consists of a quasi-deliberate giving in on the part of the patient to the pull of regression, a radical search for the rock-bottom –i.e., both the ultimate limit of regression and the only firm foundation for a renewed progression' (Bibring, 1953). Winnicott (1954*b*) has stated this problem as: 'one has to include in one's theory of the development of a human being the idea that it is normal and healthy for the individual to be able to defend the self against specific environmental failure by a *freezing of the failure situation.* Along with this goes an unconscious assumption that opportunity will occur at a later date for a renewed experience in which the failure situation will be able to be unfrozen and re-experienced, with the individual in a regressed state, in an environment that is making adequate adaptation' (Greenacre, 1960*a*; Khan, 1962 and pp. 13-26 above; Stone, 1961). Lorand (1962) has described in his patients 'a unique problem of finding themselves'. In this patient this problem of 'finding himself' entailed total destruction of the ego-ideal through massive regression and aggression. There was little capacity in his ego, with its reactive affects and functions, to initiate a 'regression in the service of the ego' (Kris, 1952). Life meant to him either being imprisoned in his bizarre defensive world of rituals and obsessions, or being lost through fusion with his ego-ideal. To emerge as a person meant getting to an undefended state of being. Then he could start.

It was a long time before we could work through to a point where this patient could tolerate not exploiting his reactive ego-functions and affects in precipitate defensive actions, and could bear to suffer disillusionment and to experience sadness and depression. Gradually, he began to envisage a future *of* his ego in a community of human beings, where he would be related to them and they to him.

I have given only a very small, though crucial, aspect of this patient's analysis and predicament. This does not do justice to the complexity of his character, the enormous strain that his illness had put on him, or how much effort, perseverance and will power it took on my part to survive his oscillations of mood and his testing my capacities. I would also like to say that this patient was a good and gentle person at heart and I learned much from him, both about the nature and pain of despair and the dignity of effort and hope.

M. Masud Khan

14

Vicissitudes of Being, Knowing and Experiencing in the Therapeutic Situation

ALL psychotherapeutic experiences that we hear discussed in various types and styles of psychotherapies today derive in one way or another from Freud's invention of the psycho-analytic situation. Stone (1961) has given a very detailed and authentic account of the nature and character of the analytic situation (see above, pp. 27-41). Here I shall only briefly state the essential features of the psycho-analytic situation. I am approaching the whole area and issue of psychotherapeutic experiences from the classical Freudian point of view. It is my belief, however, that what is true in this frame of reference is also valid for all other types of psychotherapeutic ventures.

The total analytic situation, as arranged and established by the analyst for his patient, functions in terms of: (1) the analytic setting; (2) the transference; (3) interpretations.

Analytic setting is, of course, the physical ambience that the analyst provides: the room, the light, the furniture, the couch and his own presence. Transference is something very specialized, which the analyst also provides. The concept of transference, as defined by Freud (1912*b*), has become too generalized today. The important thing about transference is that the potentiality in the patient for transference experience is mobilized and harnessed only by the analytic setting and by the analyst's behaviour, in which verbal interpretation plays a very mutative role. Furthermore, it is necessary to distinguish what the transference provides towards the total clinical process from that which the analytic setting provides (Winnicott, 1955; Balint, 1968).

The analytic setting provides space, time, and the presence of the analyst towards the clinical process, and the experiential yield from

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this for the patient is 'holding' from Winnicott's theory of parent-infant relationship. Winnicott (1960*a*) uses this concept

> to denote not only the actual holding of the infant, but also the total environmental provision prior to the concept of *living with*. In other words, it refers to a three-dimensional or space relationship with time gradually added.

The inference here is that the clinical analytic situation is essentially modelled on the infant-mother relationship. It is here that the researches into infant care on the one hand and the theories of modern ego psychologists on the other have substantially enlarged the more restricted concept of Freud of both the role of the analyst and that of the analytic situation. What Winnicott designates as 'the actual physical holding of the infant' in the clinical situation, metaphorically as well as sentiently, is represented by the role of the couch. The result of this 'holding' in terms of time and space for the patient is the experience of *being*.

In parallel and yet in contrast, the transference in the total analytic situation provides the means for an object-relationship, and thus the scope for the processing of inner psychic reality with its attendant defence mechanisms. If this comes through correctly, then it leads to *experiencing* in the patient of himself. A concomitant of the act of *experiencing* is that of *knowing*—that is, insight. Here I am trying to relate the function of the analytic setting in terms of 'holding' to *being*, and transference through object-relationships to *experiencing* in the patient.

