy which has helped me to be aware of this. I also find that my experience of relationship with my own therapist helps me to think about the range of possible responses to what my patients bring. I find myself thinking of how she might respond, and whether I respond similarly or differently there is a sense of not being in completely alien territory, and of having a map which gives me some sense of direction.

Another triangulation point in psychotherapy is the setting in which it happens, the physical and institutional container for the work. The character of the room where the therapy takes place is an important part of this. I have worked in several different rooms, and I am aware that I have done better work in rooms where I have felt more 'at home'. I feel constrained if physical space is limited, as if that makes it more difficult to open up the necessary psychological space to work, but if the space is too big it can feel uncontained. The room in which I do most of my work at the moment contains the Outfit library, and is also used by other Outfit members, so the setting contains representations of plenty of theory and peer support, and something of the Outfit as an institution, and I have felt grounded and encouraged by this. At present I am in the process of preparing to work partly from home. I am looking forward to being able to arrange my work space in my own way, but I know that this change will alter the boundaries within which I work, and between my work and my personal life. I hope that the two will feel more integrated, but it will change the shape of the container, and give me a different point of view.

My work with staff groups in the mental health services has also taught me a great deal about how the institutional setting affects the experience of the therapeutic work with patients. Two of the staff groups I facilitate have experienced a move to a new building (both are in-patient units), and there have been numerous other structural management changes. Staff have tended not to want to talk about these physical and structural changes, but in both groups around the move there was talk of the increased difficulty in containing and thinking about what felt like a higher level of chaos than usual among their patients. In a staff group session on an adolescent in-patient unit three months after a move to a new building, the talk was about how difficult they found it to tolerate the young people's attacking behaviour towards themselves, and also on the fabric of the new building. Staff were angry and upset, and focused particularly on the destructive attacks on the building. They continued to talk about aggression, but the discussion was confused and confusing – they were angry with the young people, but also protective of them, seeing them as the victims of bullying by peers, their parents and the local community. The patients also contrived to make the staff feel like bullies, so both staff and patients felt simultaneously like victims and aggressors. At this point, out of a feeling of helplessness (which probably reflected the feelings of both staff and patients), I made what seemed a very obvious remark about the move to the new building, and also commented that it seemed hard to think about what was going on, and this had the effect of opening up a space for thinking in the group. The discussion became more reflective, and it felt like part of the process of 'moving in' to the new space in which they had to contain the distress of their patients. During the transition the fabric of the building couldn't be taken for granted as part of the boundary of this space, as it had customarily been, and the containing role had to be carried by the staff alone while the point of triangulation in the physical container was no longer fixed, but shifting. So now they had become so identified with the physical building as a container that attacks on the building were indistinguishable from attacks on the staff, and the team's capacity to tolerate and process the patients' acting out their distress had been reduced as a result. My reminding them of the fact of the move brought the importance of the setting back into awareness and triangulated the discussion, enabling thinking and reflection.

It is also possible to see a triangulation between the patient, the therapist and the transference. The real relationship between two people, the therapist and the patient, is overlaid by the multiplicity of transference and counter-transference relationships which develop and shift in the course of the therapy, sometimes changing rapidly in the course of a single session like the changing patterns of light and shadow on the landscape on a windy day. For example, in a recent session with a patient she let me know by her wariness and watchfulness that she was experiencing me as her volatile and unpredictable mother. This was a return to her experience earlier in the therapy, and I think was a response to recent interruptions in the pattern of our sessions. But later in the same session she spoke of her father, emotionally dependable but physically fragile. I felt ineffectual and unable to make sense of what was going on, and on consideration felt this was my counter-transference response to her transference to me as father, which was brought out by the same circumstances (interruptions in therapy) which had triggered the mother transference earlier in the session. However the forces of transference and counter-transference may ebb and flow, the basic trust in the underlying therapeutic alliance is there as the firm seabed on which both patient and therapist can stand together as they experience this tide. I have come to understand this through my own therapy too; I have felt abandoned or misunderstood while also feeling held through the experience of those feelings.

Casement, quoting Sterba, speaks of an 'island of intellectual contemplation' from which what is being experienced can be observed and thought about. He sees this as a capacity which is learned in one's own therapy. 'It is here, in their own experience of being a patient, that therapists establish the first roots of what later becomes the internal supervisor.' (Casement 1985, p31)

Another way of seeing triangulation is in the relationship between the therapist, the patient and the material that they bring. For example, if someone tells me about a dream, their account will stimulate thoughts, feelings and associations in both of us as we look at it together, and it can become a shared point of reference. The same is true of any story that is told, whether it is a dream or the retelling of an incident from the past or the present. Through the patient's words their world as they experience it is brought into the room to be looked at.

One aspect of the material that is brought is the other people that are talked about; the fathers, mothers, partners, children, grandparents, friends, work colleagues. The room can sometimes feel very crowded with these characters from past and present. They can appear and be used in different ways. Sometimes they are the central figures in the patient's inner world, and what is said about them helps to build up the shared understanding of this

that is developed through therapy. Often they are transference figures; for example one of my patients often talked about his exasperation with his boss at work , whom he experienced as critical, envious, neglectful and incompetent, as he had experienced his father. Another patient experienced huge anxiety when entertaining friends, which related to her fear of parental conflict and distress as a child, and her concern to pre-empt this by her efforts. Sometimes they are figures with whom the speaker identifies, like the daughter whose relationship difficulties in the present mirror those of the parent in the past. Sometimes, too, the room is filled with others as a defence against focusing on the self.

Sometimes this group of supporting actors in the drama communicates something vital about the groups and systems of which the patient is a part. The intimacy of the one-to-one therapy setting tends more readily to recreate the dynamics of parental, particularly maternal, relationships rather than those with the peer group and the wider social and cultural world. In group therapy patterns of relationships with others can be replayed 'live' with other individual group members, sub-groups, the group as a whole and the therapist, but in individual therapy what is not replayed in the transference to the therapist can only be discerned in relation to the 'virtual group' which the patient brings with them. A number of my patients have come from social and cultural backgrounds which are unfamiliar to me, and I need to learn about how this affects the individual by listening and being open to changing my assumptions. I have seen a number of people for whom the major difficulty was handling the transition from adolescence to independent adult life, but cultural expectations about this vary widely, and colour what may be considered 'normal'. For example, I saw a young person who was depressed and experiencing separation anxiety after leaving the family to come and work in Cambridge. I was imagining that the focus would be on working through the feelings about this move, and facilitating separation. But as I listened to the description of family and community it became apparent that what was normal in that context was to settle locally, and remain held and supported in a network of kinship and community, and the best choice for the patient might well be to do this rather than settling for the material rewards, rootlessness and alienation of a high-flying career. Because psychoanalytic theory has tended to look inward rather than outward, it has not always given sufficient weight to the social context in which the individual and the family exist. The historical context is important too, and can echo down the generations; for example I am constantly being made aware of the long shadows cast by the experiences of parents and grandparents in two world wars on the people I see today.

In concluding, I find myself reflecting on my experience of writing this paper, which has extended over a period of some months. Like the sailor I spoke of in my opening paragraph, I have already moved on from the place where I was when I started writing, carried forward by the winds and currents of my work with patients, my own therapy and the process of graduation. I think that when I started the aspect of triangulation that is concerned with fixing a point appealed to me, and I was hoping for an exercise in clarification, still pursuing that seductive fantasy that I have held since childhood that one day I would know it all if only I thought hard enough and read the right books. The triangle viewed from the outside is a neat and containing geometrical figure, but from the inside it is a deeply confusing and bewildering place to be. I discovered this as I moved from the outside to the inside and began to try and engage both with theory and with my experience as an only child in a neatly triangular family. Writing about psychotherapy has in itself been a kind of triangulation; an attempt to internalise a relationship between what I have read and learned about psychoanalytic theory and what I have learned experientially, and to find a place for myself as a therapist in relation to that 'parental couple' of theory and experience.

References

Abelin, E.L. (1980) Triangulation, the Role of the Father and the Origins of Core Gender Identity during the Rapprochement Sub-Phase. In (eds) Lax, R.F., Bach, S., Berland, J.A. *Rapprochement.* Jason Aronson.

Britton, R (1993) The Missing Link: Parental Sexuality in the Oedipus Complex. In (ed) Breen, D.*The Gender Conundrum.* London: Routledge.

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

Page, F (1954) *Letters of John Keats.* Oxford.

Phillips, A. (1988) *Winnicott.* London: Fontana Press.

Pines, M. (1984) Mirroring in Group Analysis. In (ed.) Lear, T.E. *Spheres of Group Analysis.* Group Analytic Society Publications.

Stern, D. (1985) *The Interpersonal World of the Infant.* New York: Basic.

Winnicott, D. (1974) *Playing and Reality.* London: Penguin.

Wright, K. (1991) *Vision and Separation.* London: Free Association.

Michael Evans

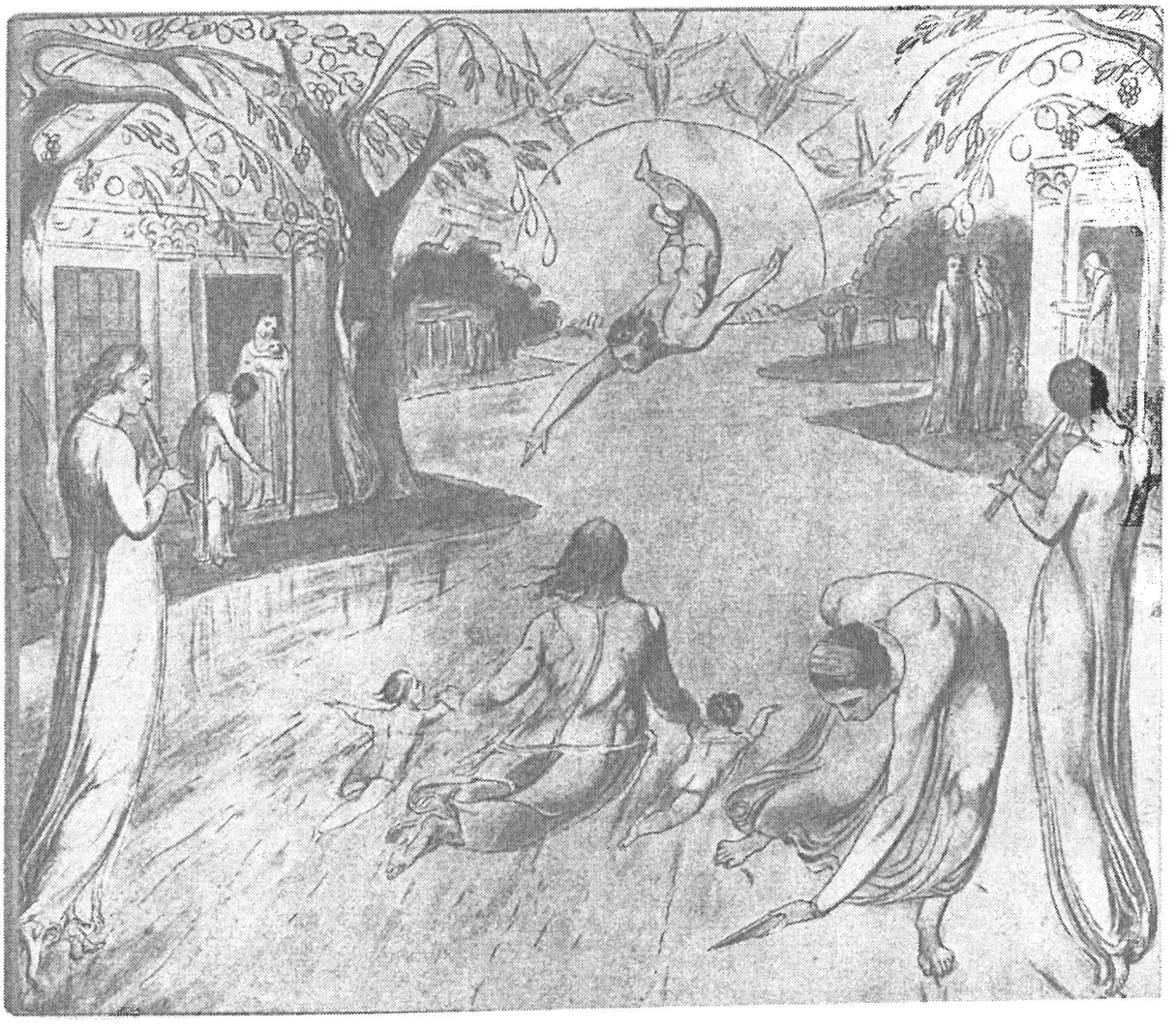
Uncanny

One afternoon I decided I had to face it and from the kindly undertaker collected my father's ashes. Were they my father's or were they mine? They came in a squat plastic box with a screw lid, larger than a kettle. Ash, I thought, was light, but this was heavy. Since the soft fluid tissues had burnt away, all that was left was bone. So this box was about as heavy as a skeleton, but condensed. I had always admired his fine shaped head. Now its form was lost, but I could carry it home under my arm.

