M. Masud Khan

20

The Finding and Becoming of Self

MY intention is to discuss the concept of *self* and *self-experience* as it actualizes in clinical work with patients. The concept of self has preoccupied analytic theoreticians more and more during the past decade, especially in Anglo-Saxon English-speaking cultures (Jacobson, 1964). The analytic researchers have the existentialist philosophers, especially those from France and Germany, as their pacemakers, even though quite often they are overtly unaware of this literature. Laing (1960) is an exception.

I shall not detail the literature here. In classical analysis, the bias has been to explore the meaning of behaviour (unconscious fantasy systems). My emphasis will be that, when we examine the person behaving in his total field of concrete reality, the concept of self takes on clinical importance.

But no matter how zealously or critically one studies this varied and perplexing literature, no clear definition of self, as a concept, crystallizes; though each of us feels sure about what he means when he uses the concept *self*, it is hard to communicate the meaning to another. And this, for me, constitutes the essential paradox of the experience of self: no one can communicate directly from his self or can be related to directly in his self. Hence the necessity of symbolic forms, as Cassirer has pointed out. The self is as much created by its symbols, as it is represented and expressed by them. The so-called *true self* of Winnicott's terminology is a conceptual ideal that is known concretely mostly by its absence. I shall refer to the symbolic forms by which a patient *knows* his self as 'notions of the self'.

Clinically, the self-experience of the patient is characterized by a very archaic and simple state of excitement, expressed often by motility. What it demands is mutuality–that is, shared trust. Its typical anxiety affect is threat of annihilation and its pervasive defence mechanism is staying dissociated and hidden, not repressed. Its domain is privacy.

First published in the *International Journal of Psychoanalytic Psychotherapy*, Vol. 1, No. 1, 1972.

The aetiology of the dislocation of self, as Winnicott pointed out, starts always from maladaptive environmental care. We encounter the self of a patient clinically only in *moments* of true regression to dependence and holding. Quite often, such moments of self-experience actualize outside the analytic or therapeutic situation, and our task then is how to enable the patient to provide ego-coverage for them. Interpretation, as such, cannot engender self-experience in the patient, although, once these experiences actualize, interpretations enable the patient's ego to find and elaborate symbolic equations through which these experiences can become a property of the inner psychic reality of the patient–conscious and unconscious. It is quite viable that a person can have identity and complex intra-psychic structuration without realizing his self, and so remains alienated from it for ever. It is only during the past six or seven years that I have begun to be aware that I tend to treat and handle the total material and behaviour of my patients in the clinical situation in two distinct ways. In this context, the research of Winnicott especially, and that of Michael Balint, has influenced me considerably. What I designate as 'self-experience' is very similar in nature to what Balint has conceptualized as 'the new beginning'.

The two distinct styles of my relating to the patient I can differentiate as:

1. Listening to what the patient verbally communicates, in the patently classical situation as it has evolved, and deciphering its *meaning* in terms of structural conflicts (ego, id, and superego) and through its transferential interpersonal expression in the here and now of the analytic situation.

2. Through a psychic, affective, and environmental *holding* of the person of the patient in the clinical situation, I facilitate certain experiences that I cannot anticipate or programme, any more than the patient can. When these actualize, they are surprising, both for the patient and for me, and release quite unexpected new processes in the patient.

The difficulty about recounting this second type of clinical experience is that, though it may take years of very careful facilitation, when in fact it actualizes and one reports it to one's colleagues, the narrative strikes them, and oneself as well, as singularly banal and unsurprising. By contrast, the clinical narratives of the structural conflicts, as reported by Freud and others, are so rich and complex in their nature and content. Furthermore, one can all too readily empathize with the logic of structural conflicts and data, even when

one disagrees with the theories deduced from them by any one analyst; whereas one is often left lacking in rapport and credulity *vis-à-vis* the second type of clinical experience.

This latter type is so *personal* to the styles of living in the patient and of working in the analyst that it is not easy to exercise that 'willing suspension of disbelief' which Coleridge recommended as essential to any creative and critical appreciation of literature. It is for such reasons, I believe, that the work of Martin James (1960) with pre-adolescents has not received the attention it deserves. The actualization of self-experience in the patient through the analytic situation is very similar to what James Joyce in *Stephen Hero* christened as his epiphanies.