Knowing in the psychotherapeutic experience results largely from the act of interpretation on the part of the analyst. Verbal interpretation is a very specialized and limited function of the *total* behaviour of the analyst *vis-à-vis* his patient in the *total* analytic situation. Interpretation is that act of verbal and affective intervention, contribution, and evaluation by the analyst which crystallizes two new experiences for the patient: (*a*) recognition of his *being*, and (*b*) the *knowing* of his *experiencing*.

The whole of the psycho-analytic theory of analytic technique is more or less centred on explicating the different modalities of *knowing* through interpretation and transference. What is less often discussed is the fluctuating interplay in the patient's total experience of himself in the analytic setting in terms of *being*, through the object-relationships provided via transference towards *experiencing*, and the

knowing of his intra-psychic reality and interpersonal conflicts through interpretation.

Interpretation in this context has highly specialized characteristics in terms of the given climate of psychodynamics and psychic reality operating in the clinical situation at a given moment (Heimann, 1956). The act of interpreting, however, should include also the analyst's reticence—that is, his *not-interpreting*. As Winnicott (1954*b*) and Balint (1968), among others, have stressed in recent years, in the area of analytic work where the setting is facilitating holding and being, it is essentially *not-interpreting* that is the analyst's contribution. To the question of *what* is not being interpreted, the answer is ambiguous. What one can identify is that the act of not-interpreting is not a simple passive act. It is the result of intensive analytic work that precedes it, in which a patient's resistances, deriving from his ego-pathology interfering with his own authentic experiencing of his *being* in the analytic setting, have been mitigated. Balint (1968) has defined this role of the analyst as 'the unobtrusive analyst', and Winnicott (1954*b*) calls it 'the holding of the regressed patient in the clinical setting'. Both these, of course, are highly sophisticated artifacts of clinical experience, arrived at through diligent interpretative work.

To put it paradoxically, un-interpretation is the climax only of interpretation. It is not possible to arrive at un-interpretation without interpretation. It is this that is implied by the statement often made that the basic ego-strength and complexity of psychic functioning has to establish itself in the patient before he can arrive at the point where the non-interpretation of the analyst crystallizes the experience of being in the patient (see above, pp. 59-68).

The second function of interpretation is that of inhibiting and organizing the inessential and discursive exploitation of transference by the patient towards discharge through mentation. There is a very great deal of compulsive material-producing which runs counter to the need of *experiencing* himself by the patient in the analytic situation.

It is only when the vectors of *being* and *experiencing* are reliably established in a patient's capacity and functioning in the analytic situation that one can begin to discuss the mutative role of interpretation towards facilitating *knowing* of all the conflictual areas of intra-psychic and interpersonal realities in the patient. Only thus can interpretation facilitate insight.

In the above re-statement of the psychodynamics of the total psycho-analytic situation, the emphasis is very much on what the

analyst does, contributes, and abstains from intrusively inflicting on his patient. Our contemporary gains from the study of infant-mother relationships, as well as ego-psychology, have brought us to a point where it is largely the understanding of the counter-transference discipline and functioning that will yield the true definition of the nature of interpretation in the analytic process.

Counter-transference is here being defined as a non-pathological capacity of the analyst's affectivity, intelligence, and imagination to comprehend the total reality of the patient. The word 'counter' in the concept counter-transference is most significant, because it establishes the fact of the separateness of the analyst from that which he is identifying and empathizing with in the patient's experience. This differentiation of the analyst's self from the patient's experience in the area of counter-transference is essential to keep in focus, because any blurring of boundaries in this context leads merely to a clinical confusion of psychic realities. It is imperative that, in the clinical equation, the psychic boundaries and processes of at least one party, namely the analyst, should always be distinctly structured and defined in terms of their functions and aims.

I shall now give clinical material from three patients to define the nature and character of specific psychotherapeutic experiences in their analyses.

Interpretation, Symbolization and Knowing

I shall report now from the clinical material of a young, highly educated, sensitive, and intelligent female patient, who had sought analysis because, in her own statement: 'There is something in myself that I find lacking and which I would like to know more about'. Emphasis on *knowing* in this case from the very beginning was the patient's, not mine. She suffered from a poverty of fantasy life. She was too rational, she felt. Analysis has now been in progress for some four years, and I report from a recent session.

