OUTWRITE

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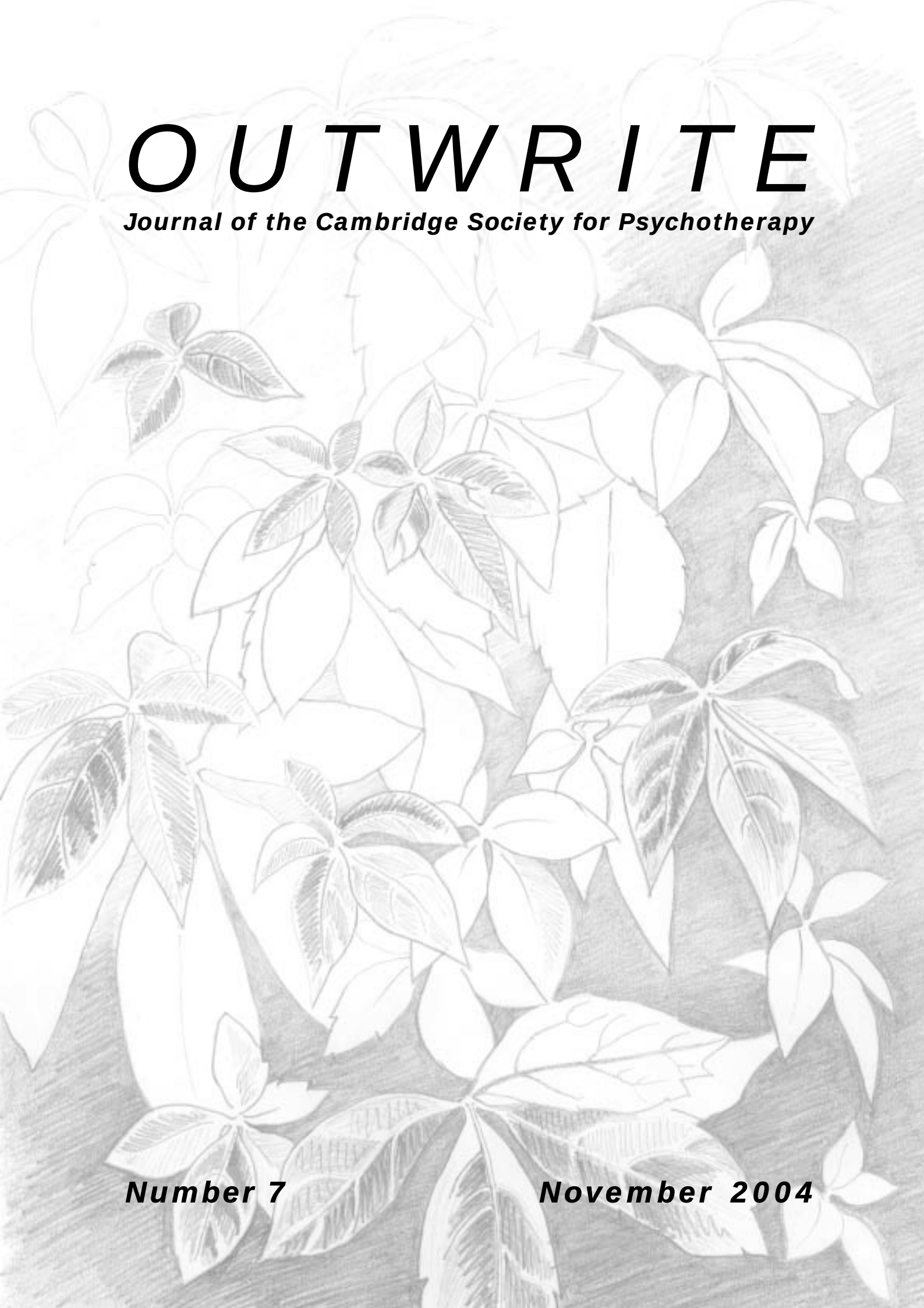

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The drawing on the front cover and other drawings inside the journal are by Lesley Kingham.

Editorial

The inquisitive traveller to a new and unfamiliar country engages with an enterprise which may be both daunting and exciting. While the surroundings and people who inhabit them are, quite literally, foreign, there may be a strong desire to get to know them, maybe even begin to understand them. The traveller may start by observing, trying to notice the small but distinctive features of the unfamiliar. There may be periods of standing back, letting the unknown unfold organically. At some point, connections may be made and a greater sense of achieving some understanding emerges, only to be confounded by the unexpected, requiring a reformulation. The traveller has to be willing to let go of the interpretation that doesn't fit, acknowledging that the unknown is usually more complicated than might at first appear. Dorothea Brooke in *Middlemarch* seems to recognize this as she argues that "signs are small measurable things, but interpretations are illimitable…."

And yet, as time passes, how often is it the case that the foreignness, while never actually disappearing, dissipates, seems less alien and more familiar. Another fictional heroine, in *A Town Like Alice*, gets it just about right:

> "It's a funny thing" Jean said "You go to a new country and you expect everything to be different and then you find there's such a lot that stays the same".

Our shared quest, as psychotherapists, is surely not dissimilar to the quest of the common traveller: how do we engage in the process of getting to know someone? Freud advises us to work in a framework of 'evenly suspended attention', Bion recommends us to leave memory and desire behind, and Keats famously extols the positive value of 'negative capability'. But we also strongly uphold the value of debate, discussion and examination, and all the articles in this issue of OUTWRITE contribute to our understanding of what it means to be a psychotherapist and practice psychotherapy.

Donna Feldman and Sarah Fahy describe feelings associated with new beginnings, while Glenys Plummer examines the central part countertransference plays in an ongoing therapy. Sarah Greaves' article raises our awareness of the need to think carefully about issues involved in the setting of fees. Ulla Brown demonstrates, in her article, the wealth of human insight residing in ordinary, non-psychoanalytic literature. Pat Tate reminds us what it may be like to be on the other side of a helping relationship, and Jenny Corrigall, Carol Dasgupta and Carole Robinson wonder about the place of humour in the therapeutic relationship. Rosemary Randall offers in her review article, an interesting and illuminating critique on opposing approaches in child-care manuals.

We want to thank those who have contributed to this issue of OUTWRITE, and we hope the enquiry and questioning evident in these articles will continue to thrive.

Carol Dasgupta and Pat Tate

Glenys Plummer

Countertransference

In an ordinary sense, countertransference involves a direct effect of one person on another. In a more technical sense, which is pertinent to Psychoanalysis, countertransference has been defined in a number of ways. Anthony Bateman and Jeremy Holmes (1995) have provided the following useful and succinct synopsis of the various definitions:

- Affective resonance and empathy (Stern, Winnicott)
- The results of projective identification (Klein, Bion)
- Part of the bipersonal or intersubjective field (Sullivan, Langs)
- The analyst's response, conscious or unconscious, to the patient's transference (Heimann, Sandler)
- The analyst's transference to the patient (Freud)
- The analyst's blind spots or resistances (Freud, Sandler)
- All reactions of the analyst to the patient (Joseph)

From yet another perspective, that of Object Relations, we understand that an individual acquires particular life experiences through his primary relationships. The essence of these relationship experiences is recorded in his being, both consciously and unconsciously, as internal objects. They also manifest in cues - subtle facial and body signals. Freud noted that once a pattern of relational experiences is registered in an individual, there may be a tendency to repeat these experiences, for good or for ill. The individual will often relive aspects of these primary relationships by projecting an expectation of the same patterns of relating within the context of subsequent relationships. He or she will select new attachment figures (external objects) and project old templates of behaviour. This repetition of behaviour is called transference. Human desire, or libido, is a powerful force. It is this energy of life which lies at the heart of transference. The projection of desire, which is instinctually created, is therefore transferred from the primary object (external figure) to succeeding objects throughout life.

The Object Relations perspective is more fluid than the Freudian, which was described by Ellenberger (1970) as "the unconscious revival of childhood situations". Object Relations allows for change and modification of these transferred patterns, partly through the new relationship and different responses of a new external object; from this point of view, countertransference is the response of the object to the transference of the individual. The subtle facial and body signals of the projecting person interact with the receiving or introjecting person to produce a somewhat pre-programmed emotional response. Joseph Sandler (1976) describes this process:

> transference need not be restricted to the illusory apperception of another person…but can be taken to include the unconscious (and often subtle) attempts to manipulate or to provoke situations with others which are a concealed repetition of earlier experiences and relationships. It has been pointed out previously that when such transference manipulations or provocations occur in everyday life, the person towards whom they are directed may either show that he does not accept the role, or may, if he is unconsciously disposed in that direction, in fact accept it, and act accordingly. It is likely that such acceptance or rejection is not based on conscious awareness of what is happening, but rather on unconscious cues.

The concept of countertransference lies at the heart of the psychoanalytic endeavour. It has evolved remarkably and profoundly in usage, as its interactive nature was not always perceived by the early Freudians. This changing use of countertransference signifies and reflects the

evolution of Psychoanalysis itself, from a one-person ethos to a two- person ethos. Freud's early biological and drive-based Psychoanalysis – the one-person ethos - became, over the years, more oriented towards ego analysis. Since the Independent movement towards a more process-oriented psychoanalysis between two people, countertransference now holds a central role as a pathway to the unconscious transference of the patient. It is seen as the bridge between the unconscious of the patient and that of the analyst – an undeniable connection.

Very little about countertransference appears in the writings of Sigmund Freud; even less is available from his daughter Anna. Melanie Klein took her lead from Freud but developed her own policy towards it. To both Freuds, countertransference was an obstacle to be overcome by self -control and further analysis. To Anna Freud's rival, Klein, the phenomenon had its uses, but she remained extremely cautious, fearing it could get out of hand. Carl Jung did not share this pessimism. In fact, by 1929, although countertransference was not an emphasis to him, he had identified the two-way nature of the concept, as well as seeing it almost as a necessity.

Hinshelwood points out (1999) that, in contrast to the early poverty of writings, 3,685 articles on countertransference were written between 1950 and 1999. Such an amount of thought and effort testifies to the meaning and value of the concept. In the Independent group particularly, it is seen as a mutual influence – a reciprocal dynamic. The countertransference can now be seen as the main route to the transference, which is the essence of psychoanalysis. The discernment and analysis of the emotional response in the analyst or psychotherapist, as the counterpart of the transference, is a clue to the patient's inner world. The analyst or psychotherapist may receive what Bollas describes as "psychic news" from the patient, through his own mind, about the patient's history and his internal objects. However, conscientious practice must also involve the analyst's willingness to consider any element of his own neurotic transference to his patient. Rather than being a problematic hindrance, countertransference has become a useful asset and a core element of the work.

Psychoanalysis in the early times, from 1895 to around 1927, was oriented towards cure of the patient's symptoms by the analyst's objective and authoritarian interpretations of the patient's unconscious. It was then an attempt at scientific endeavour, to cure the hysterical symptoms of the patient by the release of libidinal energy blocked by unconscious conflicts. The analyst's interpretation was designed to be a truthful statement about these conflicts; this truth would produce a catharsis, which would free the patient of the need for defensive constrictions. It became accepted that the patient might have an emotional attitude towards the analyst in the form of transference, but the analyst was not to have an emotional attitude towards the patient, in the form of countertransference.

To Freud countertransference was always the analyst's neurosis. The ideas of object relations were not available to him in his time, although as early as 1926, Ferenczi was challenging Freud's perception. Of the four references in Freud's works to countertransference only one is an explicit description :

> We have become aware of the 'counter-transference', which arises in him as a result of the patient's influence on his unconscious feelings, and we are almost inclined to insist that he shall recognise this counter-transference in himself and overcome it. Now that a considerable number of people are practicing psycho-analysis and exchanging their observations with one another, we have noticed that no psycho-analyst goes further than his own complexes and internal resistances permit; and we consequently require that he shall begin his activity with a self-analysis and continually carry it deeper while he is making his observations on his patients (1910, p. 145).