> By an epiphany he meant a sudden spiritual manifestation, whether in the vulgarity of speech or of gesture or in a memorable phase of the mind itself. He believed that it was for the man of letters to record these epiphanies with extreme care, seeing that they themselves are the most delicate and evanescent of moments.

Let me first quote two examples from my mentors to illustrate this point. Balint (1968) reports the case, from his early years of practice in the 1920s, of a young girl 'in her late twenties. Her main complaint was an inability to achieve anything.' After some two years of arduous analysis, Balint recorded:

> . . . apparently the most important thing for her was to keep her head safely up, with both feet firmly planted on the ground. In response, she mentioned that ever since her earliest childhood she could never do a somersault, although at various periods she tried desperately to do one. I then said: 'What about it now?'–whereupon she got up from the couch and, to her great amazement, did a perfect somersault without any difficulty. This proved to be a real breakthrough. Many changes followed, in her emotional, social, and professional life, all towards greater freedom and elasticity. Moreover, she managed to get permission to sit for, and passed, a most difficult post-graduate professional examination, became engaged, and was married.

Now this would strike many analysts as quite a fatuous happening and not analysis at all, but acting out in the analytic situation with the analyst both as witness and accomplice. To me, this appeals both as authentic and very significant, because I have learned to

accept that often self-experience in the analytic situation can have no means of symbolic and/or concrete actualization if motility is rigidly tabooed. Self-experience is intimately related to body-ego.

The second example I take from Winnicott (1963*c*), because here the true self-experience is arrived at imagistically in a dream.

> A young woman patient had to wait for a few months before I could start, and then I could see her only once a week; then I gave her daily sessions just when I was due to go abroad for a month. The reaction to the analysis was positive and developments were rapid, and I found this independent young woman becoming, in her dreams, extremely dependent. In one dream she had a tortoise, but its shell was soft so that the animal was unprotected and would therefore certainly suffer. So in the dream she killed the tortoise to save it the intolerable pain that was coming to it. This was herself and indicated a suicide tendency, and it was to cure this tendency that she had come for treatment.

Winnicott understood and accepted the threat of annihilation to this patient's true self-experience as a fact and a reality, derived from her developmental *vécu*, and respected it as such–that is, as a *need* in the analytic situation and not as an expression of persecutory or paranoid fantasies derived from instinctual conflicts.

Clinical Material

I shall report from two cases of mine. The first, a young male patient, had been referred to me because he had an acute breakdown while taking his final examinations. He had become totally incapacitated, depressed, and withdrawn. I am reporting from a session in the third year of his analysis. In the meantime he had passed his examinations and become well established in pursuing his new professional life. In one area of his psychosexual self-experience –his masturbatory fantasies–we both were struck from the start. These fantasies were of a monotonously repetitive nature. He visualized a scene in which a blond, buxom, and virile white woman is tantalizing and exciting her black servant. She never lets him have intercourse with her. At the point at which she and the slave are maximally excited, he generally ejaculates and the drama ends. This fantasy had prevented the patient from relating mutually and affectively to his contemporary females, because none of them could fit the role. For a long time we interpreted every aspect of this

fantasy in terms of pregenital instinctual components and sado-masochistic object-relations, without getting anywhere at all. Then we both became bored with this data, and our resourcelessness to do anything about it dismayed us equally.

Then this youth met a girl who exactly fitted his masturbatory imagery. She was engaged to someone else and treated him with a mixture of tantalization and contempt. This excited him enormously and passionately, and she became his life's obsession. Then one night, after a party, she agreed to have 'a drink for the road', as the English have it, at his flat, and they 'made sex' together. I deliberately eschew using the phrase 'made love' because that would entail object-relating. After an ordinarily pleasant and adequate intercourse, this youth experienced deep despair and emptiness, which he managed to hide from her. But he reported it very poignantly, with the acid bitterness of disillusioned regret, in the session.