He had wanted to be ploughed into a cornfield. The same one where my mother lay. It was 30 miles from us, but that was only an excuse. A question was, did she want his ashes mingled with her, near the place where they lived, oddly called Mingle Lane? I wasn't sure. Anyway, they wouldn't know what would happen to their mere remains. Yet in my head they seemed to understand all too well. Should I separate them in un-together for an eternity? A son who comes between struggling parents pays with an unresolved anxiety. But to obey his wishes felt equally damning, for I might remain always compliant and angry. Then more thoughts: 'Should I be the master of my conscience in the time I have left? They were born separately, and so they should end.' To throw him in the river was my idea. The River of Life - a suitably Blake-ian image for a Blake scholar. There his bones would disperse with no place on earth to mark his grave. Instead of the wind's four quarters, it would be to the seven seas that he would take 'his endless way'.

It was getting pretty late in the autumn of the day, half way towards twilight, when we arrived at the high wooden bridge overlooking the Lea. The cloud was heavy and the inky river ran straight almost to the horizon. I untwisted the cap on the container. The ashes seemed to be just granular chips of calcium. 'Now might I do it pat.' Not wanting to hesitate, I tipped about a third of the contents over the lip of the parapet just at the wrong moment when an evening wind uprose. Out of the falling bone aggregate flew a finer dust which came at us in vengeance invading our faces and clothes. But the main body of ash hit the water and settled in an incoherent mass about a foot below its surface. The wind dropped and I quickly emptied the rest. It combined with the first fall-out and produced an elongated shroud of greyness. But above the water a mist of the finer dust still hovered, and then spiralled as the wind caught it again. Just as a river mist rises and suggests phantasmagoric forms, the wind-formed dust appeared to me momentarily as a massive head, unfocused but with frowning brow. It did not speak or need to say 'Adieu' or 'Remember me'. As quickly as it had appeared the visage dissolved and was gone. Then the mist of dust settled down finally, alighted and sank into the dark water. Pale clouds appeared as reflections and melded with the grey mass of ash below. Again the wind came and hatched the surface making it opaque and depthless.

In that short time it was already darker. We left the bridge and walked along the tow path. The wind dropped. From this lower angle the water was transparent and the grey shroud that had been my father was still just visible as it was taken along by the current, but it became more diffuse as it sank into the blackness. We walked slowly and kept him company for a while until there was nothing more to see.



The River of Life by William Blake

Kalu Singh

The Self-removing trousers

How the difference between therapist and patient in their attitudes towards new communication technology affects the therapeutic alliance.

Consider these stories, some from therapeutic work in a large medical practice in the Northwest during the mid-to-late nineties, some from the 'real world', whatever that means.

1) My old man's a dustman

A mousy young man enters. It is my first session with this pre-assessed client, a trainee accountant. He speaks softly. Very soon I feel this softness is exaggerated, and probably manipulative.

"I found out that my father is having an affair. I was using the computer at home. I found these letters to his mistress, he'd deleted them: well, he thought he had. But they weren't completely deleted. He didn't know that. You can find out."

"Here's a New World!" I thought. Into my mind flooded the centuries-old clues of secret passions – lipstick on the collar, the 'wrong' coloured hair on the bed, the unusually delicate envelope not-quite-hidden in the deep inner pocket of the jacket or handbag, diaries and address books left open, the smell of the other's sex in one's partner's hair. And now there was a new source.

At that point I didn't have a PC. Though now I do, I still don't know how to reconstruct deleted material. Nor would I want to. On this machine, the facility is called RECYCLE BIN. How technology sanitises our darker impulses. Compare this clean process – using keyboard and mouse on a pretty mouse-mat – with the daily life of X, the famous garbologist. When night falls he visits the backyards of the famous and the powerful and sifts through their bin-bags: with rat-like tenacity he seeks among the slimy refuse for any saleable bits of paper, whether incriminating or just tabloid-tat.

Now imagine my young man choosing to sift and steal from his own family bins: getting his hands dirty, having to disinfect the scraps of paper to make them presentable and then hiding them somewhere else. Isn't this the nadir of dignity? Why is it less so at the white and shiny PC? Here's an unexpected answer to the Microsoft Windows advertisement strap-line, "Where do you want to go today?" *"Inside my father's underpants!"*

I thought of Klein's conjecture that the infant is fascinated by the inside of their parents, and sometimes wants to scour them out - eat, internalise or just attack.

The client described here was clearly troubled by my ordinary questions, and after the third session he requested changing to a female counsellor. My guess was that this was stereotypical thinking: a woman will be less probing.

2) It's different for girls

A few weeks later, I saw another pre-assessed client: fast-track Graduate-Scheme Retail Management. She was almost the first client's shadow: leonine and wired, her edginess betrayed her uncertain sense of strength.

"I thought my boyfriend was having an affair. I broke into his e-mail account. And he was. He doesn't know I know. You can know when someone is on-line. I've even used his email to write to her – as if from him."

Again, I thought that these people are living in a different world from me. I doubt she thought of herself as 'breaking and entering', or as a 'petty criminal'. I did, because I grew up with the reference point of these physical images: real windows and doors broken, and touchable objects taken. I thought of her at her desk, perhaps even with a laptop on a train or a beach (*'You can email from the beach'*- the Orange company advertisement strapline), her nimble fingers tap-dancing across the keyboard, successfully performing these

moves that she knows are morally, if not yet legally, wrong. Or maybe she doesn't 'know' such a truth as I do; she may not have internalised it in the same way. This virtual invasion of privacy, and virtual theft, is just something she is clever enough to do. There is a perennial moral puzzle – whether cleverness disables or at least suspends thought. If I can do something that is difficult or unexpected, surely it can't be completely wrong, or else I wouldn't have been able to do it? Such sophistry comes to feel like a reliable defence.

Technology realises, makes real, childhood fantasies – makes magical thinking true.
What is the first line of communication? – umbilical cord and placenta. Then skin, then milk, then words. And words become the first virtual medium. One learns their separation from skin. This is another of the lessons Freud's lovely little *fort-da* baby is learning. His mother is in the other room: her shape is not see-able, but sometimes her voice suddenly falls into his ears. The baby adjusts to loss, but always dreams of reconnection. Even at nine years old, Mrs Gaskell's heroine, Molly Gibson, is still dreaming of being connected to her father by a string, invisible to others, which she can tug at when she needs him. Those who've grown up with the telephone can recapture the wonder of the idea of the phone only by looking at young kids' fascination with toy phones. Until recently all kids will have had a childhood episode when they connected two tin cans with string and tried to will sound to travel round corners. In these different times most children get mobiles long before they have had to eat the tins of beans and find the string.

3) Present tense
This next client was such a modern child, at age 22 long familiar with the mobile phone.
She was clever and attractive, a theatre-nurse, certain to do well.
"I've a big thing about presents, birthday and Christmas. I get very tense. Will I like what I've been given, by my mother or my boyfriend? Will they like what I get them? After some months I told my boyfriend how all this gets to me. He was surprised, but has been very considerate. But still it gets to me. Before we separated to go home to our families at Christmas, we swapped presents to be opened on the day. On Christmas morning I rang & texted him first thing, quite early, to talk about the presents. He said my present was nice. I said his was all right, too . We didn't talk long."

My first feeling on hearing this story was of immense pity for her. Then I thought of the familiar paradox, that the new media, designed to reduce distance in time and space, should cast such shadows on ordinary human connectivity.

4) Gooseberry fields forever
This client was a bit older than the others described here: thirty-something, a successful architect, in work and mortgaged. His emotional life had always been manic and a little desperate. Having finally, after several messy attempts, come out of a volatile relationship, he was soon fascinated by another volatile woman. They had been seeing each other a lot, getting on wildly, but both had hesitated about articulating whether these meetings were actual dates and whether they were in some process with coupledom as a possible end. His nerve was beginning to go, and he suddenly seemed very anxious to know how much he was wanted, and in what way. When next he met her in a work group, he tried the strategy of coolness, and then was surprised when she suggested, "Come to my room tonight, after the meeting."
He is relieved.' I will know soon', he thinks. But when he gets there she has a small party going on. He feels miffed. So annoyed, in fact, that he can't think. At that point he is unable to think that even if she doesn't say, as she might, discreetly in the kitchen or the hall, "Stick around. The others will be gone soon", he could take the initiative and say, "I'd like to stay when the others have gone: do you want me to?"
After a little while he feels so exasperated he announces that he's going. She accepts this.
It is the early hours, the deserted, rain-lashed Mancunian streets. He can feel his head bulging with frustration as he carries home his ignorance of where he stands. Then he thinks of his mobile phone. His mood lightens as he realises he can do something, now. He chooses not to ring but to text her: "What's going on?"
Because she has her phone on, she interrupts her own party to exchange texts. The conversation is deferred. She rings him the next morning to ask if she can come over at lunch time to talk. He is more relieved than delighted. But even his attenuated joy disappears when she turns up with a friend.

As I am listening to this story I try to keep in mind that the protagonists are not gormlessly excitable teenagers.

5) All along the watchtower
An Asian man murders his wife. But he feels invincible, because he has a passport, and he's just bought a ticket out. He sits on the airport bus gloating with satisfaction and triumph. But even this is not enough. When the bus stops at Motorway Services, he goes to a pay phone, and calls the police. "I've killed my wife. But Ha! Ha! you won't catch me: I'm flying out." He retakes his seat feeling fully pleased with himself.
When the Police arrest him at the airport he is astonished.
This was a true story from the late eighties. 'How could he have been so stupid?' most people would think. I had an idea. In his mind he still thought of time as perfectly correlated with space, as it is in agrarian cultures, pre-telecom. He was still in

the Indian time-space-frame of his childhood. If he was ahead of the Police in one dimension, he was in all. Though he knew how to use phones he hadn't quite believed telecoms bring everyone into simultaneity; often, there is no ahead possible.

6) The day has a thousand eyes and ears
The New Millennium, an ordinary High Street, Saturday morning. As I approach a thirty-year old woman, I see her take a ringing mobile phone out of her bag. Just as I pass her, I hear her say, with an annoyed look and tone "I'm just going into Woolworth's! Why do you keep ringing to see where I am?"

Is this a rhetorical question? What is going on? What level of contact would be enough for her? What level of information would be enough for him? The Greek Goddess Juno jealously set hundred-eyed Argos to watch the priestess Io, of whom Jupiter was enamoured. But there is an African saying: *Not even God is ripe enough to catch a woman in love.*

7) Through a camera glass darkly
A scientific researcher in his late twenties was 'advised' by his Head of Department to see me. His multi-national company provided BUPA and brief therapy as part of the salary package. There was the possibility of his being pre-emptively deported by the company as a way of avoiding police involvement. He had lent his laptop to his supervisor who had, accidentally, found a file with images and film of young women undressing in the company's Residential Training Centre. The researcher admitted setting up secret cameras to film his girlfriend and a visiting friend of theirs who was using her room to change for dinner. This virtual voyeurism was for him a minor pleasure – and do-able because he had the skills. He hadn't been careful enough to hide the files.

This carelessness puzzled me. Unlike a dog frantically burying a bone, this task would take a computer whiz-kid a few seconds. I wondered how he expected to be seen by me, whether he thought I could put a camera inside his unconscious. He made noises of regret. It wasn't really an analytic session. Unfortunately, as he was not required to, he didn't return.

Electronic tagging arrived years ago. Geek-chic, fashion clothing wired with mobile phones and cameras, has been on the catwalks, and will be on the High Street one day. Those newly in love can never see enough of each other: those lovers who are merely suspicious will be able to see their lovers even more! Compare this with the beautiful speech from Jane Eyre:

I sometimes have a queer feeling with regard to you - especially when you are near me, as now: it is as if I had a string somewhere under my left ribs, tightly and inextricably knotted to a similar string situated in the corresponding quarter of your little frame. And if that boisterous channel, and two hundred miles or so of land come broad between us, I am afraid that cord of communion will be snapt; and then I've a nervous notion I should take to bleeding inwardly. As for you, - you'd forget me.

These sublime pre-telecom words are not spoken by Jane but by Rochester. Between drafts of this essay I read of science, if not morality, marching on. At the height of the tragedy of Holly and Jessica, The Guardian reported a father who had persuaded a researcher to implant an electronic tag into his 13-year-old daughter so that she would be traceable on his computer map. The poor girl was compliant. How deep inside her intentions does he want to be?

8) Showing off to one's therapist
My client enters. Familiar client behaviour - faffing with coat and jumper, handbag or briefcase, or the day's grocery-bag. Sits down. Then "Oh I'd better switch off the phone". Gets out mobile. Fumbles. "It's a new phone" – nervous, winning smile. Settles into the chair: shows 'ready' posture and another weaker smile.

Half of my clients this week have done this. I find it so wearying and annoying. I think, *"Why do you do this right now? Why not in the waiting room? Why not in the five yards before you enter the building?"* Then, more spitefully, I think, *" Oh you're so important, you must be connected and open to the Real World out there until the last possible moment before you enter the strange, detached, floating-world-space of therapy."* Then, more sympathetically, *"Oh you poor thing, so terrified of being unconnected to your little loop of knowledge and gossip, for a whole fifty minutes"*
Finally, the therapeutic thought: *" What does it do to both of us, therapist and patient, knowing that you have shown me that you understand that your mobile can't be on during the session? Will you resent the rule and resent me? Will I feel annoyed that you dare to resent me?"*

Sometimes of course the phone goes off, its usually trivial tones piercing the session. Then more fumbling and weak apology.