What was the intent behind Freud's position? Because Freud was a scientist he aimed for objective clarity in the analyst for the purpose of observation. The analyst must remain emotionally abstinent – the famous 'blank screen':

> The treatment must be carried out in abstinence. By this I do not mean physical abstinence alone, nor yet the deprivation of everything the patient desires, for perhaps no sick person could tolerate this. Instead, I shall state it as a fundamental principle that the patient's need and longing should be allowed to persist in her, in order that they may serve as forces impelling her to do work and to make changes, and that we must be aware of appeasing those forces by means of surrogates. (1915[1914], p165).

While humanely acknowledging that some "sick" patients will apply their need, or transference, to the analyst and desire a response, he is clear that the analyst must manage any urge to "appease", or have a countertransference. This principle of abstinence is upheld in modern orthodox Freudian practice.

Given Anna Freud's personal and professional

devotion to her father, it is no surprise that she did not modify her father's attitude to countertransference in her work with children. Despite acknowledgement of the relational elements between children and their analysts, her father's belief that an emotional response on the part of the analyst signifies need of further analysis was upheld. She wrote:

> Although the adult in the nursery serves as object and outlet for the emotions which lie ready in the child, the children should on no account serve as outlets for the uncontrolled and therefore unrestrained emotions of the adults, irrespective of whether these emotions are of a positive or negative kind.

She did however recognise that when children choose a foster-mother from available adults they were usually responding to an 'answering spark' in that adult.

Like Freud, Klein placed great emphasis on the phenomenon of transference. She disagreed with Freud on other matters, but not on the matter of countertransference. An analyst's countertransference response signalled a need for further self- reflection. Grosskurth (1986) wrote of Klein:

> She had never found that countertransference helped the patient, only herself. It should be used and controlled only by and for the analyst. She recalled that in Berlin there was a saying: If you feel like that about your patient, go in a corner and think it out carefully: what is wrong with you?

Jung devoted little literary space to the concept, though he was aware of its importance. Jung saw analysis as a relational enterprise, stating that the patient influences the analyst unconsciously in the countertransference in relation to transference and that countertransference is "a highly important organ of information" (1929). More than this, he was aware that the experience of it was necessary for therapeutic influence. For personality transformation to take place, he expected that the analyst should have strong reactions to the patient and even, to some extent, take on the illness of the patient. It has been left to his followers, particularly Fordham, to develop Jung's ideas further, which currently reflect the general Object Relations analytic climate.

In Britain in 1927, in a lecture on resistances in psychoanalysis, Glover (who at that time was Kleinian in orientation) mentioned the matter of countertransference, aware that it was "provoked by the transference". He stated that the to and fro of patients' projections onto the analyst might "put the latter's psychological integrity to the test". These statements indicate the beginnings of a trend towards a more interactive relational approach to analysis. That the countertransference may be more than the analyst's neurosis seems to me to lie at the heart of this trend.

Then in 1932, Sandor Ferenczi, in his courageous paper read to the 12th International Psychoanalytical Congress in Germany, suggested that Psychoanalysis might be extended towards a principle of intersubjectivity between analyst and patient, and become more relationship (and therefore process) oriented. While Freud had acknowledged that some people were sufficiently "sick" to be unable to tolerate the principle of abstinence, Ferenczi took this thought further. In challenging possible hypocrisy (and consequent superiority) in the analyst, he suggested that the interaction between analyst and patient played its part in healing, rather than simply an analysis of the patient's symptoms within the framework of psychoanalytic abstinence. He, like Jung, had suggested that Psychoanalysis was more than an interpretative function, that it was a relational function. This paper was not explicitly about countertransference, but it reflected a way of thinking which was part of the movement towards some equality in the therapeutic relationship. In challenging Freud's classic, authoritarian style, it represented a further move towards a more subjective and two- person ethos. Ferenczi had already written in 1926:

> If the psycho-analyst has learned painfully to appreciate the counter-transference symptoms and achieved the control of everything in his actions and speech, and also in his feelings, that might give occasion for any complications, he is threatened with the danger of falling into the other extreme and becoming too abrupt and repellent to the patient; this would retard the appearance of the transference, the pre-condition of every successful psycho-analysis, or make it altogether impossible.

Michael Balint (1968) took up this theme and developed it into the idea that people present not just at the familiar Oedipal level, where the patient's conflict may be sexual in nature. Some people may present on a more primitive level, where the problem is less about sexual conflict than about a deficit in basic needs not having been met by primary relationships. At this level, he suggested, the great difference in power between analyst and patient may lead to a great deal of hatred, both in the transference and in the countertransference . Along with this idea he agreed with Ferenczi that sometimes what the patient needed was love. With his wife Alice (1939), he suggested that the analyst is unavoidably contributing to the transference and countertransference cycle by his analytic

behaviour. The Balints stress that:

> the analytic situation is the result of an interplay between the patient's transference and the analyst's counter-transference, complicated by the reactions released in each by the other's transference on to him.

From this point of view, countertransference is inherent in the analytic 'setup'. Allowing for the inevitable interplay, the analytic task of objectivity needs to be mediated by the subjective reality of the situation. The analyst therefore needs to manage the tension of this duality – of subjective objectivity. This does not mean that the analyst does not need to control his behaviour. The Balints suggest that the allowance of analytic subjectivity necessitates even better understanding of the analyst's responses and control of them. This suggestion - of inevitable invitation from the analyst in how he presents himself - further opened the way for another line of thinking about countertransference. This thinking relates to the principle that the unmet need of the patient, which is discerned in the countertransference, may be interpreted as such rather than acted upon.

Winnicott's paper "Hate in the Countertransference" appeared in 1947, and contributed to the growing sense of humane acceptance of the phenomenon of countertransference. The kindly tone of Winnicott's address may have helped analysts feel less influenced by Freud's super-ego and authoritarian dismissal of the problem. Winnicott suggested that it might be almost normal for an analyst to experience a countertransference of hate towards a patient, as this reflected the normal hate a mother may feel towards her demanding baby. In describing the principle of "objective hate" Winnicott raised consciousness of the principle of *objective subjectivity*. This paradox represents the main usage of countertransference today. The analyst's subjectivity, in relation to the patient's subjectivity, if contained (in the sense of held within his own mind), reflected upon, analysed and interpreted, serves the purpose of objectivity. This paper also raised, for the first time, the question of disclosure of the analyst's countertransference to the patient.

Winnicott's paper was a departure from allegiance to Klein, as was Paula Heimann's much quoted groundbreaking 1950 paper "On Countertransference". It is generally agreed that at this point the concept of countertransference developed its current meaning and usage and positive value. Rather than being an obstacle to objectivity (as it was to Freud and his daughter), and a matter for caution (as it was to Melanie Klein), it became a concept that could now be seen in a more creative light. It could be seen as a therapeutic tool – "one more source of insight into the patient's unconscious conflicts and defences", as Heimann put it.

In a clear distinction between herself and Klein (who focussed more on the unconscious phantasies of the patient) Heimann also stressed the relationship between patient and analyst:

> What distinguishes this relationship from others, is not the presence of feelings in one partner, the patient, and their absence in the other, the analyst, but above all the degree of the feelings experienced and the use made of them, these factors being interdependent.

With this paper, and the conflict it caused between herself and Klein, Paula Heimann moved from the Kleinian group to the Middle group, the Independents, who developed the ideas of Object Relations and further evolution of the concept of countertransference. Heimann was far from blasé about the use of her approach. She agreed with Klein that it was not without danger. The analyst's own analysis must assist him to keep his countertransference to himself in order to maximise the therapeutic task. The objective subjectivity, or feelings and responses of the analyst, which were not acted upon but reflected upon and interpreted, became the medium of this process.

The idea of the normality of countertransference became so well established that Roger Money-Kyrle entitled his paper of 1956 "Normal Counter-Transference and Some of its Deviations". He likens countertransference to projective and introjective "oscillations" between patient and analyst. The relational, two-person status was by then so taken for granted that he suggests that the process is dependant on the analyst's identification with the patient. Successful use of countertransference in the service of understanding fails when, in fact, the analyst cannot identify with the patient. Pressure applied by the patient on the analyst may be increased, further contributing to a destructive spiral of non-understanding and a sense of being lost in the transference / countertransference loop, the insecurity of which may lead the analyst to project inappropriately. The analyst's projections may then further complicate the analytic situation. Analytic equilibrium may be restored only by the analyst's ability to retrieve his own projections from the tangle of mutual projections.

However, this disentangling of projective contributions is not always a simple matter. In evaluating the countertransference and its use, Christopher Bollas (1987) calls for "humility and responsibility" in the analyst. In order not to foreclose prematurely on a perception, it is important for the analyst to be able to tolerate the

uncertainty of "a not-knowing-yet-experiencing" state. And, going further than Money-Kyrle, Bollas suggests that a temporary loss of identity within the transference and countertransference may even be necessary for the patient to discover his own identity. This temporary loss of identity in the analyst allows the patient to project his object pattern more readily and, provided the analyst is listening to his countertransference, the results may then be offered to the patient for verification, if this is appropriate.

This method of use has particular relevance for patients who present on an earlier relationship deficit level than the Oedipal conflict level. Where some of the patient's difficulties may be pre-verbal, the child in the adult patient may be able to project (via projective identification) this part of himself into the analyst; or rather, the part of the analyst that is receptive to this projection. The analyst may then, through his own subjectivity, convert the raw experience into language suitable to the situation and in the pursuit of objectivity. This ideal depends completely on the receptivity of the analyst to the projected disturbance of the patient, his capacity to hold his own reality and to reflect on the experience as a whole.

Bollas' claim that the analyst needs to allow himself to be affected and even disturbed by the patient reflects Jung's early position far more than Freud's. His work becomes even bolder and picks up on Winnicott's idea expressed in "Hate in the Countertransference", with the suggestion that there is a case for disclosure to the patient of the analyst's subjective perception, in an indirect form. According to Bollas, this "indirect" disclosure involves "putting verbal representations of my subjective states of mind to my patient for consideration". If this can be done in a spirit of play and with great responsibility on the part of the analyst, together with space offered for the patient to reflect and comment, deeper psychic exploration may take place, as well as the fostering of trust and relational connection. This principle takes the use of countertransference, in my view, to its most practical value – as a medium of change.

The thoughtful and responsible analysis of elements of experience, communicated from one mind to another, and translation into usable language in the form of an interpretation, may intervene into patterns of living that have, over time, become at worst destructive and at best uncreative. The creative analyst may become a new object and be able to offer a different response or a different energy into the patient's established and problematic pattern of object relating in an endeavour of healing. From a stance of respectful and responsible humility, the analyst may, for example, admit mistakes in a way the parent never did, thereby restoring or initiating the patient's own self respect. In this style of Psychoanalysis the analyst is both a subjective and objective partner to his patient, rather than a neutral interpreter.

I have offered an overview of development of changes in the use of countertransference, alongside changes in the evolution of Psychoanalysis itself. Hinshelwood (1999) suggests that the new pressures of changing views on countertransference fostered "escape" from the narrowness of drive- based and ego psychology. I agree with this view, that it is these very changes in perception of countertransference that have been instrumental in the evolution of Psychoanalysis from an objective one- person cure process to a two- person subjectively objective, relational, healing process. In illustration, here are two clinical vignettes – the first, an illustration of effective healing use of countertransference, the other, an ineffective encounter with the phenomenon and a consequent failure of relationship and healing.