I interpreted to him that, so far in this area of his *vécu* I had experienced only a self-pitying mental suffering, but now I registered a new affect–that of psychic pain. I could feel that he had been let down badly, and let down through gratification. So what was lacking? I named the missing element *recognition* (drawing on Balint's concept). And I asked him what had not been recognized by both him and the girl in the sensual transaction and gratification –something very specific and particular to his self-experience that he himself could not enunciate. Then I referred back to his masturbatory fantasies and elaborated that he *needs a contractual distance* to experience his *self* in. Here I was deeply influenced by the research of Deleuze (1967) and Smirnoff (1969*b*) in the area of masochism. I explained that all our discussions of voyeuristic impulses, projection, displacement, and distribution of pregenital sado-masochistic impulses were true and valid, but as yet irrelevant for him. His truth was that he *needs* this contractual distance to experience his self. If the id-wishes are gratified, the result is merely discharge and emptiness. If the ego-manipulation of the object succeeds, the result is a sadistic, but meaningless, triumph over the object. In the masturbatory ambience his masochistic role as the voyeur yielded no growth, merely a suspended expectation of something that could happen, but never did. I added that now I could begin to comprehend why he had been able to use analysis so fruitfully in all other areas of his growth and self-fruition: it provided the ideal 'contractual distance' of his expectancy and need. But in

the area of his male-gender experience of self, he needed a woman to recognize his penis, *its* need of her, and her need of *it*–and yet to refuse it, as a mother does at the oedipal level of a child. In his childhood this process had been confused and sabotaged by too close an intimacy with his mother and from the lack of the presence of a potent mother-desiring father. This made enormous and surprising sense to him, and he ended the session by saying he felt that we had for the first time talked together, to each other, about him as a person. This, to me, is a typical example of the actualization of self-experience through the analytic situation.

The second case that I shall report is of a very different character indeed. He has been in analytic treatment and psychotherapeutic care with me for nearly twenty years. I have already recounted certain aspects of his analysis in my paper, 'Ego-Ideal, Excitement and the Threat of Annihilation' (pp. 181-202 above). He had sought treatment with me after some years of psychotherapy with a distinguished psychiatrist. His three presenting symptoms had been: alcoholism, impotence, and crippling, obsessional, religious ruminations. When he had first come to me, each night presented a terrible ordeal of choice to him. He did not know whether to go to a priest and offer himself for 'religious conversion' and serve as a missionary doctor, or, like a good Irishman, get stone drunk, or pick up a whore! His previous therapist, hoping to cure his impotence fears through corrective reality experience, had sent him to a 'call girl'. The patient had arrived equipped with a Bible and a bottle of Irish whisky. He had consumed the latter in rapid gulps and then demanded the youthful lady to kneel down, pray with him, and read the Bible–a demand that had, not unreasonably, frightened the wits out of her. It was after this therapeutic misadventure that he had sought analytic treatment.

I shall report from a session some twenty years later. The patient had done well during this period by the logic of the world, but not his own. I had weaned him from the bottle all too easily, and his sexual compulsions and fears had abated. But the religious obsessions he clung to with a militant zeal, as his unfailing technique for keeping his self hidden. For the past two years I have been seeing the patient once weekly. He *needs* me to keep himself in executive ego-fitness. He does very good work indeed, and I respect that. I have also learned from Winnicott that, if we fail our patients, we must not abandon them as persons. This is endorsed by my tradition of nurture as well.

The patient had arrived for the session in a very nasty, belligerent mood, and he berated me for wasting his youth and failing to do anything about his religious obsessions, which are quite often delusional and very bizarre. He said that he had heard of a pastoral psychiatrist and asked to go to him. I agreed with noticeable relief. He also asked to enter group therapy with an analyst he had heard of. I agreed to that, too. Then he asked if I would write to these persons to find out if they had a vacancy. Realizing that he *needed* me to acknowledge my failure, I agreed to that as well. Just as he was leaving, he became afraid and obsequious, as is his wont, and requested that I do nothing until he tells me to go ahead, but that he is finishing his analysis with me. I accepted that, too. I gave no interpretations whatsoever. I can assure you there is very little in the analytic interpretive hermeneutics that I have not fed into this patient, and to my regret.

Three days later, my secretary informed me that the patient had rung and wanted me to call him back urgently. I did. He related that he had had his first 'good dream' and felt very hopeful; he asked (he is normally a very courteous and gentle person) to come and *share* the dream with me. He did not say *tell*, but *share*! I agreed and gave him the first free hour I had. When he arrived, all bashful and cowering, he lay down (he always chose the posture, sitting up or lying down, that he felt would fit his mood) and recounted the dream:

> I come here for a session and lie down. I am silent for a long while. You put up your feet on the edge of the couch, from behind by the pillows. I am shy, but after a while catch hold of them with both hands. Then the dream becomes vague. I recollect that we began to romp with each other. I had woken up very hopeful and optimistic in the morning.