The patient came in a rather robust mood of well-being, lay down, and in her usual style started to talk quietly. She had gone to the theatre over the weekend with a female friend who had suddenly got very upset and depressed by something in the play and they had to leave the theatre. The next day, this friend had rung up the patient and talked at length about her inner problems, to which the patient was very sympathetic, and the friend had been almost crying on the phone from depression and distress. The patient, who has as a person an explicit capacity to understand others and

empathize with their moods, was left wondering afterwards how can someone become so depressed; someone who is in her own life otherwise very creative. This made her talk about how in her own life she has never felt bored, and there has always been a sort of solid sense of well-being in her, and then she commented that the sense of well-being in her somewhere always makes her think it is because an area of her own inner life is shut away from her and which she needs to know in order to be a deeper sort of person. She described her state of affairs as being well from a lack. Then she was silent for a little while, and I could feel that she was absorbed with herself. She suddenly remembered that she had had a dream which had upset her very much. She prefaced telling the dream by the statement that 'it was a new sort of dream for her'. The dream was as follows:

> Dream about my mother carrying my father's coffin downstairs. I was standing to one side at the bottom of the stairs and was upset to see that his head had to be in a separate coffin and that both coffins were so thin, I wondered how they'd managed to get his body in and thought his feet must have been hurt in getting them to lie flat. My mother opened the coffin with his head in–it looked like a cold joint of meat–skull shaped–and my mother got a knife and made an incision where the nose would have been and then scrubbed at a place on his cheek till some of the flesh came up. Then she put two apples in one eye socket and one apple in the other socket. While this ritual was going on, I felt very miserable and watched my tears sinking into the carpet.

In her associations to the dream, the patient had singled out four features as being important:

1: That though the dream's narrative may strike one as sadistic, in fact the affects experienced by her while dreaming had not that quality. Her mother in the dream, she felt, was doing something almost autistically and had no comprehension at all of its meaning. She was, as it were, involved in a ritual act without affect.

2. Her own helplessness *vis-à-vis* the mother particularly, and all the events of the dream during the act of dreaming. She was merely a passive onlooker, who registered the events without understanding anything of their meaning.

3. Though she had been able to cry for the first time in a dream, she felt distressed at the fact that her tears had aridly fallen on to

the carpet and made no real impression either on her mother or in her own experience.

4. She had the distinct feeling that the dream's narrative was saying more than the imagery of the dream, but she could not quite grasp what. This was in marked contrast to her other dreams, where the imagery had always been very explicitly representative of instinctual needs and conflicts.

In terms of the dream specifically and what I knew from the patient's history and material in the past, I decided to give a long interpretation. I pointed out that the most important element in the dream was that she was witnessing something profoundly disturbing in her mother, of which her mother herself had no understanding. Furthermore, she, that is the patient, could also contribute nothing towards ameliorating either the mother's predicament or incapacity. I here offered a construction to her that what the dream was symbolically trying to process was what the patient had grown up with and registered throughout her childhood in her mother, but had not the psychic capacity to print and make conscious at the time.

It was this particular inability to make reparation to the mother, and the phase-inadequacy of her maturational capacities that had led to the arrest of her fantasy life and pushed her to a precocious alignment with reality and extroverted rationality (see Winnicott, 1948). Mourning and sadness became unfeasible in her developmental process as a child, because neither she nor her mother had the means to cope with it at that time. I also reminded her how, during her early childhood, she had been thrown very much on her mother's resources because of long absences of her father on war service, when she was between two and six years of age.

It was most striking how this patient, who so far had been able to recall very little from her childhood and had given almost no material about her mother, now seemed to open up and describe most succinctly and meaningfully some basic aspects of her early development and relationship to her mother. I am here abstracting from material of some three weeks that followed the dream session. The features that turned out to be most important were:

(*a*) How clearly she had registered but not allowed it to become elaborated by fantasy, her mother's state of chronic and static dismay *vis-à-vis* life and her own marriage, which she had compensated for by fetishistic over-involvement with her daughter's body hygiene.

(*b*) The total absence of ambivalence and conflict *vis-à-vis* her mother because of the mother's incapacity to tolerate any form of distress, anger, and fractiousness in the child.

(*c*) How she had not at all experienced the absence of her father through all those years.