In the first case, the contract was of a twice-weekly nature, and a respectful therapeutic alliance was established with a basically positive transference to the psychotherapist. The patient was a married woman in a reasonably secure and successful life. She had not however fully come to terms with the deprivations of her early life, one of which was the absence of relationship with her father. She had lived her life in denial of the knowledge that he did not in fact care about her. As this possibility was emerging into her consciousness, she was upset and distraught in her session. From her upset state she looked to the psychotherapist and saw that he was not looking at her. This triggered the psychic experience of feeling uncared for. She angrily said from within the transference: "You don't care do you, you really don't care how I feel". The psychotherapist, who was in actual fact, a caring man, became troubled by his countertransference, which was that indeed, he did not care. In holding the duality of subjective objectivity he responded: Yes it's true that at this moment I feel I don't care for you. But I know I do care for you. So all I can think of is that this is a countertransference which reflects your experience with your father. With this truthful response, and the psychotherapist's ability to hold simultaneously both the subjective experience and an objective truth, the patient felt relieved. In perceiving that the psychotherapist cared enough to tell her the difficult truth, she was then able to tolerate awareness of the reality of her father's neglect of her and, without the necessary defence of denial, was able to internalise care from others.

A second vignette illustrates a failure of receiving a

deep level of countertransference, the pathway being blocked by the psychotherapist's own neurotic experience – the very problem warned against by Freud and Klein. The matter of identification raised by Money-Kyrle was the central issue upon which the failure rested. Both the psychotherapist and the patient had been subjected to violence in their childhoods. The patient had not initially revealed the degree of violence she had experienced, and when she did so the psychotherapist re-experienced his own anxiety to such a degree that, on the level of the violence, he became over-identified with his patient. He felt too vulnerable and anxious to be able to empathise objectively with his patient. His anxiety triggered transferential violence in the patient who made hostile attacks on the psychotherapist who responded with self-defence. If the psychotherapist had come to terms with the violence in his own life and had been able to contain the anxiety he was experiencing, rather than projecting it into the therapeutic field, he may have been able to receive the news the patient was really trying to communicate. This was that, on a level underlying the violent attack / defence dynamic, she too was anxious and vulnerable. The violence was a learned pattern, defensive in nature. The psychotherapist's own unresolved anxiety about violence prevented him from recognising that some of the anxiety may well have been countertransferential news from a deeper level of the patient's psyche.

Attitudes to the use of countertransference vary from practitioner to practitioner. Many in the Freudian school maintain the early abstinence principle. Many in the Independent groups, whose philosophies reside in the field of object relations, see analysis and psychotherapy not merely as an ordinary relationship, but as a meta relationship about how a patient makes relationships. The use of countertransference, although at times uncertain and confusing, can serve the process of objectifying the subjective. In order to achieve this objectivity, it is seen to be necessary to engage with the subjective in an objective way. In my view, Freud was correct in pointing out the danger of countertransference, but Jung, Ferenczi and the Balints were also correct in highlighting the need for less abstinence in the analytic endeavour. Klein was correct in advocating caution, and her followers were courageous in their subsequent explorations and journeys away from her stance. No one person or theorist can be the holder of all truth, and perhaps with the humility and responsibility advocated by Bollas, individual practitioners may make informed choices about their use of the powerful clinical concept of countertransference, according to their individual capacities. Used well, and not neurotically, it has potential as a medium of change in unhelpful patterns of living. Along with the evolution of Psychoanalysis from analysis of one person's symptoms to a relational and exploratory process, there has been an evolution in usage of the idea of countertransference. These changes in its usage are more apparent than those of any other psychoanalytic concept.

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Ulla Brown

A Quest for What Lies Hidden: 'You can't depend on people who just let things happen.'

I belong to the generation of Finnish children who were brought up on the Moomin books. Tove Jansson (1914-2001) created the Moomin characters in the 1940's and published several books in the series until the late 60's. She also wrote short stories and novels for adults; in 1972 she published a novel called *The Summer Book*, based on the relationship between Tove's mother, the artist Signe Hammarsten, and Tove's young niece - grandmother and granddaughter - as they while away the long summer months on a tiny island in the Gulf of Finland. *The Summer Book* has been translated into English and includes a Foreword by Esther Freud.

When I read the Moomin books as a child, their world felt completely real to me. Their reality, the characters, the landscape, was unmediated by external factors: it was a world of its own. The landscape of the Moominvalley includes, in fact, many features of the familiar Finnish landscape: the forests, the coastal archipelagos, the rocks. But its mythical features felt just as real. Living in Southern Finland, which is mostly flat, I found even the word 'Moomin valley' magical (there are mountains in Jansson's illustrations) and the tall, round Moomin house really did look like a house from a fairytale.

The Moomin family is a collection of oddly shaped, eccentric individuals (some of whom turn out to be related to each other). Some are foster relatives, others have simply attached themselves to the 'family'. Everyone is accepted; everyone's habits and needs are tolerated. Moominpappa, Moominmamma and Moomintroll form the triangle at the heart of the family, its solid core, which is nevertheless constantly shifting and expanding. The family forms a flexible space where they can all exert and explore their individuality, hide from each other, and renegotiate the boundaries.

All the characters feel the need - and have the freedom - to go off from time to time, disappear, rediscover themselves. Moominpappa decides to take his family to live in a deserted lighthouse on a distant and inhospitable island in order to renew his sense of strength and self-esteem, and his ability to (re)create his life. (At one point he spends days on end fishing obsessively, until he feels totally depressed, and then he manages to get excited about a case of whisky that might have been washed ashore… enough to reanimate his imagination). Moominmamma struggles in vain against the elements to recreate her garden, using seaweed; in the end, she decides to paint her garden on the empty walls of the lighthouse and then disappears, content and relieved, into her creation. Moomintroll needs to move out of the family circle into the forest in order to acknowledge and understand his own fears and sexual yearnings. On another occasion, he wakes up in the middle of the winter whilst the rest of the family sleep, and has to deal with both his loneliness and an unfamiliar landscape, filled with snow and strange shadows, in which nothing is solid or dependable. Snufkin goes off on his mysterious travels only to be welcomed back, no questions asked; Little My is a law unto herself and, somehow, always on hand when someone is needed to speak the (unpalatable) truth. The message of these episodes is life-affirming: it is possible to move out of relationships, to be alone and to be accepted back, just as you are.

The Summer Book is more narrow in its focus, compact, distilled, quiet, yet full of life. The reality it describes is of the everyday variety: you can see, smell, hear, taste the life in its many forms on a small island in the Eastern part of the Baltic. The story doesn't seek embellishment or exaggeration but, almost as if in spite of itself, becomes suffused with imagination and grows into an abundance of events, moods, living creatures, things, both hidden and visible. It is a story of the concrete and the magical.

At the heart of the book is the relationship, an uninterrupted communication, between the five-year old Sophia and her 85-year old grandmother. The relationship creates its own space – a transitional space, a potential space, a space for two, a space for one. Within it, the two of them engage in everyday tasks and in make-believe; they reveal themselves to each other, confront each other, hide from each other, push themselves and the other to the limits of what they know, want to know and cannot know.

In reading the book, I began to think of their relationship as an allegory for a therapeutic relationship. And, even though I could see that the allegory wouldn't quite fit (there is something contrived and artificial about that kind of exercise), I decided to ask what deeper truths and meanings such a comparison might bring up. I went back to two books by the French child psychologist Maud Mannoni – *The Child, his Illness, and the Others* and *Separation and Creativity* – to play with some of her thoughts and ideas, and take them to the island. If, as Mannoni says, 'the task of psychoanalysis is to expand the area of experience that can be articulated in the individual's own terms and own name', *The Summer Book* offers a quirky, unassuming and playful interpretation on the theme. Mannoni emphasises language as an important condition for autonomy, insisting that the child, the individual, must make the word, the language he uses, *his own*. This happens on the borderline between oneself and the other. Similarly, *The Summer Book* could be read as an illustration of what Winnicott calls 'the perpetual human task of keeping inner and outer reality separate yet inter-related'.

At the beginning of the book, Sophia and her grandmother walk on a high bit of land jutting into the sea. The wet granite is glistening in the sun. Sophia knows that they are not allowed there; her father has laid down the rules and the boundaries. Grandmother, however, has other ideas: 'Your father won't let either one of us go out to the ravine, but we are going anyway, because your father is asleep and he won't know.' Once in the water, Sophia is afraid since she has never swum alone in such deep water; Grandmother, though, is urging her to reach deeper: 'You let go of everything and get ready and just dive.'

Sophia's mother is dead. The information confronts and shocks the reader but there is nowhere to go with this information. The fact is mentioned only once, and only alluded to. Sophia wakes up on a cold April morning, remembering that they had come back to the island and that she had a bed to herself because her mother was dead. There is nowhere for Sophia to go with this knowledge, either; except that it is present in her desire to relate to her grandmother, in her fears, in her imagination, in her play. Thought may stall at this knowledge; the trauma is without words, inexplicable, yet it creates, or becomes part of, a space shared by Sophia and her grandmother. The dead mother is transformed into a space that is alive. Sophia's father is present on the island, always in the background, never fully in the picture.

Both Grandmother and Sophia break the rules – with the 85-year old leading the way. She sneaks a cigarette, slags off the pretentious new neighbours and boat owners, and decides, generally, whom and what it is worth believing in; the 5-year old orders about her grandmother, gets stroppy and shouts at her. They both cheat shamelessly at card games and call things bloody cold, or awful, or stupid. The grandmother feels trapped by her declining physical capability and increasing dependency on her son and Sophia. Occasionally she withdraws and sulks. After a period of mutual silent hostility, Sophia makes another attempt to make contact:

> 'Is it true that you were born in the eighteen-hundreds?' Sophia yelled through the window. 'What of it?' Grandmother answered, very distinctly, 'and what do you know of the eighteen-hundreds?'
>
> 'Nothing, and I'm not interested, either,' Sophia shouted and ran away.

Jacques Lacan's psychoanalytic concepts may seem heavy and laden with meaning to the point of opaqueness compared with the simplicity and transparency of Tove Jansson's prose. It could be said, though, that the speech used by Grandmother and Sophia is rather like Lacan's 'full speech', as opposed to 'empty speech', in the sense that they don't speak to each other in a controlling and manipulating fashion, ie 'from the ego'. Theirs is a speech that is found in another place; the locus of the Other (the unconscious). Nothing is excluded. They follow each other to the edge of what can be(come) conscious and don't try to censor what lies beyond the edge.

When Sophia finds it difficult to fall asleep – feeling anxious and fearful – she asks her grandmother if the door is closed. The answer is that the door is open. 'It's always open; you can sleep quite easy.'

The old woman is sometimes sad, even furious, when she contemplates the irreversible loss of things. The little girl feels fear and anxiety. She is scared of sleeping in a tent on her own; in the attic, she is scared of, and comforted by, her father's old

bathrobe, that appears to have become a nest for mice; she is terrified of losing her father (and grandmother); she is distressed by the fate of worms and other small animals. And they both have their rebellious phases – in order to reclaim back their own desire, to get closer to what they desire (Sophia says she 'hates families' but wants to get closer to her father) and to protect themselves against the traps that other people lay for them. Maybe, when you yell, 'Jesus' or 'I hate you', you have just spotted the trap. Visitors and neighbours appear boring, conventional or pretentious. Grandmother rebels, not so much against *them*, as against not being alive in herself, to herself.

'An island can be dreadful for someone from outside', muses Grandmother, as she watches the attempts of one of Sophia's friends, a little girl they've renamed Berenice, to negotiate her way through the restrictions and the freedom of the life on the island. On an island, 'everything is complete, and everyone has his obstinate, sure and self-sufficient place'… 'everything functions according to rituals that are as hard as rock from repetition, and at the same time they amble through their days as whimsically and casually as if the world ended at the horizon.' Those who are excluded, or exclude themselves, are not able to grasp their freedom - from conformity, convention, 'empty speech'. They never get to the heart of the matter: the core of their own experience, where conventions and other people's expectations have no place; does not count.

To each other, the two of them say everything. They speak to each other casually, seriously, truthfully, teasingly. Speech between them is both a release and a revelation. The adult doesn't trap the child in her words but allows the child to find her own.