What kind of symbolic-object is the mobile phone when it is in the outside world, and what is it in the therapeutic space? Imagine a society where everyone wears trousers with zips-down, and couples at will: the *zipless fuck* imagined by Erica Jong, or simply a kind of *doggy-life* imagined by Auden. Perhaps in this strange world there are places where it is required to be zipped up:

imagine them coming in to the therapeutic space, and noisily zipping-up.

Young men and women cradle their mobiles like permissably showable penises. If the penis is the male's umbilical cord in and to the outside-womb world, the female's mobile is finally the longed-for phallus. The client's act of showing the phone being switched off and put away is a minor sadistic teasing of the therapist: *You can't fuck me!*

9) A short story by Don DeLillo
We may see magical thinking and the hope of sudden wondrous invitations bursting into the present as being allowable to teenagers, even twenty-somethings. But when does it become a failure of maturation, to let go of the string? As I was writing this piece I came across a new short story from Don De Lillo. Two middle-agers meet in an art gallery; they go to a snackbar and then drift back to her flat. Neither feels much desire, though he is somewhat insistent. But his cellphone rings; he speaks briefly, then sits thoughtfully with the thing in his hand. He says, "I should remember to turn it off. But I think, if I turn it off, what will I miss? Something so incredible. The total life-altering call. That's why I respect my cellphone." The man is not aware of what he has said, and the woman does not say, "Well, I'm obviously not incredible or life-altering enough for you", or, "How about some respect for me?"

It is depressing to sense that such an older character, arriving in the therapeutic space, would be just as pathetic about the phone as a teenager.

Commentary

My intention is to look at how recent developments in communication technology alter the experience of the therapeutic space for both the therapist and the client.
My argument will be grounded in three premises.

1) The fact of *Instinctual Impatience*
This premise unites the elements of a crucial explanatory matrix – time, knowledge, action and pleasure. One always strives to reduce the *time* it takes to acquire the *knowledge* necessary to perform the *action* that one reasons and hopes will bring one *pleasure*. (The last element includes relief/cease of anxiety and pain, as well as ordinary joy and self-transcending release.)

a) *Time*
It is said that one's experience of the flow of time is related to the frequency of thoughts in one's most frequent conscious waking state, and that this ability to think is biologically facilitated by adrenaline. We are all aware of the poles of this experience:

> The few moments just before losing consciousness in sleep, or the sensation on waking from the 'just five more minutes sleep' after switching off the alarm-clock. As one is on the edge of consciousness, one's adrenaline-level is low, and thoughts are slow to form. So the sensation that one is having, or has just had, a few thoughts, prompts one to infer that only a few minutes have passed. Thus the shock of seeing that an hour has passed!
>
> The other pole is the time before an accident reaches crisis. Once one's consciousness registers the possibility of an accident, one's body is flooded with adrenaline, allowing one to think of all possible avenues of correction or flight. One becomes aware of an avalanche of thoughts filling one's head, most not registering. It seems hours or ages have passed. Usually it's barely seconds.

b) *Knowledge*
How knowledge contributes to the possibility of conceiving and executing the action that will bring pleasure determines how the time of the desire and the pleasure are experienced. Other people are either the object of desire or the source of knowledge about the objects and persons desired: they may, of course, be both: Do you love me? One may acquire knowledge in three ways:

> By mutually negotiated open exchange: ask direct questions, answer truthfully. This is the definitive moral means.
>
> By accident: overhearing, misdirected letters and emails and phone calls. A friend of mine shared the same initials as his father and brother. Absent-mindedly opening a letter, his father found out before him that his son was due in court.
>
> By intentional deceit: invasion and trap, varieties of immorality. Childhood fable: *Truth and Falsehood went swimming together. Falsehood got out early and sneaked off with Truth's clothes.*
>
> Invasion - Polonius & Claudius spy on Ophelia. Trap – Hamlet feigns madness: Toby and Maria drop the letter for Malvolio.

c) *Action*
One either makes time to act or one makes time to make excuses or even justifications for not acting. It is a basic rule in the therapeutic space that the argument from logistics - I was too busy, couldn't get to a phone/computer/envelope, missed the bus, car broke down - is disallowed. One must excavate the desire or the anxiety that inhibited action.

d) *Pleasure*
The awareness of ordinary anxiety or of the possibility of ordinary pleasure, and sometimes the awareness of the possibility of pleasure, prompts anxiety, produces various levels of adrenaline and of thinking. Part of the pleasure is created by the reduction in adrenaline and the end of the task of thinking

2) The prevalence of what I call *The Technological Fallacy*. If something can be done, it *must* be done – without thinking. A corollary of this might be, if something can't be done, one needn't think about doing it, one can live with it undone. Consider this illustration from the theatre. While waiting for *Hamlet* to begin, one doesn't see a ninety-second collection of snippets from *A Midsummer Night's Dream, The Valkyrie* and *Run For Your Wife*. It can't be done with live actors, except perhaps in a small repertory theatre. But why bother, what would be gained? And though a hologram presentation might be possible, it isn't attempted. Again, it's not considered worth it, and besides, a hologram is too filmic. But film trailers are do-able, so they are ubiquitous and inescapable. It is rarely thought that something precious is lost in having such knowledge.

3) There is what I call *an economy of the human heart*. Even the happiest and most fulfilled, most kindly and likeable people have a limited amount of genuine intellectual attention and emotional sensibility available for their use each day. They work with zero-sum accounts. I am inclined to agree with the aesthetician Edgar Wind's scepticism about the possibility of attending two art exhibitions in two days. Of course at some level the task or pleasure is *do-able*. A critic might have to go to Tate Modern, MOMA and the Uffizi all in a week. A person might listen to several friends crying or celebrating. And a psychoanalyst might have an extraordinarily busy week. That's why I say 'genuine'. I am showing my colours by this!

The reader might wonder, and quite reasonably, why I didn't begin with the expected Marxist axiom: *Changes in the means of production irrevocably alter social relations*. Or the MacLuhan maxim: *The medium is the message*, which ignores Marx's axiom by a sleight of hand. It's not that I disagree with either, it is simply that I am entering the problem from a different direction.

Good time and bad time

Here is a story I found deliciously shocking in adolescence. I read somewhere that from the field of battle Napoleon sent his mistress a letter saying. *"Home in five days. Don't wash!"* During those five days, he'd be on horseback, in a coach, on ship.... She'd be swanning between apartments choosing between velvet and silk.

I don't think I really understood until, five years later, an older Scottish Lothario to whom I told this story said, *"Oh yes, I like it when a woman is as runny as brie down there"*.

Now imagine Josephine in the age of texting mobiles, Lear jets and power-showers.
Am I arguing that something more valuable grows in Napoleon and Josephine's cervical and cerebral cells than in Ivana and Donald Trump's cell-phones? But what! Aren't I merely showing the envious oldy's spite for the stillfirmfleshed young, *"You're getting too much, too soon! You must learn to wait, and enjoy waiting"*

When I read recently of the teenage Hazlitt walking eight miles to hear Coleridge speak, and eight miles back, I was impressed and, most strangely, I felt happy for him. I thought of Pascal's 'rule': *Respect means put yourself out!* and of Spinoza's aphorism: *All noble things are as difficult as they are rare*. It is crucial to one's maturation to know that one can be arsed to make an effort. But then not every difficulty endured is either respectful or noble. Vladmir and Estragon are said to show dignity in their waiting for Godot. The elect in Purgatory show the most benign form of waiting. It is another maturation marker that one comes to understand that emotional understanding always lags behind intellectual understanding – by days if not weeks - and that even then, for the unified, emotional-intellectual understanding to become a new-felt disposition will take even longer.

The emotional highway

The Highway Code introduces us to the concept of *thinking-time* in the action of braking. All of us carry a sense of thinking-time for requesting help. Here's a story:

My good friend lived within walking distance, but still too far. What does that mean? My criterion was that whatever I was thinking or daydreaming about when I began my walk, I would lose the thread before I got to his house: sometimes several threads. I could cycle, but one thinks differently on a cycle. When he said he might move to my street, I was delighted. I thought, "Good! He will be within thinking-distance. I will see him, his kids, and his wife differently. I will be part of their daily flow, even if I don't see them more frequently. I will be in their imagination as available within three thoughts – for popping in, or being called to look after the kids for a few minutes: less time than it took to get to the old house." Sadly, he got a better house even further away.

Such limited-thought, daily-availability of others was ordinary life for most people for centuries, in

the country and even towns, until the advent of utterly atomised urban life. Perhaps we all carry a family-memory of that rhythm of availability. Is this why campus and collegiate universities are very popular?

Future-less time

One of the most tragic consequences for a child brought up in the daily, even hourly crisis and chaos of a dysfunctional family, is that there is no emotional space to imagine a future. There is just the crisis of the moment; her body and mind are soaked in adrenaline, she thinks only of how not to be destroyed and how to get or steal some pleasure. What kind of talisman is the mobile phone to such a person?

The wrong trousers

In a time of limited literacy and no telecoms, Shakespeare imagined Rumour as a many, Hydra-headed monster (Henry IV Part II). If Christ is the Word, the Good News, the devil is a gossip. And everyone loves gossip, as long as it doesn't show our dirty linen. But now we live in different times.

"In the nineteen-thirties Cordell Hull complained of print and radio that a lie went halfway round the world before truth had time to put its trousers on: nowadays it has been to Mars and back before anyone is half awake." Harold Evans, writing in The Times of recent propaganda in the second and third worlds, adds *"[There is] an aura of authenticity provided by technology, by the internet. [People say]* 'He got it from the internet.' *They think it's the Bible. Here in our new magic is a source of much misery."*

This is a lovely quote. It has its roots in the old children's fable about Truth and Falsehood mentioned above. There are ideas of nakedness, the 'true' penis, magical speed and power, and ultimate Faustian disappointment.

The task of therapy

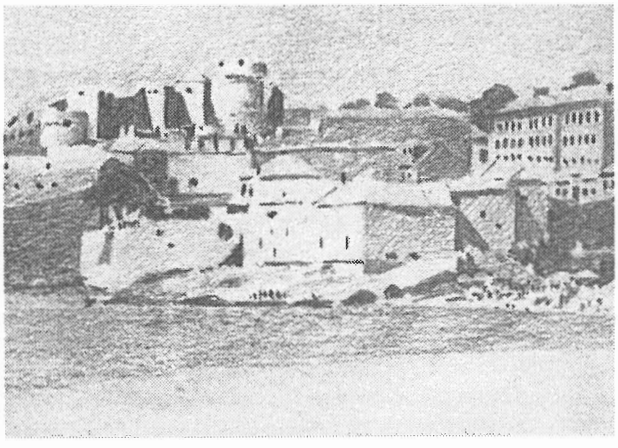
The title of this essay comes from a perfectly trivial simile by Ben Elton. He has the doltish Prince Regent say to Blackadder, *"I'm as happy as a Frenchman who has invented a pair of self-removing trousers."* Adolescents, like the Prince, want everything faster than they can imagine it! Some Abbots won't consider young novices now because, they argue, modern adolescence lasts till thirty. I think new technology carries the danger of removing the Self faster than one can tell.

New technology allows one not to be alone in-this-room-now; it allows one to be 'with' others, but not in the same space, in-this-room-now. It allows one to hurry others to respond; it hurries one's own thoughts faster than the psyche can understand and the heart can feel. Is the use of telecommunications mostly the Kleinian manic defence against an inability to be alone, against becoming the *fort-da* baby with a broken thread, the cotton reel flying into space – the next room – like a lost spaceship?

Is the highest gift the therapist can offer the gift of attention and the possibility of the strange experience of the benign dilation of time? Isn't Attention Deficit Disorder a misnomer: the failure in attention is the carer's, not the child's?

Is it the task of therapy to enable the client to think slowly, to reduce adrenaline levels, to be able to be alone, to be in the same space as others, to live with waiting for others, to live with uncertainty?

Anti-gun lobbyists plead, 'Give up your guns.' Should therapists recommend abstinence from mobiles? Should they ask their Receptionists to say to clients *'Leave your mobiles in Reception.'* (On the wall of the Interview Room in the Citizen's Advice Bureau there is a sign: *"If your mobile phone goes off, you will be asked to leave!"*) What kind of nakedness would the client feel then? Who'd be wearing the trousers then!



Barbara Tregear

"Don't tell me, show me"

"Don't tell me, show me": these are the crucial words of Dr. Jacob Moreno, the father of psychodrama. So, how is one to write about psychodrama for a readership of analytical psychotherapists? My preference would be to invite readers of this journal to a day workshop and, after you have experienced the power of psychodrama, to sit down with you and discuss the theory and methods. But I must attempt to write.