(*d*) A premature opting out for the exploitation of ego-functions in actual living, both in games and in studies, leading to the curtailment of the fantasy elaboration of inner psychic reality. Along with this was combined a very severe restriction of aggressive behaviour, largely due to the mother's intolerance of it, and the mother's highly obsessional defences in herself against hostility and aggression (cf. James, 1960; Greenson, 1958).

For me and the patient, the important thing about the dream had been her use of the capacity for symbolization, without which there is no knowing possible. For this patient, life had never been a problem–intellectually, socially, or sexually–but yet she herself had always been aware of a certain element of lack of depth in her experience of life. She had felt that my interpretation, which enabled her to see in the dream-imagery a metaphorical and symbolic way of knowing her past, had opened up for her a completely new way of looking at herself. From now on, she began to take a much deeper interest in literature and the arts, and her relationship to people, also, changed significantly. She felt she could now begin to know others instead of merely coping with them.

Similarly, she felt for the first time insight related her to herself rather than being experienced merely as an attack on her very private and unshareable self.

I am using the concept of '*knowing*' in a rather complex way. *Knowing* is more than just mental reportage of self-awareness or verbalization of memories of life experiences. There is a distinct quality of ego-cathexis plus imagination added to the remembered facts or the mental representations of past experiences for the experience of *knowing* to crystallize, and it is one of the basic functions of interpretation to sponsor this particular imaginative, affective ego-cathexis in the patient of her own self-awareness. Self-awareness by itself is an insufficient source of experience. It is the augmentation of self-awareness by ego-cathexis that alone leads to reflectiveness, and reflectiveness is the true matrix for insight to crystallize as a creative psychotherapeutic experience for the patient. I can perhaps best establish my point here by using an argument from W. H. Auden (1956), who in his paper 'Making, Knowing and Judging',

following Coleridge's distinction between primary imagination and secondary imagination, argued:

> The concern of the Primary Imagination, its only concern, is with sacred beings and sacred events. . . . A sacred being cannot be anticipated; it must be encountered . . . The impression made by a sacred event is of an overwhelming but undefinable significance. The Secondary Imagination is of another character and at another mental level. It is active not passive, and its categories are not the sacred and the profane, but the beautiful and the ugly . . . the Secondary Imagination is social and craves agreement with other minds . . . Both kinds of imagination are essential to the health of the mind. Without the inspiration of sacred awe, its beautiful forms would soon become banal, its rhythms mechanical; without the activity of the Secondary Imagination the passivity of the Primary would be the mind's undoing; sooner or later its sacred beings would possess it, it would come to think of itself as sacred, exclude the outer world as profane and so go mad . . . The value of a profane thing lies in what it usefully does, the value of a sacred thing lies in what it *is*.

I want to elaborate on Auden's definitions to establish my point *vis-à-vis* the reported dream. It is easily demonstrable how the patient draws upon her social experience of her friend's distress and works it symbolically towards a knowing of her internalization of her mother's predicament and its impact upon her development. Her experiences of well-being derived from the idolization of very archaic body-experiences from infant care with corresponding idealized attachment to primary mother. This I would attribute to primary imagination, and postulate that here, though there can be experience of *being*, little complexity of psychic elaboration through symbolization, secondary imagination and its fruition into *knowing*, can actualize (Khan, 1968). It was the provision of the interpretative work that had gradually mobilized the patient's capacity for symbolic work and knowing of her inner reality. Only through the secondary imagination can a person relate external reality (persons) to inner reality (internal objects), and arrive at that symbolic work which is the basis of all *knowing*. The fundamental role of interpretation with such patients is to facilitate their true use of their secondary imagination and symbolic process towards their own *knowing* (cf. Rycroft, 1956*b*).

The final detail of the dream deserves further mention–namely, the patient's incapacity to *experience* her own crying, as well as her mother's unresponsiveness to it. At this stage of her analysis this patient is still unable to surrender to grief and sadness in a meaningful way. Crying in the sessions is a collapse of her ego-capacities, and she feels reduced to nothing by it. It has no value as yet. It is important to bear in mind how there is no rigid chronological sequence of mutative therapeutic stages from *being* to *experiencing* to *knowing* or the other way round. In each case, one has gradually to discover with and through the patient what is the true psychic reality of a given phase of work. This patient who is solidly anchored in her *being* and has now the means of *knowing*, has yet to establish her potentiality for *experiencing* deeply and truly, which would entail also true object-relating. I abstained deliberately from interpreting the sadistic elements in the dream and did not interpret to the patient at any point that her mother's behaviour in the dream was also a projection of the patient's own rage and sadistic fantasies about the absent father on to her mother.