Grandmother confronts the frustration felt by 75-year old Verner, an old friend of hers, who calls in on his boat one day. She makes it clear to him that speaking the truth, 'talking about things that matter' requires courage and the ability to be present in the here and now. Why is he hiding behind his 'empty speech'? 'All I'm asking you is, don't you ever get curious? Or upset? Or simply terrified?' She also advises him to 'outwit' the well-meaning relatives of his who encourage him to 'take up a hobby', such as gardening, or collecting things. Afterwards, Sophia asks her grandmother whom he is going to 'outwit'.

'Relatives', Grandmother said. 'nasty relatives. They tell him what to do without asking him what he wants, and so there is nothing at all he really does want.'

'How awful!' Sophia cried. 'That would never happen with us.'

'No, never!' Grandmother said.

Grandmother can no longer quite remember, or describe, what it was like camping and sleeping in a tent. Little Sophia wants to sleep in a tent on her own, in order to prove to herself, as well as to her father and grandmother, that she is brave enough to do so. She wakes up in the middle of the night, scared, and walks back into the house – hearing every sound, seeing the faint, grey light in the sky, feeling the ground under the soles of her feet, as if for the first time. She tries to stand up to her fear. How to feel things when the fear threatens to eat up the experience? The aliveness of her experience is pitched against her fear: the fear loses and, in the end, she goes back into the tent. For Grandmother the loss of the memory of what it is really like to sleep in a tent, is very painful: 'And unless I tell it because I want to, it's as if it never happened; it gets closed off and then it's lost.' The question for her is, how to feel alive? How to feel alive when the experience has become faded and fragmented? Sophia's experience refreshes the memory of her own. Something new can emerge and be created out of things that are feared, have become lost, or have remained unlived for a long time.

When Grandmother struggles with her dizziness and loses her walking stick and Sophia climbs to the top of a high wall, terrified and confident at the same time, they contemplate each other, yet again, from the distance created by the older woman's frustration and the little girl's unknowing trust in herself. Afterwards, Grandmother asks Sophia if she should tell her father what a brilliant climber Sophia is. 'Sophia shrugged one shoulder and looked at her grandmother. 'I guess maybe not', she said. 'But you can tell it on your deathbed so it doesn't go to waste.'

Above all, Grandmother and Sophia play. The whole book is, in a way, an ongoing description of a play space, a transitional space, a potential space; a space that moves, shifts, expands and contracts according to the needs of the players. There is an area of dead forest on the island – a tangled mass of trees beaten by the storms, or already rotting and sinking into the earth – which the family call 'the magic forest'. It forms a contrast to the tidied up and orderly part of the island and becomes a repository of all the bones that Sophia and Grandmother gather and the strange-looking animals that Grandmother carves out of wood. The carved animals vanish into the forest; the trees sink deeper into the earth or each other's arms; fresh green moss grows over everything. Grandmother often goes into the magic forest after sunset – when

the shapes and forms have already lost their defining outlines. Everything is allowed to be, to disappear and reappear. Rather like in the unconscious.

Sophia is enchanted by a postcard she receives from Venice and by her grandmother's description of the city. The two of them set out to recreate Venice in a bit of marshland near the sea: they dig canals and build bridges out of stones, and grandmother makes palaces out of balsa wood. The following night, there is a storm and the Venice on the tiny island in the Gulf of Finland sinks into the sea. To console her, Grandmother carves a new Doge's Palace for Sophia. It isn't the same but it will have to do. Something can always be salvaged. Something can be repaired. Make-believe is better than what is real because it can be re-created over and over again. Make-believe makes you believe in what is possible.

'In the severe case', says Winnicott, 'all that is real and all that matters and all that is personal and original and creative is hidden, and gives no sign of its existence'. The ebb and flow of play, the *interplay*, the union and separation, between Sophia and Grandmother represent the opposite: more is revealed, thoughts and feelings are laid bare, surprises come to the surface, whatever is found is received with curiosity. If the sea washes away the miniature Venice, it also brings unexpected treasures. It is always worth going to see what has drifted ashore. 'A person can find anything if he takes the time, that is, if he can afford to look. And while he's looking, he's free, and he finds things he never expected.' Mannoni talks about creativity being 'the condition for the subject's truth' – and you could say that it is this 'truth' that the characters continue to look for and discover.

In discussing Lacan's and Winnicott's thoughts on play, Mannoni says that creative play and self-fulfilment arise from moments of relaxation. The object has to be found by the infant, not by the mother, (by the patient, not by the therapist): 'the infant does not find the object if the environment does not give him the opportunity to be alive amid the objects surrounding him'. It is worth going to see what has drifted ashore, what can be found in the attic, in the magic forest, on the neighbouring island, in a secret cave and the long grass that leads to it. Objects are found, lost, destroyed and rediscovered: father's bathrobe, the two cats that Sophia alternately loves and rejects, storms, happiness, God, Hell, herbs that might make an elixir.

Sophia works through her anxiety in different ways, sometimes alone, sometimes with her grandmother. All of a sudden, she can't bear to be near, or touch small animals – anything from beetles, caterpillars, worms, tadpoles, daddy-longlegs to small fish. They are helpless, they die easily and she absolutely hates that. She can't bear her own persecutory thoughts. Appalled by the fate of angleworms, in particular - she accidentally cuts one in half with a spade and, in spite of Grandmother's assurances that the two halves will grow whole again, Sophia sets out to do her own reparative work. She decides to write a book. Not being able to write, she dictates the chapters of 'A Study of Angleworms That Have Come Apart' to her grandmother. 'Other pitiful animals' are included, too, and, as she catalogues the appalling deaths of some of these animals, she reaches the full extent of her fear and fury. 'Sophia stood up and shouted, ''Say this: say I hate everything that dies slowly! Say I hate everything that won't let you help! Did you write that?'' ' After exhausting her topic, Sophia suggests that Grandmother might do an illustration for the book; she is not that bothered about the book any more. But she knows that this is one more story, a significant one - even if she is ready to walk away from it now on to something else - that makes her who she is. She says she doesn't want to have it read back to her. 'I don't have time right now. But you can save it for my children.'

The freedom that exists in the relationship between the two characters allows both of them to find and express their own desire. Each is able to desire her own self, as well as the other. The parents either make it, or don't make it possible, for the child 'to be born to the state of desiring', says Mannoni. With her grandmother Sophia doesn't need to consider what Grandmother wants her to be: there is no confusion about herself in her mind. On the other hand, there is no escape for her – in her grandmother's company – from the experience of fear, from the challenge of expanding her sphere of experience, the task of *knowing* herself. When she wants to go swimming at the high point of the promontory, Grandmother doesn't stop her as she half expects (and hopes). She finds the water cold and deep, she is nervous and anxious, rather stunned that she has been allowed to descend on her own into such a deep part of the sea. 'You can't depend on people who just let things happen': it is both Sophia's voice and the narrator's voice; for even Sophia understands – just – as the narrator understands, more fully and through greater experience, that the only way to learn and to create is to let things happen.

The backdrop to Sophia's experience is the grandmother. She is the container, she holds the little world of the island together. She is the guardian of the island. She is the island, with its

very definite boundaries and its inexhaustible, unfathomable inner riches. She is curious, inventive, alive and alert to everything around her and to her own experience; she is equally at ease with the concrete and the imaginary; the light and the dark. The darkness that Sophia is still afraid of, that makes forms lose their outlines and identity, and makes sounds sound disembodied, holds no fear for Grandmother. But she cannot escape from her own fragility. She is there at the beginning of the book, trying to maintain her balance as she is looking for her false teeth; she is there at the close of the book, walking slowly and carefully into the dark August night (she refuses to have a chamberpot in her bedroom). She sits down on a tree stump to regain her balance and, for a moment, confuses the thumping of her heart with the sound of a herring boat. She thinks that's funny and decides to stay outside, in the dark night, for a while longer. It is another one of those moments - both transparent and filled with something deeply felt, joy, sadness, fear, energy - for which she has such a knack. They are allowed to arise, stretch themselves, and fade away. Life is not lost; creative life is not lost.

Tove Jansson calls her book a 'novel' even though it is clearly not entirely fictional. In making it sound fictional she, as it were, hides and protects the 'real' people and events – and lets the essence of them be more strongly felt. And why call it an allegory for a therapeutic relationship? Perhaps, to point out that meanings and truths are woven into and revealed by relationships in a multitude of ways: through patience and spontaneity, silence and confrontation, imagination and encouragement, through expressions of grief and humour.

The tiny island itself expands through the activities and imagination of the two players. As the two of them crawl in the grass, build their Venice, plant bulbs, wait for storms to abate, marvel at the treasures of the forest and the sea, the space between them grows almost infinite. The play space, says Mannoni, is also the space of analysis. It is a space in which the subject can question who he is. If there is trust and reliability, a potential space opens up, an infinite area of separation which can be filled creatively through play. And, maybe in the end, it is best only to trust people who let things happen.

With a long summer's night ahead of me, I'm on my way from Helsinki to St. Petersburg by boat. The boat glides past small islands in the Gulf of Finland. Can I see Tove's island, Grandmother and Sophia's island, the Moomins' island? A light greyness and a fine drizzle begin to cover the sky, hiding away the coastline. The small islands look vulnerable and anonymous from the deck of a big boat. Becoming thicker, the drizzle only gives glimpses now into the surrounding sea and islands, and protects what is, and remains, another world.

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Sarah Greaves

Saturdays child works hard for a living: some thoughts on fees

I remember an old friend once confiding in me that the greatest fear she had for her children was that they would be unable to earn their own living. As a young mother, this thought had never occurred to me. That particular part of my children's future was something I took for granted, in the spirit of that relentless Protestant Ethic in which I had been brought up. Whether male or female, rich or poor, we earned our living and carried our own weight. Indeed, as life has unfolded, further observation, if not experience, confirm that to be unable to make one's way as a result of one's own efforts is indeed a miserable and shameful state of affairs. This psychic state is often painfully revealed in the privacy of the consulting room. In addition, the question of fees in the private practice setting can exacerbate the potential for humiliation– can the patient pay his own way? Is the problem financial as well as emotional?

How to make one's way in the world emotionally and financially is the stuff of psychoanalysis. The commitment to positive moral development, integration, and creativity is worked through face to face in the transference and the real relationship, in the process of psychotherapy. This happens by confronting hate, envy, frustration, loss in its many forms, and yes, love, desire and admiration for others. A failure to do this in life may result in the development of defensive and damaging psychological strategies. In psychotherapy one is trying to address those barriers to living a full life. Whatever the content and subject of any given session, the process is underpinned by autonomy, self-reliance, reciprocity, concern for self and others, and the capacity for healthy dependency. Encouraging a patient to be a succubus or incubus is anti-analysis and anti-development.

As a psychoanalytic psychotherapist and supervisor engaged in this endeavour, partly in the private sector, it is my experience that the setting of a fee structure and the actual mode of payment highlight both the basis of reciprocity and the differing roles in the relationship. This is magnified in the hothouse of the transference. If the patient is finding emotional and financial autonomy difficult, paying the therapist directly can, in some cases, lead to a plethora of unconscious phenomena: splitting, projection, omnipotence, manifestations of hostility, devious manoeuvres, sometimes done in a sadistic or masochistic way. On the other hand, a small number of patients who can ill afford it will offer to pay almost anything in order to be seen. Various forms of acting out may be related to the essential dynamic of power / powerlessness in the relationship between psychotherapist and patient. Even a person with a developed inner integrity can, under great emotional distress and anguish, react in the transference by acting out over fees, even if temporarily. The experience of regression, often essential to the healing process, also leads to lack of differentiation and other forms of confusion. It is a state of mind requiring understanding, not collusion.