This was indeed an extraordinary dream, quite untypical of him. His dreams, if erotic, were mostly fetishistic in content, and if non-sexual, were mostly nightmares in which his life was being threatened in some traumatic situation. The *new* element was that of playing. And it is significant that he could dream this dream after *terminating* his analysis with me, by his own choice and decision. He asked me whether I agreed with him that this was a *good* and *hopeful* dream, and I said, 'Yes!' quite emphatically. He then wanted to know what I made of the dream, and I explained it at considerable length. Here I shall give only a summary of what I said to him. I reminded

him that he was the second of two sons and that his father had broken down with an acute melancholic illness when he was five. His father had then resigned from his job and become 'hospitalized' at home, looked after by his mother. His father and mother were indeed good and devoted parents, and his father's breakdown was an unexpected and real tragedy. It was after his father's breakdown that all his phobias and fears of noises had started, and he had withdrawn into an obsessive world of making radio sets and other things. He was a precociously intelligent and oversensitive child, who had done quite well till then. Some time later the religious obsessions had started. When he was nine, his mother had sent both the brothers to school as boarders, and I felt sure it was to save them from the morbid moods of their father, who had already become anchored in his illness in an organized way. The patient had now become asthmatic as well! The patient interrupted me at this point to tell a strange happening on the first day of his new school. All the students had assembled in the class, awaiting the teacher. Upon arrival the teacher had found the patient hidden under the desk and naturally had asked him to make himself *visible* (the patient's phrase), to the mass merriment of the class. This memory was not new to him, but he had not been able to share it with me so far. He felt now, after the dream, that he could trust me enough to share it with me. I pointed out that his father's breakdown had put a burden on his mother and him that was beyond their resources, and that he had reacted to it by a complementary invalidism. I explained how the only way he could make a reparation to his father's predicament was by *impersonating* it in his own life. This had also robbed him of the playful elaboration of phase-adequate aggressive drive and mutuality with his father. The patient could never take the risk of coming aggressively and spontaneously alive in his own person and right. In the dream he took this risk and found it feasible.

This dream and its clinical aftermath constituted a true self-experience in the clinical setting and amounted to 'a new beginning'. This may strike the reader as absurdly and pitiably meagre for a twenty-year analysis, and I myself share that feeling, but I also acknowledge how limited we are in our capacity to facilitate the self-experience of a person once it gets so dislocated, hidden, and reactively defended in childhood. What I can own up to is that, were this person to start afresh with me today, knowing what I do now, I should handle him quite differently. We need never be

ashamed of our ignorance; it has been with us from the beginning of the species and will see us to the end. What we need to fear most is our denial of our ignorance.

Discussion

One of the most revelatory papers of Winnicott is 'The Capacity to Be Alone' (1958*a*). One remark in it has changed my whole understanding of the totality of the analytic relation between the patient as a person and the analyst as a person. I quote:

> Although many types of experience go to the establishment of the capacity to be alone, there is one that is basic, and without a sufficiency of it the capacity to be alone does not come about; *this experience is that of being alone, as an infant and small child, in the presence of mother.* Thus the basis of the capacity to be alone is a paradox; it is the experience of being alone while someone else is present.

We have learned a vast amount about the ways in which the patients involve us transferentially in their intra-psychic conflicts. Winnicott is, however, specifying a different nuance of this total relating–one in which the patient knows, realizes, and experiences that the analyst is there, present and real, and can disregard him to fructify his true self-experience. Balint (1968) was reaching toward a similar goal when he talked of the analyst as 'a provider of time and milieu', and demanded him to be 'unobtrusive and ordinary' and thus 'create an environment, a climate, in which he and his patient can tolerate the regression in a mutual experience'.

The two patients I have referred to are almost extreme examples of *compliance* in childhood to a failing environment that leads to a false self-organization, according to Winnicott. In another context, Winnicott (1963*c*) states:

> There is an intermediate stage in healthy development in which the patient's most important experience in relation to the good or potentially satisfying object is the refusal of it. The refusal of it is part of the process of creating it.

It is significant that the latter patient arrived at his capacity to dream *his* dream, when he had refused me and I had been able to meet it. Similarly, in a somewhat different way, the former patient, in so far as he had become independent of me through

becoming a professional, wage-earning person, was able to allow the *distance* in which his self-experience could be printed.