Those opening words, spoken many years before the introduction of drama, art or music therapies, separate psychodrama from purely verbal analysis. Moreno lived from 1892-1947 (cf. Freud 1856-1939); like Freud he was born and raised in Vienna, and he too was a psychiatrist, but in addition he had a passionate interest in the theatre and acted and directed. He decided that the best theatre was when the actor played his own life, so he organised 'Theatres of Improvisation and Spontaneity'. Then he realised that this technique could be of more use to those acting than to the audience. He moved to New York and in 1936 opened his own sanatorium, and later his own psychodrama theatre at St. Elizabeth's Psychiatric Hospital, Washington. So the roots of psychodrama are firmly in the theatre.

Peter Brook, in his book *The Empty Space*, tries to explain the power of drama; he writes that a man walking across an empty space while someone else is watching him may or may not be an act of theatre. What makes the difference? He answers, "I suggest it is when the spectator becomes interested and projects some of his own feelings into the person on the stage." Later in the same book he points out that the French word for a performance is a representation: that is, a 'making present'. He continues:

> For representation is not an imitation or description of a past event, a representation denies time. It abolishes that difference between yesterday and today. It takes yesterday's action and makes it live again in every one of its aspects – including its immediacy.

This idea of abolishing time is fundamental to analysis.

In a psychodrama group, the members have the opportunity to be audience, to act part of their own life and to take other roles. All these experiences may be therapeutic. Sometimes, being a member of the audience watching the psychodramas of others may be enough. Marcia Karp, the doyenne of psychodrama in Britain, used to run weekly public sessions. One woman attended for several months, always sitting in the back row and never saying a word. Eventually she came up to Marcia and thanked her, saying that her problems were now solved through watching the psychodramas of others. At other times, however, we have an 'acting hunger'; this is vividly illustrated in Pirandello's 'Six Characters in search of an Author':

> **Father:** The drama is in us. We are the drama and we are impatient to act it – so fiercely does our inner passion urge us on.

and then later:

> **Stepdaughter:** I'm trembling with desire.....Simply trembling with desire to live that scene (and then she starts to set out the scene exactly as the protagonist does in a psychodrama). That room....Over here is the shop-window with all the coats in it.....And over there the divan, the long mirror and a screen.....And in front of the window that little mahogany table.....and the pale blue envelope with the hundred lira inside. Yes, I can see it quite clearly.

Sometimes we learn by reversing into the roles of people significant in our lives and sometimes it is by playing other, unknown roles. I worked with a group member who was an agreeable, intelligent middle-aged woman. To her surprise she kept on being chosen for angry roles, which she thought were most unlike her. However we all started to consider this, and she began to explore her own hidden anger. For the protagonist, reversing into roles of people that are significant for him is an

immensely learning experience. For other group members, playing parts new to them is also important. By trying out new roles, one extends one's role repertoire and, paradoxically, establishes one's own identity more firmly. Moreno once wrote, 'Roles do not emerge from the self, but the self may emerge from roles'.

The therapist is also the director of the play, and much that has been written about the role of a stage director is useful to the psychodrama director. Roger Grainger, a dramatherapist, writes:

> By demonstrating its own structural differences from the ordinary world, theatre dislodges us from our prepared positions, so that we can enjoy the imaginative experience of mutuality and sharing, the expansion of our own private world which we find so liberating once the barriers are down. From a technical point of view, theatre may be seen as a way of arranging people and objects to produce the maximum degree of concentration of the human senses.

Psychodrama can be effective both short-term and long-term, and psychodramatists often run short courses or weekend workshops. When I run a weekend the participants may be people already in long-term therapy (they are often encouraged to come by their therapist), counsellors and therapists who want a taster, or people with no experience of therapy. This last group obviously needs special care. I build up a friendly atmosphere by shared food and coffee breaks in which I participate. We do a range of introductory exercises, or 'warm-ups'.

At a weekend workshop, I once directed a psychodrama about a woman's envy of her sister having a baby, and her resentment towards her partner that she was childless. She chose to enact the birth scene with herself in another room. The mother in labour was played by a young woman whom the group was meeting for the first time, and whose baby they had met at lunchtime. We all connected in differing personal ways with this universal experience.

I now prefer to practise psychodrama in a consistent weekly long-term group, and here, as always, I combine group-analytical thinking with psychodrama methods, although I keep the two practices distinct. The conditions of the group correspond with the way most groups operate in this particular agency. Clients can stay for up to two years, and the groups have firm boundaries about time and not meeting outside the group. The most obvious difference is that the psychodrama group lasts two hours, rather than the usual one and a half hours. I have also facilitated group-analytical groups, and I realise that there my style is different. In the psychodrama group I am warmer, more directive and less strict about not revealing anything about myself. As a psychodramatist, I am aiming to create a safe container so that group members are able to undertake a risky venture.

The setting is a large pleasantly furnished room, with chairs, beanbags, cushions (at one time we had a very useful settee), small tables and a room divider. There is also a box of 'props,' containing masks, small objects, lengths of material, a telephone, a fan, a baby doll etc. At the end of the room nearest the door is a circle of chairs of exactly the right number, including ones for absent members. This is analytic custom but, unlike an analytic group, where the members assemble in a waiting room until the conductor summons them, for this group they assemble in these chairs as they arrive and are chatting together when I come in, exactly on time. As this is an on-going group, instead of having a structured warm-up we have about thirty minutes of unstructured talk, which often concerns last week's session, current concerns or group dynamics. I, with the help of the group, am looking for a theme and a protagonist. When these have been agreed we move into the enactment phase.

The seating is rearranged. The protagonist and I sit in the large stage area, and the others form an audience. I ensure the chairs in the stage area are placed so that the 'audience' can see; because, as well as taking the role of therapist, I am also a theatre director and am mindful that the audience needs to see, hear, understand and, hopefully, be emotionally moved. I discuss with my protagonist where she wants to start and who else we need. I then ask her to choose someone to play the parts. A chosen person is free to refuse, though we will probably explore this later. I then ask the protagonist to sit in another chair and BE that other person, partly to show the actor how to do it, and partly to get the powerful experience of being the other person - perhaps the nagging wife, the neglectful parent or the hated employer. The chosen actor and other group members may ask questions or make comments at this stage but I guard against it becoming a discussion; our purpose is the enactment. I also ask the protagonist to 'set the scene', using whatever is in the room.

We then begin the enactment. I may use other techniques: if the scene is too painful, confusing or repetitive, I may ask the protagonist to step out of the scene and watch someone else playing her part. We may use 'doubling'; if an audience member thinks an important thought or emotion is not being expressed, they can move behind the actor and utter the unspoken. I will probably use more

role reversal and we may move to earlier time; for example, a man could start a scene about an angry boss and then go to a memory of an angry father.

I make sure that we have about thirty minutes left for the final stage. I bring the enactment to a close, often reminding the protagonist that there is plenty of time to revisit the material in a later session. I then ask the protagonist to clear the scene (it is important that she does this herself). We resume our seats in the circle. I ask each character to speak from the role and to de-role him- or herself. We then 'share' by talking about which bits in our own lives were activated by this drama. Sharing moves into a less structured discussion, and we finish on time.

There are many variations on this classical form. Sometimes I use symbols and images, sometimes the whole group explores a theme, sometimes we explore the group dynamics in a living form. To illustrate this diversity, here is an account of one session in a long-term group. I have altered the description of the protagonist to preserve anonymity, but have retained the sequence of the session.

The woman who was unable to cry

The protagonist is Samantha, a beautiful woman of 35; she has been a singer in a nightclub but is presently unemployed. She has suffered a great deal of loss throughout her life and is lonely and depressed. She lost her twin brother David when they were 4, has had many lovers, but seems unable to sustain a lasting relationship.

The previous week, Samantha told us that she had been unable to cry for most of her life; she connected this to being ridiculed and punished for crying as a child. This was horrible because now her unhappiness had to stay locked inside, as it could not be expressed. This week I reintroduced a former idea of having separate chairs for anger and sadness; these feelings had been discussed in the group but were confused and partly suppressed; the intermingling of the two feelings seemed to reduce their force. My proposal was, that by separating them, people would be able to recognise and express these feelings more clearly. I asked the group to sit at one end of the room facing the stage area. I then placed a bright red swivel typing chair for anger and a dark grey beanbag for sadness on a diagonal line, and opposite placed a neutral-coloured upright chair to represent the object of these feelings.
The group sat in silence contemplating these images. There was no need to hurry. I made a comment that people, including two members who had not yet witnessed a psychodrama, might be embarrassed at the idea of performing but encouraged them to contemplate 'The Empty Space' instead of worrying about performing. One established member of the group moved into the angry chair and said how angry she was with her psychiatrist. The group had heard this before and it was done without spontaneity. There was then a long silence.

After 5 minutes of silence, Samantha moved on to the grey beanbag and related reasons for feeling very low: the lack of effective help from doctors for her many ailments, her lack of any work and consequent shortage of money, and no invitations for Christmas. I invited doubles. One woman doubled " I feel hurt and rejected because no-one wants me". Samantha amended this to her friends not meaning to hurt her, but pursuing their own agendas without considering her needs. She didn't perceive the doubles as empathy but rejected them, saying she did not want sympathy. Another group member suggested a link to Samantha's original family, who had left her, and I put chairs for father and mother. I then asked her if I could add a small cushion to represent David; she agreed; gazed at it and appeared very sad.

Samantha returned to the present day and her anger at doctors, so she and I put a chair to represent the doctor. Occasionally she moved into the anger chair. A double suggested that she had always put a lot of effort into life but had not got much return and that this was unfair. Samantha returned to the theme of not being able to cry and said she was uninterested in other ways of showing sorrow such as 'tearing her hair out'. She said she was in Limbo, unable to be angry or sad. I put a large, pale cushion between the sad and angry chairs and Samantha sat there, in Limbo. This very much represented what had been happening in the group - a reluctance to express emotions. As director, I longed to help her overcome this block and I wondered whether to suggest the thumper or beating a cushion. I handed her a small drum, thinking she might beat it to express anger. She began, very gently, to make a rhythm. This developed into a song about a girl who is so beautiful that no man can stay with her, and she is left on her own. Samantha was using the already written tune and her musical skill partly to show, but also to hide. She seemed like a little girl 'showing off' in front of parents. I moved nearer to her and suggested that the song represented her loneliness, and she agreed. I asked for one word to describe her childhood and she said 'solitary'. I then removed all the object chairs and said: 'You have an empty space. Who would you like in it?' She replied, 'David', and began to cry.

Her tears brought relief and release. This was followed by deep sharing from the group.

Psychodrama may be used with individuals or couples. Symbolic objects, empty chairs and role reversal will probably be used when working with individuals. One colleague who works with people who hear voices, asks them to be another person who knows them well and to describe themselves; this is part of his assessment process. When he asked one young man, 'Who knows you well and could describe you to me?' the young man thought and then said, 'God'. So, he was role-reversed into the role of God.

In marital therapy, it is very powerful to ask the couple to reverse roles. However, psychodrama is essentially a group process. For some people it is the experience of being in a group where people risk self-disclosure and intimacy that is the most important healing.

Psychodrama has a different flavour to analytic work. It is both more cathartic and more optimistic. Moreno wanted to increase people's creativity and spontaneity, and believed that engaging in the psychodrama process did this. Apparently, when he met Freud in 1912 he said, 'You analysed people's dreams; I try to give them the courage to dream again'.

Peter Brook, speaking of the theatre, said, "A few hours could amend my thinking for life." The same is true of psychodrama.

References:

Brook, Peter (1968) *The Empty Space*. London: MacGibbon and Kee.

Fox, Jonathan (1987) *The Essential Moreno*. New York: Springer.

Grainger, Roger (1990) *Drama and Healing*. London: Jessica Kingsley.

Pirandello, Luigi.(1954) *Six Characters in Search of an Author*. London:Heineman.

Peter Lomas

On not being able to write

In a speech delivered shortly before his retirement as President of the Czech republic, Vaclav Havel, poet, playwright and statesman included these words:

> And I've discovered an astonishing thing: although it might be expected that this wealth of experience would have given me more and more self-assurance, confidence, and polish, the exact opposite is true. In that time, I have become a good deal less sure of myself, a good deal more humble. You may not believe this, but every day I suffer more and more from stage fright: every day, I am more afraid that I won't be up to the job, or that I'll make a hash of it. It's harder and harder for me to write my speeches, and when I do write them, I am more fearful than ever that I will hopelessly repeat myself, over and over again. More and more often, I am afraid that I will fall woefully short of expectations, that I will somehow reveal my own lack of qualifications for the job, that despite my good faith I will make ever greater mistakes, that I will cease to be trustworthy and therefore lose the right to do what I do. (1)

In another speaker such a confession could well be a pose, an exercise in false modesty. Not so in Havel, who gives the impression of unusual honesty. Puzzled to find himself in this state of mind, he attempts a partial explanation: he attributes it to his unusual and dramatic public life. I find this unconvincing, for it is not uncommon in those of us who lack such achievements. It is certainly a state of mind with which I can easily identify.