Therefore how to deal with the setting of fees is fundamental to the integrity of the therapeutic relationship and the well-being of both participants. It is the psychotherapist's role to protect the holding environment of the therapeutic enterprise. She is also earning her living. Yet it has been my perception that many colleagues and supervisees in private practice feel obligated or desire to offer a sliding fee scale and to negotiate fees with each new patient. (This is not the same as being occasionally open to reducing a fee in adverse circumstances.) This well-meaning offer may aggravate a delicate situation and, in fact, jeopardize a relationship of mutual respect. Ordinarily the psychotherapist would, as part of her role, be relied on not to intrude with her own agenda, (or what she projects into a patient as his agenda) but to be responsible for holding the boundaries. I wonder about the ubiquity of the sliding fee scale: its wisdom, its origins, what it

engenders. It certainly conveys a message to the patient, to the community of therapists, and to the world at large.

There are people who desire psychoanalytic therapy and who are genuinely unable to pay. I certainly wish to help this category of patient, but I doubt the effectiveness of a face to face arrangement between the private therapist and the patient in the isolation of the consulting room. Part of my thinking is about how one can effectively and respectfully manage those who require funding. This requires the psychotherapist to differentiate between people with limited finances and those who have a tendency to be sponging, exploitative or even just misinformed. The latter can be rich or poor.

In my experience most patients can pay their way financially in life and therefore in therapy, and do so willingly. In fact it would be offensive to them to behave in any other way. It could also be insulting if a psychotherapist were to indicate an inability to pay a standard fee. Such an opening might even throw doubt on the professional calibre, unfinished issues, or interpersonal acumen of the psychotherapist. The patient's difficulties are more existential, involving psychic survival, maintenance of relationships, inner loneliness, loss and disappointment, or chronic distress, manifested in sometimes crippling symptoms. This is what they are there to deal with. Other patients are suffering from recent misfortune or trauma, having previously lived a good-enough, satisfying and balanced life. All of the above will adjust their own budget to pay for something essential to their well-being, rather than demean themselves by asking another to take the shortfall. If unable to pay the fee they will adapt to seeing another psychotherapist, perhaps less experienced, but not necessarily less effective. They exhibit pride as in self-respect.

There can be in both of those overlapping categories a potential for regression and some unconscious acting out over fees, but this is relatively easily sorted out, often at the initiation of the patient, who wishes to talk about his feelings and understand them, rather than have them catered to in a literal way. He actively wants to address unconscious manifestations, examine his inner world, monitor how he treats his objects. He wants to learn. He is not there to strike a deal or avoid payment. In either of these categories the payment of fees is not a fundamental issue to be addressed in the character structure of the patient, though it can be revealing.

However, for some patients, no matter how well-off, balking at paying fees for psychotherapy is central to their character structure. They may be innately exploitative or parasitic in inclination. They may resent paying money for the attention and care of which they have never received enough. 'That kind of love should come free' is the inner refrain. And the therapist may be expected to compensate. There can be other components, one being that of a conscious or unconscious intention to disturb the emotional equilibrium of the therapist; the patient, in the transference, may feel his emotional survival is entangled with the very being of the therapist/parent. His phantasy and projection around that are his 'reality'. Money, need and survival get confused. The patient may see the therapist as cold and ungiving, keeping her wisdom and know-how for herself, or alternatively as a huge business conglomerate. In such a state of mind, a patient can, unconsciously and in desperation, attack the Achilles' heel of the psychotherapist - her income. The therapist can feel bullied and resentful, but so overwhelmed by massive projections that she is unable to think clearly. She may be tempted to do the equivalent of a means test but not wish to humiliate her patient. This can lead to an extremely loaded and frequently unsatisfactory encounter. Once an arrangement is made it will be difficult for the therapist, even with hindsight, to back out of it. In addition she may feel that she has participated in creating a false relationship, detrimental to a functioning analytic relationship.

The psychotherapist in private practice is accountable for her own assessment of the patient, the fee she charges, and its collection. It is not merely a business transaction, because she is simultaneously addressing powerful conscious and unconscious emotional issues. If the psychotherapist is offering a sliding fee scale, she is on the frontline concerning her capacity for assessment, both emotional and financial. As many psychotherapists earn their main living in private practice, their own self-definition and financial survival are at stake. The initial consultation is a compounded and demanding task, and it takes place in the heat of the transference and countertransference.

There is a very real danger of a psychotherapist exploiting a patient and in particular a very needy and vulnerable patient. I believe reports of greedy therapists who charge exorbitant fees and who charge rigidly for missed sessions no matter what circumstances prevail. But I have never yet met one who does this. On the contrary, I have met many caring supervisees and colleagues who rush to the rescue and too often take the shortfall if the patient's means appear to be limited. 'Appear to be' is rather a crucial phrase here, as over the years I have heard many descriptions of the person on a

reduced fee scale turning out to run expensive cars, to have children at fee-paying schools, or to be protecting untouched capital, and yet expecting the psychotherapist to reduce her income. Out of decency and perhaps an inner scenario of guilt and reparation, ultimately leading to omnipotence, the therapist makes herself vulnerable. There is also the possibility of an unexamined need to be needed. The outcome of being duped can be denial or deep resentment. The wisdom of initiating or participating in the process of offering and negotiating a reduced fee scale is therefore open to scrutiny and serious questioning. It affects the psychoanalytic endeavour.

One of the issues I am raising therefore is, to what extent, if at all, should the psychotherapist in private practice adjust her fee to what appears to be the financial need of the patient? In doing so she holds herself to ransom and subsidizes her patient. I suggest that her role in listening, containing and metabolising material and projections, feeding back when appropriate, and perhaps interpreting attitudes to fees when relevant, works best within strict boundaries which enhance clarity. Taking on the additional and difficult business of financial assessment will distort the transference, in terms of reality and whose responsibility is what. The therapist / parent will be communicating that she is the one who will do without, will revolve her needs around the patient and bear the loss.

I have heard that for some patients and supervisees it has become the custom to arrive and, instead of asking what the fee is, to state rather emphatically how much they are willing to pay. It sounds like assertiveness training gone wild. Such lack of regard for the other, such self-entitlement, is something to be addressed in the therapy. The emotions felt by the psychotherapist in such provocative scenarios can put at risk her capacity to maintain a balanced outlook. Her own professional role and personal concerns are being challenged and compromised. As an outcome of multiple anxieties she may feel churned up and therefore fail to protect her capacity to use the container / contained relationship, and enter the real work of psychotherapy.

A psychoanalytic psychotherapist may view her role in different ways. She may wish to offer a sliding fee scale across the board, or state a standard fee and be open to reducing it, or she may stick to her standard fee and refer out, or participate in a low fee referral scheme. Whatever her choice, it will be crucial for her to differentiate between real financial difficulties, temporary regression, and a patient who may deceive and who is exploitative and parasitic.

I have found it helpful to have a thorough understanding of individual character structure. This entails observing the capacity for reciprocity in relationships, respecting others and what they have to offer, and feeling gratitude and a desire to offer in return. Or is there an exaggerated tendency to feel envy, to attack the good object so it can no longer give, followed by descent into grievance or despair? These dynamics may be re-enacted in terms of fees. A well-intentioned psychotherapist who holds up an umbrella for the literal enactment of exploitation, delusion, or destructive envy is not going to help the patient become a decent, functioning human being. With many patients there is nothing sinister going on, they may just lack knowledge and understanding, and require elucidation. In pursuit of this understanding I would like to look at Bion's understanding of commensality and parasitism.

Commensality and parasitism

Nature is clever. Think of the human baby: nature makes him a delightful little parasite, who evokes nurturing and feeds off others. The early mother / infant relationship, supported and protected by the father, contains the difficult and hazardous movement from parasitism to commensality (literally meaning, 'eating at the same table') as described by Bion[(1)]. The infant develops into a separate and individuated adult, capable of standing on his own two feet emotionally and financially, capable of give and take, of the capacity for concern, and therefore of intimacy. All this unfolds to a greater and lesser extent in all of us, and is by no means always stable in any of us.

In order to enjoy a commensal relationship as adults, we have to be separate, to have our own emotional resources and our own inner container: that is, to be capable of symbolic thought and the creativity that that engenders. This is the outcome of a 'good enough' constitution, as well as the 'good enough' relationship with parents and siblings. This state of mind enables us to have a DIY kit inside, which enables a healthy dependency or exchange. One hopes the quality of this relationship is that of a capacity for concern. It is this capacity for concern which encourages autonomy in the other, pride as in self-respect, and an urge for equality. It is only in this psychic state that both parties can cooperate and create something together - an idea, a project, a baby, something life-giving. This is a commensal relationship. I am suggesting that the psychotherapist tries to come as near as possible to a commensal relationship in the therapy process, allowing for the inevitable asymmetry of self-revelation in the enterprise and the power

differential. A fair enough exchange is enacted – the psychotherapist works on behalf of the patient, and the patient pays.

In contrast, think of the Ichneumon fly (this example was given me by Arthur Hyatt Williams), which feeds on the caterpillar, keeping it alive as long as possible by saving the vital parts of its prey until the last so that the fly can survive as long as possible. Such a parasitic relationship in adults is not growth-producing or creative. It destroys the possibility of a third party, a creative 'child'. It may also destroy both parties.

As a psychotherapist one observes over the years that many parasitic client/therapist relationships are concealed with the help of substance abuse, dysfunctional hypochondria, private incomes or trust funds which are not acknowledged, and other forms of conscious and unconscious deception. A marriage or partnership can be at its best commensal, at its most derogatory a meal ticket for life, at its most exploitative giving free labour and sex for bed and board in return. An interesting sub-group are some artists, who expect special allowances and privileges because they are 'dedicated to their art' and this takes priority over paying their own way. The therapist tries her best to keep away from a dynamic of parasitism as either caterpillar or fly, but this may be not be easy.

Origins of the sliding fee scale

Human nature has a tendency towards altruism. In the late 1960's many radical thinkers such as Ivan Illich,Thomas Szasz, Peter Lomas, and Morrie Schwartz were trying to get away from the medical model of psychiatry, which pathologised, labeled, and stigmatised. They were committed to providing training based on dialogue rather than didacticism, and they sought to provide training for a wider range of people, not necessarily medically trained or from an elite group. As part of this political movement there was a move to provide psychoanalytic psychotherapy for members of the public who desired and would benefit from it, but who ordinarily would not be able to afford it. Many of us who were in this project at the beginning are still committed to the movement. Hence the emphasis on sliding fee scales and, in the early days, altruistically doing without in order to help others.

Many women were committed to confronting the sexism inherent in psychoanalytic theory. Notions on sisterhood also led to low fees, and empathy was a much-used word. The confusion at that time amongst women about helping others by women doing without was, with hindsight, nothing other than misplaced middle-class angst and sexism. As an outcome, this lack of self-regard as to one's professional worth led to women psychotherapists charging very low fees, letting themselves be shunted into volunteerism, and/or joining counter-culture trainings which did not provide qualifications. Fortunately, the 'closet sensibles' studied psychoanalytic theory from a feminist perspective, joined rigorous trainings, and established a profession in which women excelled and also charged fees at a reasonable rate. We realised that rescuing one's sister by charging her low fees when her husband could well afford to pay, or when she herself could get a job, was the outcome of a false consciousness which oppressed both women.

Historically, dedicated doctors and vicars and their wives often gave unstintingly of themselves in generous and unbounded ways. The wives were of course not paid. A less pleasant type was the 'Lady of the Manor', such as Lady Catherine de Burgh in 'Pride and Prejudice'[2] or Mrs. Eliot, with her 'lame ducks', in ' The Middle Age of Mrs. Eliot'[3]. Such characters dispense unsolicited advice to the 'poor and needy'; instead of payment they want gratitude and the opportunity to patronize.