The whole issue of the role of aggression in self-experience is too complex and crucial to be discussed here. But I want to draw the reader's attention to a statement by Harry Guntrip (1971) that I find most helpful in this context:

> Sex is primarily biological and then becomes personal, aggression is primarily personal and then becomes biological.

One of the difficulties we encounter clinically with recognizing and handling the self-experience of the patient in the analytic situation is that aggression emerges in concrete and devious ways, and often it is the analyst who has to *dose* aggression in his behaviour before the patient can arrive at the capacity to process his own. Some aspects of this I have discussed in my paper, 'On Symbiotic Omnipotence' (pp. 82-92 above).

Conclusion

I am well aware that I have failed to define what I mean by self-experience. And, to my knowledge, no one else has succeeded in doing so either. I must share with the reader certain reservations about the usage of the concept of self in the clinical context. Quite often, reading the literature, one gets the impression that those who use the concept of self tend to treat it as an idyllic, non-conflictual, pure state. Even Winnicott is not free of this bias. By definition, his concept of the *true self*, as contrasted with the *false self*, carries the implication that the use of the adjective *true* somewhere connotes a pure, unadulterated state of personalization that could be reached in ideal circumstances. Winnicott (1960*b*) has postulated a *false self*, which gets organized in reaction to impingements from a not-good-enough holding environment in infancy and childhood. By this, Winnicott implies an exploitation of the biologic endowment toward survival, which dissociates the person from his *true self*. I agree with that, but I have grave doubts about the existence of a hypothetical *true self*. My clinical experience inclines me to believe that sometimes 'notions of self'–quite illusional and delusional as well as quite untrue of his style of ego, id, and superego functioning–can establish themselves in a person. This person is then ill in the self-system and negates his ego-autonomy, to use Hartmann's (1939) phrase, to compel these notions on himself and others. Rousseau's *Confessions* give a very tortured and dramatic

account of this (Guéhenno, 1962; Starobinski, 1971). Suicide in certain cases is an extreme instance of this, when a person from a *notion* of what he believes to be his *true self* destroys his ego and id. Thus, the self-system can have as much pathology as the systems of ego, id, and superego.

The most graphic account of the sickness of the self-system is perhaps given by Antonin Artaud in his letter of 30 November 1927 to Docteur Allendy. I quote one statement of his:

> Or il y a en moi quelque chose de pourri, il y a dans mon psychisme une sorte de vice fondamental qui m'empêche de jouir de ce que la destinée m'offre. [There is something rotten in me. In my mental process there is a sort of basic evil which hinders me from enjoying what destiny offers me.]

There is a distinct danger of romanticization of a pure self-system. Guntrip is his book, *Psychoanalytic Theory, Therapy and the Self* (1971), betrays this tendency very clearly when he says the aim of psychotherapy is to sponsor 'an original unique person with creative capacities to produce the unexpected', and later on says:

> When a baby is born, he contains a core of uniqueness that has never existed before. The parents' responsibility is not to mold, shape, pattern, or condition him, but to support him in such a way that his precious hidden uniqueness shall be able to emerge and guide his whole development.

We have all seen to what nihilistic, as well as idealistic, extremes Laing (1967) and Cooper (1971) have pushed the mythic pursuit of a true and unique selfhood. I only want to say that I do not share these utopian notions of selfhood, but I do believe that each human individual does have a sense of the wholeness of his self; that this is more than can be accounted for by our structural hypotheses; and that this self-experience can get dislocated or hidden or can even fail to personalize, if the early environmental care is too maladaptive. My work guides me to infer that most withdrawn states in life and regressive states in analysis carry the potentiality of a reaching out toward the self-experience that has become dissociated in the person, and, if we can clinically provide adequate 'holding', then such self-experiences can materialize and help a patient to personalize and to restore his dissociated self to full participation in his day-to-day living.

It is my belief that in all psychotherapeutic work with patients,

psychotherapists and analysts have to provide two distinct types of relating from their side. One type of relating is covered by interpretative work, which helps the patient to gain insight into his internal conflicts and thus resolve them. The other sort of relating, which is harder to define, is more in the nature of providing coverage for the patient's self-experience in the clinical situation. The knack of any psychotherapeutic work is to strike the right balance within these two types of functions in the therapist.