A while ago I was encouraged to send a contribution to Outwrite. I made several attempts to respond to this. Each one started with a spontaneous idea which, on reflection, seemed to have promise. Each time, however, as I elaborated the idea, accumulating a collection of notes and the beginnings of a draft, I lost heart, unable to convince myself that I had anything to say worth saying. The present article would probably go the same way were it not for the fact that, having confessed and confronted the problem, I may put aside misgivings and just do it.

What I aim to do here is to approach the problem by means of a description of, and reflections on, my personal experience – leaving aside the numerous contributions to the subject in literary memoirs and psychoanalytic theory. This not only spares me work, but offers a chance of coherence in a short paper. As with Havel, my age must be a factor, but I will come to that later.

Why do I want to write? Firstly, because I enjoy it. The enjoyment is, however, a complicated one. It has more in common with climbing a rock face than lying on a beach in warm sunshine. It has an aesthetic quality: even a paper on psychotherapy is a work of art, however bad a work of art. And, if the endeavour goes reasonably well, there is the anticipation and satisfaction of accomplishment.

Secondly, the wish to be heard. The urge to express oneself, to make an impact on others and share ourselves with them is basic to our nature. We have only to watch small children to realise that this is so. Many of us have not been well understood in childhood and this lack will increase our urge to gain a hearing, yet inhibit our capacity to fulfil this aim. The consequences vary enormously: one possible consequence is an urge to write. Writing is an odd way of communicating. It is a lonely and unsociable occupation with no immediate results. But it can help to dissipate a sense of isolation.

Thirdly, writing can constitute a wish to change what appears to be wrong, mistaken or unjust in one's environment. If I tell my neighbour that the Prime Minister is a thickhead, it is less likely to

change the situation than if I publish it, couched in acceptable language, in the Sunday papers. And it seems likely to be more potent than putting a cross on a voting form every few years.

Fourthly, ambition. I want to be respected, if not a star. Although, in the face of television and other electronic devices, writing is becoming an outmoded art, it still retains some prestige. And, for those of us who work in, or under the shadow of Academe, the prestige is significant and can make or break careers. Some of us are more possessed of this emotional need than are others and much has been written about this. Simon Schama, with engaging honesty, put the matter very simply: "Oh yes, I feel inadequate. But feelings of inadequacy are the *sine qua non* of good work. Every writer I respect is haunted by such feelings".

Fifthly, distraction. The distinction between a spontaneous urge to do something and engaging in an activity to avoid a feeling of emptiness is not easy to make, but we can often be aware when we are pursuing the latter course.

The reasons we adduce for a certain type of behaviour are never sufficient. In addition to these explanations, I have a sense that I write because I have to. I feel rather like the climber who, when asked why he went up the mountain, said, "Because it is there." It may be that such an impulse is basically inexplicable. One could think of it as the accumulated force of all the reasons, conscious and unconscious, that can only find expression in this particular activity.

If, in the face of a strong urge to write and some ability to put sentences together we find ourselves unable to do it, there must be powerful reasons which hold us back. The following come to mind:

Firstly, a lack of confidence that we have something to say that is sufficiently important to make public. This apparent lack may have the virtue of humility and be a recognition that too much is written already. Perhaps it takes a certain degree of arrogance to write. The wiser we become the more likely we are to become aware of the scarcity of valuable writing and the limits of one's own talent. On the other hand, the lack of confidence may denote a failure of nerve or a neurotic feeling of inadequacy. Paradoxically, the sense of insecurity that drives us to write can also make us falter.

Behind all this is the courage to be – to present one's authentic self, in whatever form, saying to the world as it were, "This is me. I'm worth having. What I express is worth receiving." The ability or inability to do this has been the subject of intensive thought in both the psychoanalytic and existential movements, but it does not apply to writing any more than to all our endeavours in life.

Secondly, writing requires a lot of time and a high degree of intellectual and emotional dedication for which few get paid. The emotional involvement is, I believe, the most hazardous aspect of the task. The factual reporting of a comparatively simple event may be accomplished, well or badly, without too much of this kind of investment. When, however, we embark on a less definable undertaking which demands whatever imaginative powers we possess, the matter is different: we have left the known road and are in the woods with no discernable path and no clear destination. We know, from their own testaments and from their biographies, the sacrifices the greatest poets and novelists make on behalf of their writing, and the resulting impoverishment of their personal relationships: it is as though they are gripped by a sickness. But even we who are amateurs, whose work is not writing but who write about their work, may feel at times as though they have a mild dose of the malady. When I write I feel that I move a little away from everyday life and enter a virtual world. I feel slightly disembodied, or as if I had put my psyche through an unnatural movement which does it no good.

Writing about psychotherapy requires us to use a different aspect of our attention from painting, but both are an effort of creativity. For this reason Marion Milner's work on difficulties in painting is relevant (2). Milner suggests that creative activity compels us to enter a state of fusion with the other, comparable to the experience of a baby before he or she has established the boundaries between self and outer world. This change of state involves risk and may account for a sense of having to wrench ourselves out of our usual frame of mind. All occupations have their perils. Psychotherapy demands intense emotional involvement but, unlike writing, we are relating directly to people and, unless possessed by a *folie-à-deux* or practising in an alienating way, we are still rooted in the ordinary world.

Thirdly, for much of my time working as a therapist I thought in psychoanalytic terms. Gradually, however, I have changed to ordinary language, for I found I simply could not stretch psychoanalytic language to encompass the way I worked. I found, for example, that I tended to use words such as ordinariness, decency, justice, sulk, tact, negotiation, etc., which have been with me for most of my life and which, although they may be translated into psychoanalytic theory, are distorted in the process. When I now write about my work it

feels natural to use everyday language. However much Freud's theories have inspired me in the first place, I no longer feel I can make any useful contribution in his terms. For this reason I am often unsure as to how much I write is a repetition of what has already been written in other words, or whether I have managed something more fruitful. The problem is most acute and most inhibiting when I write for a readership who primarily think in terms of psychoanalytic theory. What form of words would I need to bridge the gap between the two languages? I take comfort in the belief that ordinary language is the most subtle way we have of talking about human beings and how to help them. If this is true the personal inhibition I describe has a more widespread application.

In view of the hazards of writing and the uncertain outcome, it is little wonder that we seldom embark on it or that, if we do so, we may quickly stumble. And it is unsurprising that we look for means to lessen the degree of our emotional involvement and evade full responsibility for our product. There are many ways of doing this, several of which are to be seen in psychotherapeutic papers and books. We may, with apparent humility, make no claim for our own viewpoint and hide behind the authority of other writers. Some papers are so splattered with references that they are practically unreadable; the authentic voice is smothered by a display of book-learning.

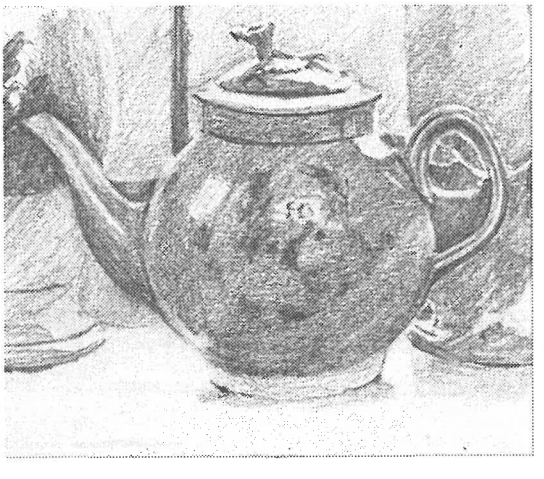
Another manoeuvre is to present our work in as objective, detached and unemotional a style as possible, describing our technique and formulating the patient's experience in terms of a model of psychopathology. In doing so we spare ourselves the discomfort of revelation. This is in contrast to the method of great writers who, by directly or indirectly revealing their hearts, move us deeply and illuminate the world. We cannot match them, but I believe that if the crippling form in which therapists are expected to write were removed, most of us could find our voices enough to generate a viable literary mode.

And now the question of age. As we grow older our bodies are all too clearly functioning less well, and this deterioration will include the brain. But the brain is complex to the point of mystery and appears to have a surprising capacity to compensate for organic change, and we cannot be sure that its laws are quite similar to those of the rest of the body. There are few people whose minds are as alert as ever at 90, but there are none who could run 100 metres in 10 seconds. If there is some truth in this the deterioration of mental ability with age may depend significantly on our attitude to living. Our ambitions may fade because we become tired, or because we feel we have achieved enough to satisfy ourselves, or because we may recognise, sadly, that the hopes of youth were pipe dreams – we cannot, after all, change the world. Once the desire lessens, all the particular reluctances and resistances come to the fore. Perhaps this is why I am now writing about such difficulties.

Was Havel right to be anxious? I think so. Not because of any loss of quality in his address, but to alert himself to the danger. Once we become complacent about our presentations, once the fire has gone out of us and with it the anxious need to communicate our passion, we would do better to be quiet, hoping that in time what Keats called 'negative capability' may engender a renewal.

References

(1) Havel, V. (2002) *'A Farewell to Politics'*. New York Review of Books, XIXI No. 16.
(2) Milner, M (1957) *On Not Being Able to Paint*. London: Heinemann.



Reviews

The Psychotic adolescent male and psychiatry: an uncomfortable mix

"Inside My Head": Channel 4
Review by Nick Hay

Earlier this year a series of programmes called 'Inside My Head' was shown on Channel 4. The first of these, a story about Michael, a 16-year-old who has had two episodes of schizophrenia, highlights some of the limitations of the psychiatric model in thinking about and treating young men.

As the film opens, Michael is at a football match with his father. He is smoking a cigarette. He smokes a lot of cigarettes. He introduces himself: "I'm Michael. I'm ill.....I've got suspected schizophrenia". He tells us how his thoughts get louder and louder and he can't stop them. Later he calls these 'voices' – which sound like his own, arguing with each other. They started in year 9 following his return from an exchange visit to Germany. He recalls how, at school, he has been called a 'fucking schizo' and people say things like 'you're bloody mad, get away from me'. He looks lonely as he wishes that the teachers would support him with this, but they say they can only 'have a word'.

The presenter tells us that the family is worried that Michael might deteriorate in the coming months because of the stress of his impending GCSE's. Michael has been a bright student but because of his illness has had to reduce the number of subjects he is taking, from 9 to 5. However he retains his ambition to study German at university. The scene shifts to Michael's home where he introduces us to the parrot, Rocky. Rocky and Michael get on extremely well. In fact Rocky is the only creature to whom Michael introduces us; he introduces neither his parents nor his brothers. The brothers are obliquely referred to but appear nowhere in the film. This young man is isolated.

Michael uses the words, "I am ill". He does not say, "I feel ill", nor does he say, "I have a psychiatric diagnosis but I am currently well". It seems that he has been told that he is ill. Is it wise to give a diagnosis of a major mental illness such as schizophrenia to an adolescent? It is fairly clear what the diagnosis might mean to the doctor: it describes a set of medical symptoms and defines what medication to prescribe. But of what use is it to a 16-year-old to think of himself as mentally ill and to have such a label? Surely he will at the least feel disabled and barred from much that society may offer, including work, and at worst, that his life may as well end now. It is noteworthy that Michael himself describes his diagnosis as 'suspected' schizophrenia, which perhaps may be his way of putting some distance between himself and the possible implications of it. Such a diagnosis could easily wait until things become clearer; many of these early experiences can be described more simply as 'psychotic episodes' and can often be related to extreme stress. Could the voices he describes be drowning out some very stressful thoughts? Could the experience of being in another household in Germany have raised unconscious discomfort about the nature of his own?

Mother describes Michael as having been "a bit eccentric sometimes, but we loved him just the same (as the others)". The past two years have been a 'nightmare' she says, with anger and resentment. She points out how they have "saved the NHS all this money because he lives with us and we get no break from it". She describes the psychiatrist as a "wonderful scientist, marvelous with drugs.... but dealing with the everyday practical problems...." She tails off, suggesting that she is alone with all of that. She describes how Michael once went into a trance-like state and had hallucinations, "which couldn't have been very nice for him". These are strange words to use about something so traumatic, and perhaps indicate how hard it is for her to understand what goes on in Michael's head. She says, "The devil took over": Michael would go into a rage; or he would go on all fours pretending to be a dog or a cat. She says things have improved since he has been taking

Risperidone (an antipsychotic drug), which keeps a 'lid' on his psychotic symptoms. Mother has a lot of faith in tablets. She does not appear to wonder whether there might be something that Michael or anybody else in the family could do in order to ease bad times. Her strategies are tablet-based. After one particularly difficult night, during which Michael was hallucinating and could apparently see a man being stabbed repeatedly, with blood going everywhere, she checks up with him whether he has taken the proper dose, to see if this might explain his deterioration. Perhaps she does not think it relevant to speculate about what had been going on for Michael in the home or school that day.

Mother is angry, too, about the response of others to Michael: "People think he is lazy, he's rude, he's got no manners. If he had a cancer, he'd have more sympathy". Meanwhile Michael, who appears to have heard all this before, is enjoying the playful antics of Rocky the parrot, much to Mother's irritation. Later, in a particularly fine moment in the film, Father wants to check Michael's drugs but these are guarded by the parrot, which won't let Father near and pecks his finger.