Present day phenomena

As psychoanalytic theory and practice develop, ideas about the process of healing, as in the container/contained relationship, have become more refined. I have selected the parasitic and commensal dimension, though others exist. As adults our inner worlds often unconsciously dictate how we are in relationship. We now know that experiences of falseness and deception, double-binds and mixed messages, and living with a willfully misunderstanding object, contribute to making people ill. From Freud we know that what children suffer passively, they do actively to others. For a therapist to collude in a corrupt re-enactment of an internal scenario such as falseness or dishonesty with a patient, leading to parasitism, is tantamount to treating the illness with its cause. A therapist is not going to help someone on their way to integration by colluding with lack of reality or moral fuzziness, such as self- deception in the area of low fees. It is this aspect of radical politics, feminism and do-gooding which temporarily misled a movement. To personally assess and deliver magnanimously across the board, particularly if this has connotations of being more humanistic and more caring, thereby taking the moral high ground, suggests a misapprehension or perhaps even omnipotence and arrogance in the therapist. It does a great disservice to the patient. Bion calls this state of mind 'morality without morals.'[4]

In subsidising a patient, even a very obvious case such as the single parent with three children on social security, it is still important to be aware of the implications of concretising the issue of fees and money, and neglecting the meaning or phenomenology of being in such financial straits, or the symbolic meaning of money. Of course, there is no dispute about some people needing funding in order to change their circumstances. However, money and payment have many meanings in the transference, as in 'greedy devouring mother' or 'bountiful mother overflowing with the milk of human kindness' or 'right to exist as separate person'. There is also the experience of each individual: money can bribe, money can give status, money can be used to demean and money can be given instead of love, to mention only a few. One of the issues here is how in understanding multiple aspects of a person's relationship to money one can avoid getting side-tracked into literal responses, action, and collusion. This is the psychoanalytic task. Ensuring that funding gets to the people who really need it is a task of another sort. A further challenge is how to be resourceful, respectful and effective in doing this.

In not offering to negotiate over fees but stating a standard fee, the psychotherapist may have to deal with a more negative transference, instead of a cosy collusive one. As previously mentioned, a prospective patient may expect to negotiate, to bargain, even to state his own fee, and will be taken aback at having to deal with the therapist's standard fee rather than his own need, real or imagined. Of course, he may also be relieved: paying the required fee is less cloying, and the patient does not feel indebted and guilty. Or, he may have fantasies of being hard done by: are 'siblings' paying less and if so, why? To concretise such imaginings does not assist in their exploration. Ultimately, the patient can be grateful that he was respected enough to manage the truth, and was allowed to confront within himself the necessity to pay his own way in life. This is growth-enhancing.

The profession of psychoanalytic psychotherapy has now emerged: it is arduous and demanding work. A consuming, expensive and rigorous training is usually preceded by a degree or two, and frequently by a professional training in something else like medicine, counselling, social work, teaching, the ministry or nursing. However, psychoanalytic practice is often attacked by the mass media, and not just the gutter press. Psychoanalysis, starting with Freud, has always had an uncertain reputation. There is ongoing suspicion about the unconscious, about sexuality and, these days, about the questionable and even shameful issue of a profession that deals in feelings. In addition, stories about exploited and vulnerable patients who started out depressed and financially solid but ended up abandoned by their therapist, penniless and suicidal to boot, seem to make good copy. The emphasis is often on how 'anyone can hang out a shingle' as a psychotherapist, rather than on the quality of training, wealth of experience, conscientiousness and caring of most practitioners. Accurate descriptions of the true nature of the work, qualifications and training, and the positive enough outcomes in many grateful patients do appear, but seem left to the small print.

I wonder how much of this is perpetuated by the profession itself in its lack of clarity or self-definition? There is now a smörgesbord of psychotherapies on offer: psychoanalysis, psychoanalytic psychotherapy, creative psychotherapies informed by psychoanalysis such as music, art and body therapies, counselling in its many forms, brief non-analytic psychotherapies, CAT and CBT, Gestalt, psychosynthesis, New Age crystals. The general public are not aware of what it is all about. If practitioners are confused about their role and self-definition, about their place in a complicated hierarchy, about their right to be paid as professional persons, this confusion is only going to provide disinformation for the general public.

A further complication in all of this is that within the profession there is a great deal of competition and rivalry for referrals. This can lead to denial, moralising and envy around the issue of fees. One psychotherapist is over-extended and another is waiting hopefully by the phone. This can, of course be related to experience and ability, but it can also be related to place in the network and cliqueishness. In frustration and demoralisation a psychotherapist may sometimes take on almost any client at any fee in order to work. This fraught situation seems to inhibit open and honest discussion, so that instead of addressing real grievances and trying to establish a fairer referral system, a breeding ground for calumny and malicious rumours can develop. The existence of the greedy exploitative psychotherapist, real or imaginary, serves the purpose of having within the profession someone to scapegoat and revile. So also does the existence and fantasy of the bountiful psychotherapist overflowing with milk and good will, to the detriment of others who need to be paid. This gives a 'legitimate' excuse to be horrible, to throw stones, to feel morally superior, rather than to look at oneself and the real issues, honestly and openly.

It may be a painful truth for the psychotherapist in private practice, that despite being highly educated and cultured she is in fact 'working class', in the sense that, if she stops working no income appears

miraculously in her bank account. It may be salutary to remember that, for those whose income is 'pin money' (and who may therefore charge low fees), such privilege, whether from having a private income or a high-earning spouse, does not mean that one is a more generous person: the money is just not missed. It is not a reason for self-aggrandizement at the expense of colleagues who work to earn a living, but a privileged status for which to be grateful.

As psychotherapists we are often committed, even devoted, to our long-term patients. In order to keep faith with this we have to be financially and emotionally able to be generous, and to move away from a hunting and gathering stage of development. Rather than precariously teetering on the brink of financial viability, and being embarrassed about charging fees, we need to be able to be there both for ourselves and our families, and for our patients when misfortune and tragedy strike. There are situations such as bereavement and illness in which the therapist herself needs time off. Similarly, the patient in such circumstances may temporarily be unable to pay his fee. I would hope psychotherapists will not be led astray by a false consciousness, in which we neglect to listen to our professional concerns, needs and standards. If we are sufficiently secure, confident, and financially stable then we will be able to respond out of genuine humanity when it is needed.

The painful truth for the patient is that to have limited means results in less opportunity and choice in the private sector. On the other hand, a person with a limited income could be very high on a low-fee organization list. The reality is that the gap between the desire to have something and the wherewithal to achieve it is one of the many frustrations we all have to deal with in life, whether it concerns money, talent, love, or luck.

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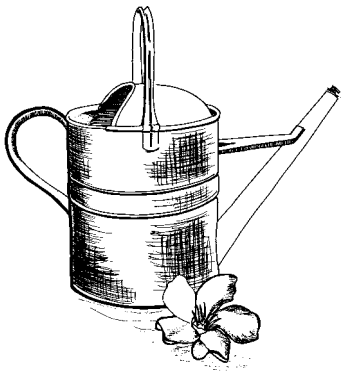

Pat Tate

Minor Surgery

It was just a small operation, but I had put it off. Well, anyone would, wouldn't they? Unless they were one of those sad people who actively seek to be cut up by surgeons – and, as a doctor, I've met a few of those. No, I had long been aware of my symptoms, and had hoped they would just go away; many symptoms do. But when the numbness in the fingertips of my left hand changed from intermittent to permanent, I went to my G.P. like a sensible person and asked for 'advice' about my carpal tunnel symptoms. He understood the code, asked where I wanted to be referred, and all was set in motion. I was being responsible – taking care of the body, the only one I'll ever have, and I want to go on using it forever, or at least for a long time, and I want to pretend it's not getting older, or at least not very. And it would not be good to be an otherwise frisky 95-year-old with a numb left hand.

In the clinic, the surgeon doesn't remember me as a medical student but knows my medical status and I am in and out miraculously quickly, with an early operation date in my diary. I'm sure this is not unrelated to me being a doctor, but that doesn't prick my conscience much – if I worked for Marks & Spencer, I'd get a discount. The consultant has told me, "Operation Friday afternoon, big bandage till Monday, small bandage after that." So it doesn't really seem necessary to alter or cancel any of my commitments. I can carry on as usual. In fact, I arrange to see two extra therapy patients on the Friday morning in question. Superego, narcissism, or just plain bravado? Also, I wash my hair and trim finger and toenails. This could merely be forward planning- but it seems the body is getting some extra thought and attention.

At the hospital ten minutes before the stated time (middle class behaviour, nicely calculated) I begin a long afternoon of waiting. A fluctuating group of us wait in various permutations throughout the afternoon, going away and coming back somewhat changed – in a hospital gown, or with a black arrow on a limb, or even being sent away altogether. One hopes there is a system here, but it is not an obvious one. This makes for anxiety, and a certain degree of crossness. I could organise all this so much better! How dare they waste my valuable time in this way!

I am aloof with the others who are waiting, I have brought a professional book which I am to review, I wear my status like a badge. But horrors! A nurse takes me aside, asks what I would like to be called! I'm sure she expects me to offer some form of my first name, but I just can't do it. Hesitant, I apologise too much – I'm sorry to be so old-fashioned and formal, but I do prefer 'Dr. Tate'. She takes it well. Later, when I hear other patients being summoned, it's true that some are called by first names, but a few are Mr. or Mrs., and I feel foolish all over again, in a different way.

I have been a patient in the past, but I had forgotten the embarrassment of relinquishing my own clothes (which I feel proclaim a lot about me) and becoming simultaneously anonymous and barely covered in a hospital gown. And what did the nurse think of that nasty spot on my back as she tied up my gown? Is my body acceptable, or disgusting? Indeed, well along in the processing, the Registrar considers my body might NOT be acceptable (for surgery, at least) due to a gardening injury, a blister on one finger. If the skin is broken, we can't go ahead. "Oh no", I lie, "the skin is definitely not broken", omitting to mention my extensive pokings of the blood blister with various sharp instruments.

One of the other persons-in-waiting looks very familiar to me, but I can't place her. When the ebb and flow of people leaves us briefly alone together, I apologise and ask where we have known each other. She is a former patient. I am embarrassed, but she is kind and generous, and we talk amiably.

In a small room, the surgeon himself administers the local anaesthetic, carefully explaining in advance

what he will do. I avert my eyes too late to miss sight of the enormous needle which stings and burns. There is nothing in this scene that I can recognise from those in which I was at the other end of the syringe. I am passive, agreeable, and thinking it is important that this man likes me, finds me the Right Sort of patient. I know intellectually that he would not be cruel or careless if he didn't like me – if anything, he'd be more careful – but that knowledge in the head is swamped by helplessness. I am careful to be grownup, a professional, a cool cooperative person with a GSOH, not fazed by any of this – but somewhere, not far away, is the frightened little girl of 8 who spent a lot of time in hospital, had a lot of operations, and was not big enough to be anything besides Good.

At long last, after the hours of inefficiency, into the operating theatre. I hadn't expected this! A proper theatre, cold, with tiled walls & floor, and a real operating table on which I am to lie. "No need to take your shoes off" I am told. Then why, in heaven's name, did I have to remove my bra? I insist on removing the shoes on principle, accept a blanket, feel surprisingly comfortable lying there, like a chilled offering. The man who has settled me so nicely asks, "Did you used to work at Hinchingbrooke Hospital?" Dear me, he remembers me as a very junior doctor after 20 years! More reassurance as to who and what I am, but conflict as well – am I doctor, or patient? Or neither?

The gowned and masked nurse directs me to do various things with my arm – I don't do them properly and have to be re-instructed (more shame), but eventually the arm is swabbed and wrapped to perfection, and the surgeon appears, with a silent but nonetheless distinct fanfare. He is all covered up – nothing human there but the eyes behind the spectacles. The voice is the same, but the appearance is something out of Dr. Who.

Do I want a screen put up so that I can't see what's going on? No, of course not, I'm no wimp, but I certainly don't look in that direction, feigning interest in the fascinating pattern of the tiling. There are painless but unpleasant grating sounds and tuggings going on in my hand, the surgeon and the nurse seem very intensely concentrated, bent over that part of me, while the rest of me is disregarded. The surgeon calls for "another blade"- dear me, am I so tough that I have damaged the knife? It all seems to go on quite awhile, until the surgeon heaves a big sigh and says, "Well, that's a pretty knackered-looking nerve. I like to see them go pink when the pressure is released, but this one's just white." A sudden surge of self-reproach – you did leave it too long, you fool, you're irreparable, and you've lost his respect as well. I say out loud, "I'm thinking pink!" Eventually the surgeon says it looks OK and closes up. I am mightily relieved until I begin to deconstruct that episode. Did the nerve really go pink before he closed, or did he lie to me? Is the nerve actually in bad shape, and he needed to let me know straight away that I shouldn't expect a good result? Or does he say that to everyone, in the spirit of Aristotle, who wrote, "Tell the family of every patient that the patient will die. If he does die, you are seen as an exceptionally wise and learned doctor. If he does not die, you are seen as an exceptionally skilful doctor."

Eventually the hand is bandaged up in a huge ball of cotton wool and gauze. Since the initial injections to numb it, there has been no pain, indeed, no sensation – all the stress has been about something other than pain. I walk into the recovery room in high spirits, calling out to the nurses with whom I had been so stiff earlier, "Hello, Team!" I observe that I am relieved to be alive. Did I think there was a risk I might not survive a local anaesthetic? (Well, there is, but not, so far as I'm aware, with this type, and anyway, thinking doesn't enter into it.) I am chatty with the neighbouring recoveree and with the nurse who brings me tea, and I even do a brief careers guidance session with one of the nurses, and show her the book I have been guiltily reading all afternoon. I ask a nurse to help me on with my upper clothing - somehow, the spot on my back seems less damning now. Then, at long last, five hours after arriving, I am leaving, a postoperative patient. Once again I have sole ownership of my body.

But that body has been breached and penetrated. Not the core of it, really quite a distant part, a hand, and the left one, at that (the non-dominant hand, as the nurses said). By being awake and present for the procedure, I actually have much more powerful and available emotions about this little operation than about other, more serious ones in the past. In spite of all the reassuring landmarks in this episode, reminding me that I am a doctor, that I have knowledge, that this is all familiar and commonplace, I still have experienced the helplessness and fear of a patient, and I am hugely relieved to be alive and 'intact', save for the (already-healing) cut.

We do this sort of thing fairly often – voluntarily put our body, or part of it, into the hands of another who is not our lover – a hairdresser, a shoe salesman, a massage specialist, a G.P. who takes blood pressure or examines the sprained ankle or the sore throat. We accept care from others. There is a school of thought that points out that caring and being cared for are two aspects of the same process. I am both a carer and a cared-for, both a client and a therapist, both patient and doctor. It is important that I am aware of this, and allow one role to inform the other. Whatever it is, it is not Minor.

Sarah Fahy and Donna Feldman

Joining the Outfit

Joining the Outfit as student members was, for each of us, perhaps a little daunting and rife with fantasy. A whole entity of the weird, wise, and wonderful, rather than a collection of individuals. A 'secret society' whose identity was less 'out there', less available than other trainings. Something rather opaque and rather arcane. In order to access the Outfit, one had to know of their existence in the first place. One had to have been, at some level, pre-initiated.

Perhaps the purpose of writing this is to go a little nude (and here we differentiate between nude and naked) about the process.

For both of us, Lesley was the first contact. Generous and reassuring, Lesley was available throughout. Perhaps she was also the bridge between our fantasies and reality, as we negotiated our way through the differing descriptions of the Outfit and esoteric paper-based information.

The informal meetings came next, and we each found these individual meetings over coffee a helpful way in. Helpful also in defusing some of the mystery pre-acceptance, and the first step to appreciating the fact of distinct individuals post-acceptance. It was hard to think what to ask, and we were moved through a range of thoughts and feelings, sometimes prompted to think philosophically and consider our own motivations in wanting to join, and at other times going organic and trusting that the questions would evolve either directly or indirectly out of the meetings themselves.

Attending the student group meeting as applicants brought its own anxieties, but provided a very real experience of the group process, and a scary-but-exciting glimpse of the creative work in progress. It also offered the potential of a group of people with whom to share ideas.

The letter of application was tough (giving enough but not too much) but extraordinarily helpful. Seeing ourselves on paper provided us with new ways of looking at ourselves- black and white, same us and different us. There was also the distance / perspective that allowed us to appraise objectively, and perhaps appreciate the commitment that had brought us to this point.

The formal interviews were perhaps toughest of all, and brought with them their own persecutory and paranoid fantasies. Hard not to feel vulnerable, exposed, judged. Hard not to over-analyse our own contributions (or lack of them) afterwards. Harder still to trust our internal gauges post-interview and not pass sentence on ourselves. Perhaps though, at some level, we did realise that interviewers were not looking for us to 'get it right', but were looking instead for the capacity to reflect.

Joining the student group (and the Outfit 'family') is perhaps to re-experience oneself as a baby again, dependant on and needing the goodness of others. What happens when that goodness is forthcoming? What happens when it isn't? Helpful stuff, but scary nonetheless. Persecutory and paranoid fantasies surfaced again as we struggled to express and contain ourselves. The loudness of our internal voices at times drowned out external voices; how shameful and alone this felt. Projections were rife as we split off the good parts of ourselves and gave them away willy-nilly ('they are so clever and I am so stupid'). And as we gave away the good parts of ourselves and were further diminished, we became even less sure of who we were in the new context. We experienced ourselves as clumsy and gauche as sentences popped out of us before we could check them. We queried ourselves and the training from all directions. Were we up to it? And perhaps this was enhanced by the feeling of joining a group that had a history together, with established protocols, and similar levels of training. A difficult time, with us arriving as someone was graduating. With

hindsight though, it is hard to see how we could have avoided what now seems like an inevitable initiation.

Throughout these first introductions, we also experienced the 'compulsory' pairings which helpfully took away the responsibility for locating allies, and by the end of term we were moved to recognise each other as siblings in the family, with complementary reassurances rather than competing needs.

No sooner had we joined after Easter than it was the summer break, which perhaps provided a chance for some of the dust to settle, for us to do some digesting, and to reclaim our split- off parts. The autumn return to the student group brought with it a sense of rightness and belonging, a feeling of being very grown up and an 'old hand'. Of course, having new babies helped.

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Jenny Corrigall, Carol Dasgupta and Carole Robinson

Laughter in the consulting room

Two men, Bob and Matt, are walking together across Parkers Piece when to their great surprise they see a penguin. They wonder what to do. Bob says to Matt "I've got to get to work – you take the penguin to Linton zoo and I'll meet you in the Kings Head tonight – usual time" and off he goes. Later that evening Bob arrives at the pub and can't believe his eyes when he sees Matt standing at the bar holding the penguin's flipper. "Why in heaven's name have you still got that penguin – I told you to take it to the zoo." To which Matt replies "Oh, we had such a good time together at the zoo today that we are going to the cinema tomorrow".

If someone started a psychotherapy session with you by telling you a joke, how would you react? Your response as a therapist is likely to depend on how much you already know of this person, their relationship with you, the relevance of telling you this joke or any joke, and perhaps how you are feeling that day. The telling of a joke will have different motivations and meanings. What if the person sitting with you just wants to make you smile and laugh and share the pleasure of humour with you. Is this allowed?

Our discussions began with laughter during a Reading Group. We have met as a group reading psychoanalytic work with enjoyment and interest most of the time. But laughing gave us new energy and interest. We have really enjoyed sharing thoughts and ideas as we prepared to write. We looked forward to meeting with a feeling of excitement previously absent. It is this creativity and sense of being alive which we wanted to think more about coming into the therapeutic process. Maybe this relates to Peter's recent question to us all about where excitement is in therapy.

As psychotherapists, we do a serious job and we take it seriously. Can we simultaneously relax with our patients, be unguarded ourselves and enjoy the basic communication of laughter. People have always known that laughter is important to health, happiness and feelings of well-being. Now research has found this too. Laughter clinics have been set up to help people laugh, while scientists speak of the healthy release of endorphins through laughter. People do seek laughter: we enjoy comedies, laugh at jokes, and could in the past put money into a slot machine to laugh at and with The Laughing Policeman.

Laughter, when spontaneous, comes from the depths. It feels a primitive rather than a learned response, emerging in an unprocessed and unmediated way. It is an intense physical experience and can be out of control. We can momentarily lose control of our bladders, whatever age we are, and may overlap into crying. We speak of howling with laughter and 'I laughed till I cried'.

Laughter with someone else can be infectious and the shared moment can break down barriers of age, race or gender. We can certainly laugh alone, but it always refers back to a social context - a memory, a joke someone told us, a television programme, or a book we've read.

There are people who cannot laugh, who we cannot imagine laughing, either in the therapy room or anywhere else. We wondered whether such people have lost, or ever had, a sense of humour. Have the events of their lives, and the impact on them, made it too dangerous to laugh, to open up, to let go? Do they even recognize the humour in a joke? What is missing, what has gone wrong? It does feel as though something has solidified in some people we see, as though there is too great a fear of sharing, or letting go tight control. This can be one external sign of an internal isolation, perhaps based in shame. Being able to laugh at some dread together can be a release, and can help someone begin to let go and find acceptance.

Smiling may be the beginnings of this process of opening up. Certainly, smiling can be a stock, social response and not go beneath that surface, but smiling can be an open and warm response to another. It may also be a way of testing trust between two people, from which humour may develop.

Teasing may be a start to a shared playfulness too, but can so easily be a risk, since it can be cruel and sadistic(as in the school playground). But teasing also has positive aspects, as an indication of trust, understanding and love. Maybe I only tease people who I feel trust me, or I trust, where there is a certain level of intimacy. Teasing in the therapeutic context requires us to keep in mind the potential dual threads of trust and attack.

Men often relate through playful banter, and it is important to be aware of this. It may be defensive, but it also promotes mutuality, and may be a starting point while someone tests out you and the whole situation of therapy. Again, it is important to see beyond the undoubted defensive aspects of some laughter. A related point is that sometimes we might make a mistake. Our timing may be wrong, or we may laugh in the wrong place - but hopefully this can be explored. It is important to keep humour alive.

Humour is risk taking. As therapists is it too risky to share and enjoy humour? There can be a humour that defends against pain (Blackadder) and we may laugh at what is essentially painful. Humour can also be an attack (Dead Ringers) and we may laugh or be invited to laugh, at someone else's naiveté and vulnerability (Some Mothers Do Have 'Em). It is of course important to be aware of these possibilities.

We might, in laughing with a patient, be colluding. We might fail to pick up and analyse something important. We may be defusing a tension which could usefully build up. We certainly need to be alert to laughter being used to keep something at bay, or to block some strong feeling or memory. Part of this may be a need to keep some control and stop something happening. We will hope to pick this up, in ourselves and in those who come to us for therapy, and explore it where possible. But we think it's worth the risk.

There are ways in which humour can bind the teller and hearer, while distancing others. For example, we could have started the joke at the top of this article with 'There were two Afrikaners, Van der Merwe and his friend' (in South Africa); 'There were two Irishmen' (in England); 'There were two Newfies' (in Canada outside of Newfoundland). The same jokes are told within all cultural groups at the expense of, and to distance oneself from, an outsider group. If aware of the importance of humour in culture, we also have to be aware that different cultures have different attitudes to what is funny, and it is essential to be aware of this in therapy. Humour does need to be negotiated. What is acceptable will differ between cultures, certainly, and also in the new culture of the therapy room.

The sense of being alive, and the energy in humour, and the connection of humour and play are vital in therapy, as well as in life. The exploratory aspect of play, which in an adult therapy will be playing on words, playing with ideas, free-associating - all encourage releasing an energy and reflecting on it together. The capacity to laugh at oneself can be a signifier of maturity, indicating that something has been worked through and digested. Most of us, in life as in therapy, are aiming at meta-cognition, a thinking about our thinking, a developing ability to reflect on ourselves, our lives and our relationships.

Sadly in writing this we've not been able to capture the experience we've enjoyed, the richness of the discussions… language and maybe self-consciousness have limited us. The next article perhaps.