What would it be like to be a dog or cat in this household? It might get stroking and other affectionate touching. The parrot seems to do quite well for attention. Michael gets masses of attention, but much of it is negative and critical. Is it worth speculating about who might be being stabbed and bleeding to death? Who did the stabbing? What could be a meaning of this? Michael seems strangely calm when talking about it afterwards. He might reasonably have been very frightened. It is almost as if the hallucination is in some way cathartic for him. Could this then be an angry, vengeful image? Is possible that it is Mother who thinks that Michael is lazy? That it is she who would have more sympathy if he had a cancer?

Father speaks more softly about his son. There is an affectionate moment between them when Michael plays with his father's hair and face. Father says he doesn't like this but it is said gently. Later there is a scene in which they are fishing together. It looks peaceful and amicable. Father, however, doesn't like what he sees as Michael's lapses in self-control. He probably has a point here. There is a moment in the film when Mother switches on the video camera with the intention of recording one of Michael's 'bad habits'. (Would a 'bad habit' be part of a mental illness?). She calls him down from upstairs in a somewhat provocative and sharp manner and demands the return of her bag, which Michael apparently has taken. She says, "I am going to do what you do". Michael mimics her and it is clear that she feels intimidated by this. He then notices that the video camera is running, asks why, and upon being given the truthful answer, switches it off. Control, indeed! There is another incident, described by Michael himself. The parents had asked him not to smoke in the living room but he continued to do so. His father had stood over him, perhaps threatening. Michael didn't like this so he pushed his father back into the chair. "He tried to knock me off my throne because I was acting like I was in control of everything around me", Michael says with some insight and clarity. He then rugby tackled his father, held him down and shouted at him. The presenter asks him if he thinks he was behaving 'strangely'. An odd word to use to describe such violence. "I had a violent impulse; you don't attack your Dad. There is an unwritten law that your Dad can try to control you but you are not supposed to control him back". The presenter tells Michael that she thinks he was quite nasty to his Dad, and quite cold. Michael, in responding, explains that it is as if there are "two little blokes inside my head who have an override button - they take control - like I might push someone over". The presenter now wonders aloud if she should have stayed to film it all. Michael gets upset and cries out, "It's not me, stop saying that, I'm not like that.....the illness is like another person". He looks for a dictionary to look up a word he has used, but cannot find it and, in his frustration, wants to sweep everything off the shelf. The presenter gets anxious and asks to suspend filming. She feels things have got 'too intense'.

There is a further example of Michael's desire for control, talked over with his community nurse. He acknowledges that he had put his head through the glass in his bedroom door. "I was just pee'd off, just in a mood....I was trying to get attention, because I was in a stress, big stress". "So it wasn't that much at all then", says the nurse, who then goes on to discuss with Michael whether his 'social interaction skills' have got a bit damaged. "God, I need a cup of coffee!" says Michael. He tells the nurse that his drugs are too strong, which was something he had wanted to discuss with the doctor, but that the parents had just gone ahead and got the tablets anyway, without consulting him.

As the end of the school year approaches, Michael prepares for the school Prom. The presenter asks him if he fancies any of the girls. He screws his face up and says that he can't fancy any of those that he grew up with. The ones he fancies are the ones he doesn't know – "the ones with a bit of mystique about them". He gives a wry and slightly shy smile and says, "I'm telling you far too much...I haven't even talked to a psychiatrist for that long – not without lying". Michael is probably quite capable of lying to a psychiatrist. He could also quite possibly be manipulative, threatening and blackmailing. But these things are not, of themselves, illness. What might his instincts be

about girls? This household is a very masculine one. There is only one female – Mother – with whom Michael's relationship is damaged. Could he fancy a girl?

We are then into the school holidays and the presenter tells us that the anxiety in the family now is that the sudden lack of routine for Michael may bring on signs of his illness. Could it be that the increased exposure to the parents' anxieties might be a more likely cause of stress, leading to symptoms? Father accuses Michael of being 'edgy', quoting, as his example, how Michael goes out on his scooter at night. He tells the presenter, in front of Michael, that he thinks there is "another crisis coming up". Michael is wearing his crash helmet indoors. Is it too fanciful to wonder how this might protect his head from the goings on in the house? Father describes Michael's difficulties as those of an adolescent but more 'exaggerated'. This seems like quite a reasonable assessment, but he does not follow it up with any thoughts about why this might be. Indeed, Father seems quite bemused by the fact that 'other people find Michael OK' and that the difficult behaviour appears to be experienced only by 'those closest', explaining this with: "It's a chronic illness he's got". Neither parent shows any inclination to look at his or her own part in interactions with Michael. Father tells us that his own mother had a similar illness and that he had managed to distance himself from her. He says he can't do this with Michael. What was Father's early experience of a woman? What part might this play in how Michael might see a woman, and in particular, his mother? Michael now gets ready to leave the house. He wants Father to give him the 'thumbs up' acknowledgement that he is leaving. Father struggles to understand and finds it 'really strange' why Michael should want an acknowledgement that he is leaving the house. Perhaps Michael might welcome any kind of acknowledgement that he is important enough for someone to notice that he is leaving the house.

Michael is coherent and optimistic about his plans for getting a qualification. Nevertheless he is introduced to the Special Needs course at the local college, where he has been referred because of his difficulty in focusing and concentrating. He tells us that he is trying to come to terms with having 'learning difficulties', something he hadn't thought about before and which he has just been told that he has. He is clearly struggling with this and looks into the camera with a somewhat conspiratorial look, as if playing along with the adults, who he thinks have clearly got it wrong.

Michael's GCSE results arrive. He has passed German and maths with C's and the rest with D's. "Brilliant", says the presenter, somewhat patronisingly. "Not brilliant", counters Michael, "but good enough", and walks off. He accepts a place on the Special Needs course and immediately starts to decline. Father describes 'this mood swing business' as a new thing. There is a sad scene where Michael is trying to get himself ready for college and cannot get organised. He finds his parents' intrusions unhelpful. Mother's anxiety is running high and she can only focus on the fact that his orange juice bottle might leak. Father quietly helps him to check that he is properly packed. Michael then appears to fall apart in front of the camera. His hands are shaking and he cannot speak; he looks desperately at the presenter, perhaps hoping for some understanding. Mother offers him a tablet. She has little sympathy and pointedly asks the presenter if the camera picks up someone "just being rude". She says that if things fall through at the college they will have to look at a residential 'outlet' – a strange word, outlet for what? - then it becomes clear as she explains that the outlet is for the family, which cannot continue to function with Michael at home all the time. His "integration, or lack of it, is holding us all back". Father has suggested the family splits up – she to live with the two brothers and Father to live with Michael. Could it be that Father himself might quite like to be separate from Mother? The presenter, rather unnecessarily, asks Michael whether he is looking forward to college. He doesn't answer. The scene ends with Michael sitting outside on the garden bench smoking a cigarette and saying, "You can't just chuck me out", before going sadly off to college. The only reassuring noises come from Rocky the parrot.

Michael deteriorates further. He overdoses on his antipsychotics. Perhaps this is a desperate attempt to help himself feel better. There is a sad scene with his mother. He has his head in her lap. "Are you all right Michael?" she asks him unnecessarily, as he looks awful. Michael comes out with an amazingly clear summary of what is going on. He is having difficulty in knowing who is real and who is not, whether objects are there or whether they are not. He keeps bumping into things because of seeing double (a side effect of the increased medication?). Mother says to the parrot, which is sitting next to them, that "we'll have to see if we can help Michael" but it is said with little hope. Michael fears that the parrot is now frightened of him. Mother explains that Rocky "likes being with ladies rather than men because they are less aggressive".

Michael is admitted to an adult ward in a psychiatric hospital for 6 weeks. We don't see this part. Afterwards he describes the experience as 'horrifying'. It seems too much to talk about so he lapses into familiar joking mode, giving as the reason that the other patients were all older than

he was and all mad. This is probably quite true. A 16-year-old should never, in my view, be admitted to an adult ward – there is too big a risk that it will replicate parental relationships.

The last scene in the film shows Michael, now living in a hostel, explaining that he has lost the use of his German. "It's not like riding a bike, it goes. That was quite a useful skill that I have just put down the pan" This is said with a wry, sad smile. He then breaks into his familiar smile and gives us the 'thumbs up'.

Michael comes across as a warm young man, defensive perhaps in what he experiences as an unkind world, sometimes looking to the interviewer, who is female, for support. He is an attractive person, light hearted and with a sense of humour. He is real, lacking the blunted affect of the person with long-term schizophrenia, or on long-term neuroleptic drugs. He describes himself as a "very happy person....it's the only way to be". But he feels lonely: "I would like to have had more friends". Perhaps he will make some, now that he is away from home.

For psychiatry and for his family Michael will probably always have an illness. It seems that no one has been able to differentiate that part of him that could simply be an angry adolescent. The parents in particular are unclear about what is illness and what is not. Perhaps they ignore their instincts about this. Perhaps anger cannot be expressed in this family, so it is pathologised by the parents. Perhaps Michael does this too, so that he can be angry and say, "It's not me, it's an illness". Did the relationship between Mother and son fail in some way at a much earlier stage than the apparent onset of illness, and did this damage Michael's perception of himself? For example, would she have preferred a little girl? Did Father pick this up and give some sense to Michael that he was OK? Michael is lively and has a strong sense of being a person – and he appears to have little if any shame, in contrast to Mother.

For me, there are familiar aspects to this tale. Young men with psychotic episodes sometimes do not, in my experience, mix well with psychiatry. The assessment by the psychiatrist can be a very unbalanced and limited business. Power and fear are often central: the power of parents to put a particular point of view which may be true so far as it goes; the fear of the psychiatrist that he will be found wanting and accountable to the parents if he does nothing and things deteriorate; the adolescent who is unwell and feels disempowered and frightened. I have seen psychiatrists collude with parents, encouraging them to attribute deteriorating relationships with their offspring to mental illness, ignoring the parts that they themselves may play. The psychiatrist is frequently set up to step straight in and take over the role of bossy parent who does not listen. The power to enforce admission to hospital can be experienced as the power to stop a young life in its tracks. The power to enforce medication in hospital can be seen as an ever-present parental demand for compliance - a power that may be substantially extended into the community under the terms of the proposed new Mental Health Act.

Michael's story shows how the psychiatric model can be a very narrow way of looking at mental illness. Michael appears to be intact as a person and the heavy emphasis on illness has the capacity to destroy him, rather than to support him. Currently it is said that there are insufficient psychiatrists per capita of the population. Perhaps those that exist are hard pressed to give the time or resources to think differently about what makes a young man mad with the world. Or perhaps, they could think in this way but know themselves to be restricted in what they can offer, so do not even bother going down that route. When dealing with a fraught family it might be very tempting for a psychiatrist to prescribe major tranquillisers and give everyone a bit of peace. It takes a confident doctor indeed to take the risks needed to avoid what can be an abuse of youth, in order to pacify demanding and anxious parents.

The psychiatric model is also restrictive. It may only be a short while before a tranquilliser no longer works, so another is tried, and another, and another. The psychiatrist will put forward biological and chemical explanations for this or just state that the effect of drugs on people cannot always be predicted. Could another explanation be that the effect of drugs gradually wears off, exposing the patient once more to the rawness of original traumas, which perhaps have been forgotten in the rush to restore tranquillity? I have seen a number of young men remain in hospital for months or years at a time, given a variety of different medications, but with no real change in their mental state. What I notice does or can change is their openness and desire to work with the staff, which may have been apparent on admission, but which can turn into a bitter hatred of the psychiatric system, the vehemence of which can be startling. There is a part of me that thinks that Michael's best chance may be to forget illness, get on with his own life independent of his family as best he can, and keep clear of psychiatry for as long as possible.

'Inside my head' was shown on Channel 4 television on 16.6.02

The Radicalism of Peter Lomas

The Limits of Interpretation: Thoughts on the nature of psychotherapy by Peter Lomas. New edition 2001. London: Constable and Robinson. Reviewed by Michael Evans.

Peter Lomas was trained as a psychoanalyst at the British Institute and underwent a long analysis himself. Now however he describes himself simply as a therapist and has for much of his life taken a critical view of psychoanalysis, its theories, the techniques it advocates and its practice. He is particularly aware of ways in which psychoanalysis has influenced psychotherapy, an influence which in some respects Lomas regards as pernicious even though he fully acknowledges that the form of therapy he practises is founded on Freud and the movement. Much of the material in this book comes from his critical engagement with psychoanalysis. Lomas is in sharp disagreement with Freud's advice about technique. He is particularly critical of the influence of the concept of the so called 'blank screen' and the medical model that produced it. Freud began his famous Papers on Technique in 1911 but did so under pressure and published them in 1914 with some reluctance. It was felt that psychoanalysis would run wild in the hands of the wrong people as the movement enlarged its membership. Possibly he felt that a prescribed technique would produce an unwelcome uniformity and rigidity of conduct and it is well known that Freud himself did not practise by the book. However publish them he did, and other treatises on correct techniques have proliferated such as those of Ralph R. Greenson and Frieda Fromm-Reichmann, whose books are on many therapists' shelves and whose precepts pervade supervisions and feed the anxieties of trainee therapists.

It is not often that an author has the chance to revisit and re-write an earlier work. The new version of *The Limits of Interpretation*, published 14 years after the first, has been much refined and strengthened. It adds up to a far more forceful and explicitly radical set of arguments against current ways of practising analytic psychotherapy. The fundamental disagreements with Freud and Klein have been developed further and extended to include a critique of the limits of Winnicott's approach, even though Lomas admires these pioneers and sees himself as a scion, if a wayward one, of the British movement. The book may also be a reaction to the widespread growth of cognitive therapies and short term counselling which are indicative of the present day movement towards quantification, cure and accountability. Psychoanalysis itself was based upon a scientific approach and psychotherapy as an institution is to a large extent enmeshed with hospital departments and doctors' surgeries. The trainings have lost some of their independence as they come under the influence of the professional organisations to which they belong. There is a deal of pressure on therapists of all persuasions to be accountable and to be able to measure their own progress and their results. Lomas believes that despite the merits of self assessment and openness there is a price to pay. The ideology of instrumental rationality fostered by contemporary politics and by professional organisations is putting pressure on the therapist to turn in a performance which is correct according to current theories and dogmas. This makes it almost impossible for him or her to be patient, to create an authentic, personal relationship in which the emphasis is on process, and in which being is more important than outcome. It also tends to petrify new thinking as to how psychotherapy might develop or change for the better.

So his book stands like an awkward boulder against both established figures and theories, and current orthodoxies. But the new edition of *The Limits of Interpretation* is more than a polemic, because it represents a dialectical exploration of the author's central beliefs. As with all thinkers these arise from reflection upon vivid personal experiences: in Lomas's case with mothers and

babies, with families and groups, and one-to-one therapies with adults. He writes from experience and matches what he has learnt against the theories of others. He is no respecter of received ideas or of the persons who pronounce them, yet the tone of this book is moderate and sometimes humorous. It is written in a dialectical rather than a dogmatic manner. Although Lomas clearly values the potential of psychotherapy very highly, this is a book about the limits of interpretation, and also the limits of theory and its proper place, the limits of truthfulness and the limits of the scope of psychotherapy.

It seems to me that there are fundamental contradictions in psychoanalysis and the analytic approach to psychotherapy which must inhibit any useful change or development in the patient. As is well known the first rule of psychoanalysis is that the patient is required to free associate. That is, the patient is required to speak and describe his thoughts as they come to mind without censorship or inhibition. For me the thoughts I have, such as they are, are inextricably tied up with the emerging words. But the word 'thoughts' is misleading, because what comes into my mind when in a passive state consists not just of thoughts but other things - images, imaginings, feelings, moods and half remembered things. Also bodily feelings.

How to put all this stuff into words? Are they the same thing when experienced by me feelingly, as when spoken by me? Other questions follow. To whom am I speaking? Perhaps to myself as if alone? Perhaps to my therapist? Or is it to the transference which my therapist stands in for? If I am in awe of my therapist, or if I think he is bored, or indifferent, or has a bad cold, will this alter the nature of what I say? Although the injunction to free associate sounds straight forward, it is actually extremely difficult if not impossible. Patients are not ideal patients. Unlike Freud most of us do not have the luxury of selection, thereby rejecting those patients who are deemed 'unsuitable'. Furthermore Freud was working in Vienna decades ago when most of his patients suffered from problems described as 'hysteria'. We are more likely to meet those with low self esteem or some form of alienation from themselves.

For some, fears are aroused by the process of therapy and the demand to produce associations - fear of embarrassment, shame, madness, being misunderstood, being judged, penetrated, possessed or destroyed. I once had a patient who in the second session mentioned an operation for tinnitus that he feared he might have to undergo. He described the process as having a hole drilled from the back of the head through to the chambers of the ear, and then instruments being inserted. He felt that that was what I was about to do to him. So many defences are put in place which inhibit free association. It is of no avail to instruct the patient to speak without shame or embarrassment if shame and embarrassment are the overriding problem for the patient. In any case free association should not be demanded as a rule, but freely given. Clearly the role and conduct of the therapist will play a part in how far the patient achieves the putting into words of whatever is coming into consciousness.

The second stage of the psychoanalytic method is interpretation as a tool for the task of breaking down the defences or the resistances of the patient. The analyst is on a search for truth and must therefore remain relatively neutral. Freud described this as the 'blank screen'. Interpretation is made in the interests of truth because psychoanalysis claims to be a science. However there may be a contradiction between the interests of truth and that of the good of the patient. For the 'truth' is always the product of psychoanalytic theory which exists before the patient's utterance. The interpretation takes place when the evidence fits the theory. Lomas challenges Freud's claim that analysts can listen to the patient with evenly suspended attention. How can he do this if his mind is cluttered with theoretical concepts and if he is constantly looking for material which is amenable to his theories?

If we take conventional interpretation as being a verbal and rational deduction made to the patient which reflects an idea that the therapist has about the unconscious meaning of the material presented, the effects on the patient can be dire. The patient can feel penetrated or understood in ways that make him more cautious about speaking freely - the exact opposite of the freedom of expression that is demanded of him. Furthermore, the interpretation made this way emphasises an imbalance of power in which the emotional, random and somewhat messy outpourings of the patient are met with the therapist's rationality. Freud, in theory at least, wholeheartedly supported the virtues of this kind of relationship which is marked by an intellectual response. The all too human wish to get close to the patient he considered damaging. In his technical papers he advocated that the analyst should be like a surgeon.

If a metaphor for the relationship between therapist and patient is needed I think Lomas would prefer that of friendship rather than surgery, but both seem inappropriate. The concepts of ordinariness and common sense along with the notion of therapy as comparable with friendship are used by Lomas continuously and are central to

his thinking. These beliefs are opposed to Freud in a very precise way, for when Freud recommended the surgeon's 'coldness of feeling' as a good model he also maintained that for the therapist to reveal details of inner life or family situation was a serious technical error. Lomas finds Freud's dogmatic opposition to all forms of gratification and his metaphors of the surgeon and the mirror profoundly inhumane and unhelpful. We need to understand the roots of these core beliefs and his opposition to Freud and to explore how far they are useful and justified.

Central to Lomas's thinking is a strong objection to the unnecessary exertion of power, and the oppression of those who are subjects of power. He is not saying that most or even many therapists are malignant in their use of power. But the theories and the recommended techniques of analytical psychotherapy are undoubtably productive of a power relation between therapist and patient. I will describe this as institutional power, because it is built into the system regardless of the personalities of the practitioners. However, a large part of the power of psychoanalytic therapy is given to it, not by its institutional structures, but voluntarily by its membership. I am speaking of the enormous transference that is made by all of us to what we subscribe to. The edifice of Freud is like Gruyere cheese, shot through with holes but still standing up and still revered. The fifty minute hour, the codes by which the patient starts the sessions, the task of interpretation, the rules of abstinence, are but a few of the many conventions which are set in stone and are so difficult to question. There is one criterion of good practice which no doubt we would all subscribe to: Is what I am doing in the best interests of the patient? Unfortunately what we do is all too often in the interests of a misplaced loyalty to correctness of procedure and interpretation which may or may not be in the interests of the patient.

In his book Lomas does not seem to find the term 'free association' particularly useful in that he does not use it much, but prefers to think of 'free association' as a process that might take place in the general context of an openness in the relationship between patient and therapist. Openness between two people is what he is after. He is at one with Freud about the therapeutic value of the 'chimney sweeping cure', but at loggerheads with him as to how this might best come about.

Lomas shows us how interpretation can and does take place much more subtly through body language and voice inflection. It takes place through the channel of ordinary exchanges during the session and he illustrates this with interesting vignettes. Insight for the patient is arrived at by degrees through the interaction between two people who are 'other' to each other. The difference between them will generally be felt as sufficient challenge. The prerequisite for this kind of encounter is that the therapist is present with the whole of himself, not just the intellectual part. The whole person implies the use of intuition, senses and feelings along with rationality.

So how are we to think about the institution of psychotherapy, of Freud, Klein, Winnicott and the rest of them, in a critical light? How can we escape and what could we put in their place? Another and perhaps better way of asking this question is to say: How can we approach our patients in a fresh way? How can we be truly receptive, attend to them with respect and wonder, discarding the voices of other?

This is not a new problem. Parallel examples can be found in the 19th century. John Constable was bedevilled by the conventional schematic landscape paintings of the followers of Claude Lorraine, with their hot brown foregrounds and gradated blue distances. There seemed to be no other way of painting. Constable's response was to remark: 'When I sit down in front of nature the first thing I try to do is to forget that I have ever seen a picture.' The Impressionists had similar difficulties because the art training of the time included the close study of the old masters. In exasperation Camille Pissarro recommended that the entire Louvre should be burnt to the ground. This is the same thing as calling for the burning of all Freud's collected writings. Cezanne responded to this suggestion by saying that Pissarro was right, but that he went too far. Instead he recommended that the Louvre should be closed for a hundred years. The point of all this is that Constable, Pissarro and Cezanne wanted to see the world with fresh eyes. In the same way a therapist might want to be open to experiencing the patient not in terms of psychoanalytic theory but as a complex individual who is a part of the force of nature. It was not that the painters did not have theories and conceptions, but rather that they wanted to relegate the importance of these in order to facilitate openness to new ways of seeing. As with psychotherapy, a reverence for the old masters can get in the way.

Just as Lomas sees that it is important for therapists to resolve or de-intensify their transference to the institution of psychoanalysis, so he must encourage the patient to undo his continually reformulating transference onto the therapist and onto the structured sessions of the workplace. Classically this is supposed to happen (if all goes well) towards the end of the therapy, but for Lomas it is an ongoing process. When the

transference is a positive one the patient may think of the therapist as an expert, or as having superior knowledge, wisdom or ability to make order through his capacity for making interpretations. No doubt there is something reassuring, even therapeutic about this idealization in the short term. Lacan observed that the patient thinks of the therapist all too easily as 'the one who is supposed to know'. No doubt it is relevant to the process that Winnicott described as 'holding'. In a chapter titled 'The Parental Metaphor' Lomas takes up the issue of therapy as a process of re-parenting and is rightly critical of the consequences of excessive mothering or fathering. The therapist can then all too easily makes a transference onto the patient, seeing him as a child, rather than as an adult with the capacity for taking responsibility for his destiny. Such parental models creates an asymmetry in the consulting room inimical to good therapy. Of course dependency does occur and one of the typical resistances to therapy is the fear of being without agency or resources in a therapeutic situation which continues without end. But Lomas very sensibly points out the countless ways in which we are all dependent, and this can be healthy and is not at all the same thing as feeling infantile. The problem for Lomas is how to reduce the intensity of idealisations and to make the ethos of the exchange between two people as real and as ordinary as possible, so that the sessions are experienced as a meeting of minds.

Here as elsewhere Lomas is again up against the Freud of the papers on technique. Freud was totally opposed to anything that smacked of gratification of the analysand's normal needs. Tokens of affection, offers of support or love, news about holiday plans, sympathy for the patient's suffering and the like were obstructions to the fundamental rule entailed in the real work of association and analysis. All such gratifications are a distraction from the work of dismantling the resistances. The therapist must abstain from all forms of empathetic response in order to intensify the patient's yearning for love and approval. This was the only way to expose the neurosis, and as a method it distinguishes classical psychoanalysis from other forms of treatment.

Such an austere way of going about things as Freud recommends is hardly likely to produce the confidence or self-belief that one might hope a patient would acquire, nor a trust or openness towards the therapist which is, after all, a pre-requisite for free association. The artificiality of such techniques designed to starve the patient of the minimum encouragement is abhorrent to Peter Lomas, but it feels important to emphasise that he is by no means advocationg a love-in as an alternative. Some patients make a play for rewards. Others are so starved they hardly recognise love when it is offered. The therapist uses his intuition in response to the individual. Lomas argues that the psychotherapeutic set-up is a situation necessarily defined by abstinence on the part of therapist and patient: for example, the austerity of the 50 minute hour, communication by speech only and the moment of payment. These realities are harsh enough and are likely to produce negative feelings. Without any further abstinence or interpretation on the therapist's part the set-up will demonstrate to the patient, through repetition, that there are limits to the satisfaction of his endless infantile desire and open the possibility of a resolution of his conflicts (if that is what the problem is).

I come now to the most difficult problem presented in this book, which arises from the issues already raised. If there is to be a degree of openness and trust between the two people then how far can the therapist be open to the patient? What are the effects of self-disclosure and reciprocity? Clearly there are periods when the high level of anxiety of the patient, his suffering or immersion in re-living some trauma, makes the therapist's own concerns irrelevant. But in the process of working-through during a sustained therapy, the situation is likely to become more opened out and the two people have time to take stock of what is happening between them. Freud of course was interested in discussing the transference situation with the patient but not in a way that revealed anything about himself. He strictly ruled against self disclosure and to this day any therapist who admits to this transgression risks becoming an outsider. The patient after all is paying to be listened to and to be supported and helped. Why should he pay to help the therapist?