Review

Sue Gerhardt, *Why Love Matters: How Affection Shapes a Baby's Brain.* Brunner- Routledge 2004. 246pp. £9.99. Christina Hardyment, *Dream Babies: Child Care from Locke to Spock.* Oxford University Press 1984. 334pp.(Currently out of print but available second-hand on Amazon.)

Reviewed by Rosemary Randall

Sue Gerhardt's book *Why Love Matters* belongs in the tradition of child-care and advice manuals for parents which Christina Hardyment analysed historically in her book *Dream Babies.* Gerhardt's book received almost universally congratulatory reviews when it came out earlier this year and I bought it in the hope that it might make a helpful present for a young friend who had recently had her first baby. I was glad that I read it first and was able to find an alternative gift but the experience spurred me to analyse just why I thought it was such an unsuitable present.

Gerhardt's book – like many in the genre – does not recognise its location in a tradition, instead emphasising its own innovativeness and importance in correcting the errors of the past. Many such books look to an external authority to validate their arguments. Over the centuries reason, nature, religion, philosophy, medicine, ethology, anthropology and of course science, have all been appealed to. The excesses of behaviourism in the pre-war period led to hard science going out of fashion to some extent, replaced by the softer disciplines of child study and, with the revival of feminism, a return to the centrality and validity of individual maternal experience. Gerhardt however puts science firmly back in the driving seat.

Her thesis is that it can now be shown that the biological systems involved in regulating emotional life are subject to social influence: neuroscience has demonstrated that early experiences establish a framework for emotional life that is structured in the brain. She argues therefore that the infant requires an acute and tender responsiveness if its future life and health – and indeed that of society – are not to go astray. Her book is mainly taken up in describing in great detail the mechanisms of emotional regulation and the consequences of its malfunction.

The call for tender responsiveness in infant care is not of course a new one. As Hardyment points out fashions in childcare come and go and most 'new' trends have an antecedent somewhere. Gerhardt does not acknowledge this however. Dazzled by neuroscience she presents her call for responsiveness as innovation. She could be forgiven for ignorance of the delightful Andrew Combe who wrote in 1840:

> Adaptation to the wants, feelings, and nature of the infant – so different in many ways from those of the adult – ought to be made the leading principle of our management. (Quoted in Hardyment, p.81).

But the ignoring of her own background (she is a psychoanalytic psychotherapist in the independent tradition) and the work of writers like Winnicott, Fairbairn and the object-relations school is more puzzling. She does not, as one might expect, argue that neuroscience confirms certain aspects of such theories. Instead she sets up the straw man of Freud and proclaims herself – personally - the victor:

> Unlike Freud…I look instead for the unseen patterns of relationship that are woven into our body and brain in babyhood. (Gerhardt, p.14).

And although she acknowledges the roots of her arguments in attachment theory this is done with curious gaps. In discussing recent studies of severe deprivation in Rumanian orphanages, for example, she writes as if the work of René Spitz in the 1940s did not exist. This denial of history and context is an important part of the book's ideological thrust but it is not the book's only short-coming.

Hardyment suggests light-heartedly in the introduction to her book that child-care writers can be classified as broadly 'cuddly' or 'astringent' – child-centred and responsive on the one hand, adult-oriented and strict on the other. Amongst contemporary writers Gina Ford with her rule-

bound *Contented Little Baby Book* probably belongs with the astringent while Gerhardt lines up with the cuddly. Her book is paradoxical however because although she evinces great sympathy and care for the infant she thunders terrifying warnings to the child's parents. Where 17th Century puritan writers threatened hell and damnation Gerhardt lists a terrible litany of disasters that will befall the child of unresponsive parents: cancer, addictions, anorexia, depression, PTSD, personality disorders, anti-social behaviour and a criminal career. 'The violent children of the future are now babies' she warns. (p.167). And in case concern for the infants themselves is not sufficient, she invokes self-interest as well:

> The babies who are born now and in the years to come will be the adults who nurse us in old age, who manage our industry, who entertain us, who live next door. (p. 218)

Such sentiments are a familiar strand in child-care manuals. Hardyment quotes Gwen St. Aubyn from 1935:

> The neglected toddler in everyone's way is the material which becomes the disgruntled agitator. (Quoted in Hardyment p.159).

Gerhardt raises such fears to the pitch of a moral panic, offering little in the way of support or encouragement to the struggling parent. If you are a mother who has sometimes finished a cup of coffee before going to your baby (p.211) you are likely to feel very bad indeed after reading this book.

Given the sharp moral and polemical tone of this book the question inevitably arises of how reliable its scientific argument is. Much of the material Gerhardt presents in the early chapters is certainly interesting and clearly described and she cites numerous studies in support of her case. It is difficult for a non-specialist to judge the science but it is possible to observe that Gerhardt has an easy, journalistic style which slides over elisions in her reasoning and avoids some difficult questions. For example in Chapter 4 she uses the anecdotal evidence of her own mother's cancer rather than any statistical study as the centrepiece of her argument that the suppression of feelings leads to this particular type of illness. Her language frequently slides from speculative statements in one paragraph ('This suggests…' / 'This may…' / 'This could…') to treating these same statements as established fact in the following paragraph or page. The argument is then rounded off with an emotive assault on the reader's guilt and anxiety:

> How cruel it is that those who were less well cared for in babyhood may also have a greater likelihood of suffering physical illness in later life. (Gerhardt p.103)

This is a tactic which speedily forecloses on any rational debate. Other causes of cancer – environmental, viral, genetic, or just bad luck – are not discussed and no space is left to consider the validity of her argument.

A slightly different, but also fairly typical, example is her presentation of studies of cortisol in Chapter 3. Here she mixes evidence from human and animal studies (mainly rats and monkeys) and from adult and infant studies without discussing the caution necessary in extrapolating from animals to humans and from adults to babies. Sometimes she doesn't reveal that a study quoted is actually one of animals and not of humans. (For example Lyons et al on p.66). This sloppiness makes the material difficult to judge and inevitably weakens her argument. This chapter culminates in description of a study which found that 3-4 year old children in a day nursery had raised levels of cortisol (an indication of stress) while children placed with a responsive child-minder did not. Gerhardt (and possibly the researcher quoted though this is not clear) draws the conclusion that the child-minder's individualised care is therefore preferable but this is not really borne out by the description of the research. The study found that children in the day nursery did not 'look stressed or behave as if they were stressed' (Gerhardt p.74) but that none the less their cortisol levels rose as the day wore on. Gerhardt concludes that this means that really they were stressed, although they didn't show it. This is not proved however. Rather, an interesting question has been raised which needs further investigation about the relationship between observable measures of stress and levels of cortisol. Were the children stressed without showing it? Or is cortisol not a good measure of stress in children of this age? Either could be true. Even if Gerhardt is right on this point however there are further questions that need to be asked before she draws the conclusions she does. For example, could the study be replicated in other day nurseries or was it merely true of this one? What might the effects be on children's cortisol levels of varying patterns of care and management in nurseries (in relation to things like sleeps, lunch time, balance of stimulating and restful activities etc), of staffing levels, staff training, children's home backgrounds and so on. Without consideration or at least discussion of such issues no conclusion is possible.

I have dwelt at length on these examples because I think they reveal the author's methods of constructing an argument and presenting evidence,

methods which run right through the book and which are intellectually flawed and at heart deeply ideological.

The ideological drive of a book is often easier to see historically than at the time when it is written. It is not easy for anyone to be fully aware of the social movements they are part of and it can be surprising to realise in retrospect that one may have acted in support of social forces or class positions that one did not overtly embrace. I have no doubt that Gerhardt's intention was to write a book that would benefit babies and parents. What she has actually written however is a book which appeals to the current climate of anxiety-driven social control, which panders to illiberal and anti-feminist sentiment and which encourages parents to mistrust their own responses and defer to experts.

The last period in which hard science was so forcefully appealed to in child care manuals was also one of the most repressive. Hardyment describes the 1920s and 30s as decades when the twin gods of Watsonian behaviourism and Truby-King's feeding regimes disabled mothers' intuitive and spontaneous reactions to their babies, inducing misery in infants and doubt in parents. Gerhardt enlists science in an opposite cause but her language and the air of repressive authority are the same. She speaks frequently and approvingly of 'experts', 'research' and 'important studies'. Science demonstrates what the ordinary human eye cannot see. In the process parents' ordinary responses and the multiple variations of infant-mother reactions are down-graded. Despite the book's title '*Why love matters*' its language is not that of love. Love is replaced by the need to regulate emotion (a favourite and recurrent phrase) and affection by the requirement to socially programme the brain (p.38), while communication becomes a question of 'experiencing pleasurable arousal' (p.41). The idea that parenthood might be a matter of spontaneous enjoyment, wonder, relationship and fun finds little expression in Gerhardt's book. Just as in the 20s, science must not be argued with.

Winnicott, for all his idealisation of the mother-infant couple, understood the importance of encouraging confidence in new mothers, supporting them in their good intentions for their infants and validating their experience. He opens *The Child, the Family and the Outside World*, the book he addressed directly to mothers, with the memorable sentence, 'To begin with, you will be relieved to know that I am not going to be telling you what to do.' Gerhardt has little such confidence in the average parent.

Hardyment notes that the late 70s and early 80s were an encouraging time for women who wished to bring up their own children rather than the dream children of the experts (Hardyment, p.xi). Feminism was encouraging the production of books based on women's own experience and they felt bolder in challenging the wisdom of the manual writers. The Open University child-care courses which I worked on at that time mixed verbatim reports from mothers with the opinions of 'experts' and structured demands to parents to observe and experiment for themselves and to question the views offered. Such openness may still find expression in school-gate conversations and in internet chat rooms where women share experience but it has little echo in Gerhardt's book.

I imagine that most readers of *Outwrite*, like myself and like Gerhardt, would subscribe to the idea that the first months and years of a child's life are crucially important. I imagine that Hardyment's 'cuddly' model rather than the 'astringent' one would also find more favour. I would hope however that readers would also value the respect that Winnicott in his patrician way tries to show to mothers, and search for child-care advice that is open and encouraging and which embodies more than the anxious instruction and apocalyptic warning which typify Gerhardt's book.

Times change and in a more repressive era, like today's, a book like Hardyment's is invaluable as a defence against the anxiety-provoking and guilt-inducing ministrations of experts who may turn out to be more ideologically motivated than they realise and possibly just plain wrong. I found her helpful in the more open early 1980s when my son was young. Understanding how views had changed and evolved, and examining the justifications offered for practices now deemed crazy or dangerous, made it easier to reject doubtful advice and learn from experience. The need for child care manuals is unlikely to go away and the best can certainly offer welcome information and support. While not a substitute for a manual itself, Hardyment is an excellent guide to the genre and I would choose her any day over Gerhardt as a gift to a new mother.

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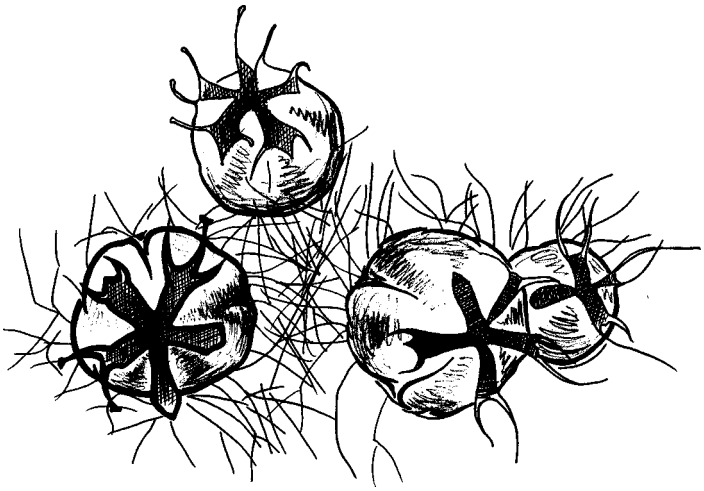

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