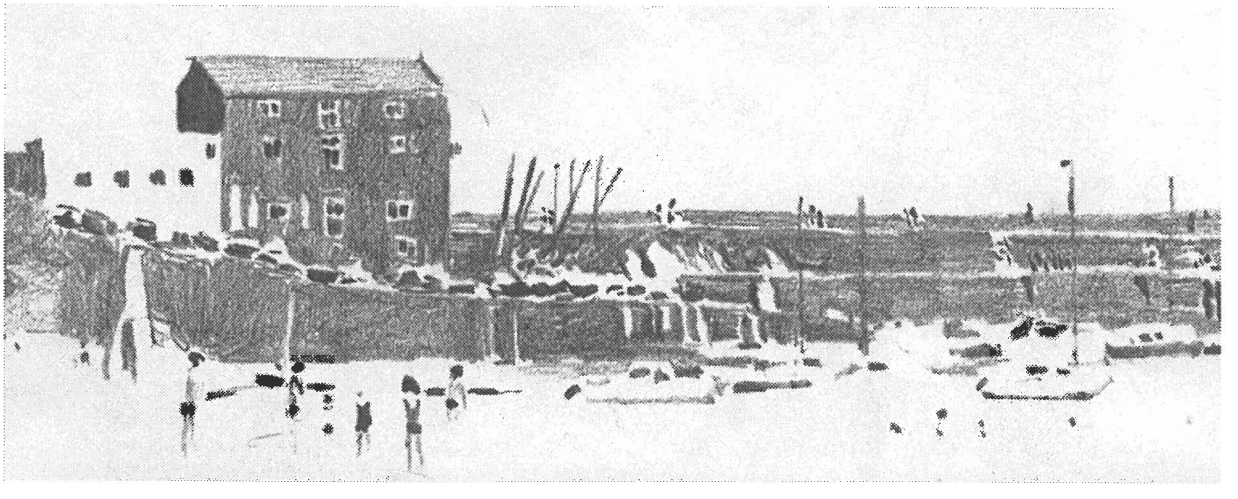
Lomas gives good arguments for his case, some of which I will attempt to express in a moment. The difficulty that I have with the level of engagement that Lomas subscribes to, is that it could lead to difficulties that are beyond the capabilities of the therapist. We all have our limitations. He offers no guidelines about revelations of self to the patient. How to do this, and when, and how frequently? This is because such levels of involvement cannot be regulated by or even discussed in terms of technique. The point of this kind of intimacy is that it must be authentic, that is, sincere. The therapist has to use tact, and his intuitive capacities and his feelings are his most valuable assets. But how to cultivate these? To be fair, the author has written a whole book about this. But without a manual the therapist has to learn how to fly by the seat of his pants, and flying can be dangerous. I think Lomas should have issued some warnings as to how

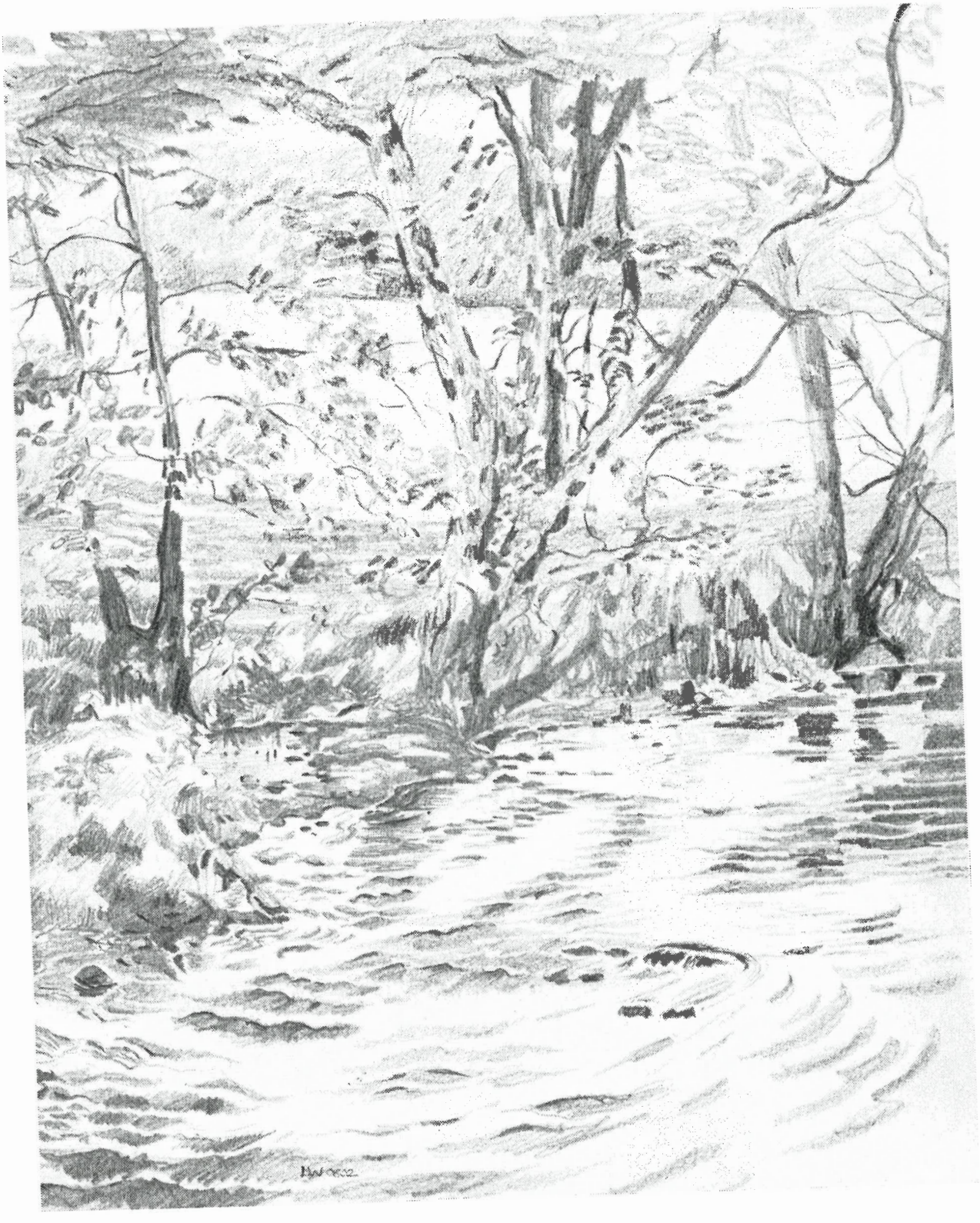
things could go badly wrong. However, he does make a strong case for the kind of therapy that he advocates and I will set out what I have learnt about the validity of his approach.

According to Lomas, the therapist will be most useful to the patient if he responds with his whole being rather than just with his professional persona. This he describes as 'living with the patient'. If the patient's own needs are the only subject for discussion week after week, there develops a climate of unreality. The situation is unhelpful if it sustains rather than unravels the patient's narcissism. The typical response is an interpretive one, but Lomas argues cogently throughout this book that the value of dissection has its limits and may not be of much use - hence the title.

Charles Rycroft suggested that a discursive interpretation using the verbal cognitive part of the mind is often merely reductive. The attempt to show hidden meanings, beneath the surface of the patient's words, and to reflect such meanings in different terms, can have the effect of reducing the patient's belief in his own experiences. An alternative response, Rycroft suggests, would be to answer the patient with the therapist's own primary process responses. That is, the therapist uses his own feelings and associations. This, when it is possible, brings about a greater sense of equality because both parties are taking a stroll into the unknown, and the patient's self-preoccupation is reduced and seen by him in the light of the therapist's more visceral engagement.

Of course if one subscribes to the view that all of humanity is fundamentally paranoid, narcissistic, and driven by sexual or destructive mechanisms this approach to therapy would be irrelevant. Even though the history of civilizations does seem to show with horrible clarity that the human race is but a shower of shit, yet there are other points of view. Lomas points out that Fairbairn, in sharp departure from Klein and Freud, proposed that infants reach out to the loved ones from the very beginning of life, and as empathetic and intelligent beings they respond quickly to the moods and feelings of their mothers or primary carers. Harold Searles found that his very sick patients had a strong often unconscious need to be therapeutic towards him. Of course it does not follow that such signs of ruth have to be indulged in, except with great care, because the earlier failure to heal the sick parents may be at the heart of their problem. But Lomas puts the view that in some circumstances patients can find it helpful to be aware of their therapists' vulnerability or frailties as well as their values and passions. For one thing, revelations of self will occur quite unintentionally even in the most formal therapies and many patients are capable of acute observation and are not fooled all of the time. However here we are discussing voluntary levels of disclosure. Patients may find that this does make the therapist more real for them and Lomas gives good examples of this. The consequent sense of reality and a real relationship gives the patient something invaluable. He can come to believe that the therapist is truly committed, that he does care if the patient is present or absent, that the patient can be pro-active and effective upon the life of the therapist. Lomas believes that the long term goal of such a therapy is not the deconstruction of the patient's neuroses, nor just the reduction of long standing anxieties, though this is very important, but the opening up of the patient's self-belief that he can make a difference however modest and take part in the general creativity of nature.





Back issues

Back issues are available from the Editors. Price £3.50 including postage.

OUTWRITE 1 August 1999

Articles
Listening to children through play *Carol Dasgupta*
Dreaming and taking notes *Rosemary Randall*
Inner death and the wish to die *Leila Gordon*
Some reflections on the wish to die *Peter Lomas*
Creativity: a sketch of an idea *Michael Evans*
Book Reviews
Committed Uncertainty in Psychotherapy: editor Lucy King, reviewed by *Vivienne Seymour-Clarke*
Flow - the psychology of happiness by Mihaly Csikszentmihalyi, reviewed by *Margaret Farrell*

OUTWRITE 2 **April 2000**

Articles
Trouble with love in the analytic encounter *Lesley Murdin*
From history to psychotherapy *Jill Shields*
The unexpected absence of the therapist *Ann Cockett*
Actaeon impulses *Walter Morgan*
What are you looking for? *Bruce Kinsey*
A perspective on group and individual therapy *Hilary Taylor*
The turn of the screw – hysteria and the uncanny *Sian Morgan*
Book Reviews
Cassandra's Daughter: A History of Psychoanalysis in Europe and America by Joseph Schwartz, reviewed by *James Pollard.*
The Unknown Matisse: A life of Matisse. Vol.1 1869-1908 by Hilary Spurling, reviewed by *Michael Evans*

OUTWRITE 3 **February 2001**

Articles
Meaning: reflections on an ancient culture, modern living and psychotherapy *Glenys Plummer*
Object relations: a view of Chardin *Pamela Arriens*
Balint in two worlds *Pat Tate*
Can there be a unified psychotherapy? *Peter Lomas*
Book Reviews
Doing good? Psychotherapy out of its Depth by Peter Lomas and *Peter Lomas and the Question of Science* by Peter Rudnytsky, reviewed by *Michael Evans*
How much is enough? by Lesley Murdin, reviewed by *Isobel Urquart*

OUTWRITE 4 **December 2001**

Articles
Matricide *Sian Morgan*
Sibling Rivalry – a partial story *Carol Dasgupta*
Fathers and phobias: a possibly psychoanalytic point of view *Roger Bacon*
Poems *Loraine Gelsthorpe* and *Michael Evans*
The Outfit's early years *Lucy King, Margaret Farrell, Sian Morgan and Rosemary Randell*
Moving between cultures *Clara Lew*
'AD 2001'. Drawing by *Michael Evans*
From criminology to psychotherapy – and back again *Loraine Gelsthorpe*
Reading with children *Julia Pyper*
Reviews and Responses
Saving Masud Khan by Wynne Godley. A response from *Peter Lomas*
Where analysis meets the arts: the integration of the arts therapies with psychoanalytic theory. Edited by Yvonne Searle and Isabelle Streng. Karnac 2001. Reviewed by *Rosemary Randall*
Mind over Mood? The paradoxical triumph of Beck's cognitive therapy by Paul Crichton. A response by *Peter Lomas*
Talking about emotions: psychoanalysis and neurobiology *Isabel Urquart*
A Midsummer dub *Walter Morgan*

OUTWRITE

Journal of the Cambridge Society for Psychotherapy

Number 5 *December 2002*

CONTENTS

Page No.

Editorial 1

Articles

Psychotherapy and drug use: in the drug clinic and in the consulting room Mike Bell 2

Accidental therapist Liebe Klug 12

Triangulation – opening up a space to work Hilary Taylor 15

Uncanny Michael Evans 20

The self-removing trousers Kalu Singh 22

"Don't tell me, show me" Barbara Tregear 28

On not being able to write Peter Lomas 32

Reviews

The psychotic adolescent male and psychiatry: an uncomfortable mix Nick Hay 35

The radicalism of Peter Lomas. The Limits of Interpretation: Thoughts on the nature of psychotherapy Peter Lomas. Reviewed by Michael Evans 39

Published by The Cambridge Society for Psychotherapy, 41 Beaulands Close, Cambridge CB4 1JA.