Today, when we have a vast conceptual vocabulary available to us to translate a patient's dream-imagery with, it is important to restrict our range to the patient's symbolic capacity in our interpretative work. Also, this reticence is part of what I have earlier on defined as the analyst's *un-interpretative* function (see above, pp. 168-80).

Experiencing Versus Mentation

I shall now report briefly from the analysis of a male patient with brilliant academic achievements, who had had some five years of analysis in another country which had been most helpful to him in getting him through his academic career. Laing (1961) and Guntrip (1968) have given succinct phenomenological descriptions of this type of schizoid person.

He had come seeking further analysis because of his incapacity to rest from what he described as his 'interminable mental constructs', which were his only way of attaching to others, apart from absurdly passive and perverse sexual experiences with women, that left him always depleted and enraged. He politely and passively blamed his previous analysis for having exaggerated his tendency to read meanings into everything rather than experiencing, and it was from this that he felt he needed to be cured.

One of the basic difficulties this patient lived with was what he

called the 'insatiable chatter in his head', which he could never stop. He arrived for every session with his customary load of already interpreted material and left every session with a sense of acute futility at having experienced nothing. There was a total absence of reverie in him. His dreams were very much like pictorializations of psychological abstractions of his daily contacts. Any interpretative work that one did at this stage merely added to the 'chatter in his head' and exacerbated his cancerous mentation.

Not to interpret was equally futile, because it gave him the feeling of having destroyed the analyst in the clinical setting and filled him with both panic and dismay. To find the sort of interpretation that would 'shut up the chatter in his head' was the first task, if he was to experience anything. I shall now report on the session in which this happened, but I shall have to give a little bit of background material to it.

Alongside his interminable 'chatter in his head' this patient also suffered from inexhaustible hypochondriacal symptoms which his first analyst had diligently interpreted in terms of their psychodynamic meanings. I had taken exactly the opposite course with him. I had found him a very able physician and handed over that side of the equation of his total behaviour to the physician, and adamantly refused to interpret it. He had arrived on a Monday session and reported that he had had various minor surgical operations done on his body over the weekend. He emphasized how physical pain was one thing that gave him momentary rest from the 'chatter in his head'. He did something very simple in this session which was unusual for him. He took the blanket from the chair and wrapped himself in it and lay down. After a little while, he complained that I had given no interpretation at all, to which I responded that any interpretation on my part would undo his gain from having experienced respite from his mentation during the pain incurred by him over the weekend from his surgeons. He lay down quietly and gradually his breathing sank to a low rhythm, and he fell asleep.

He woke himself up automatically just about five minutes before the end of the session. He said he had been asleep and had not dreamt. 'What a relief!' he added.

The next session is the one that I want to report on. The patient arrived, requested that one of the lights be switched off, which darkened the room considerably, lay down, and after a little while I could hear him crying. He cried the whole length of the session;

then he gradually collected himself, sat up, thanked me for not having disrupted his experience, and said that so far as he could recall, this was the first time he had experienced himself as a person living through a private emotional state to which he had absolutely no clue, and yet he had tolerated not tinkering with it mentally. The real gain to the patient from this experience of himself was that he felt now he had available to him in himself a real experience of quietude and affective sentience, which he could contrast to his 'chatter in the head'. Up till now, one of the most aggravating features of his endless mentation was that though he knew it to be a morbid and wasteful state of self-dissipation, he had no other type of self-experience to correct it with. This helped him to move from obsessive introspection to a reflective evaluation of himself.

After this experience, which happened some six months before the writing of this account, this patient has, by his own volition, changed his whole way of life. From living a compulsively collusive and cluttered existence with others where his main form of self-dissipation was conversation, he is living for the first time in his life a sort of private existence. In his work, also, he has shifted from being compulsively productive to long stretches of reading and studying. In analysis he speaks thoughtfully, and it is possible for him to relate meaningfully to his past and present. What I wish to emphasize here is a very distinctive use of interpretation towards delimiting and curtailing the mentation. Unfortunately, even this description is hardly adequate to the complexity of the affective interchange between the patient and myself in the analytic situation through our very presences in the setting. It is my contention here that excessive interpretative work with such a patient turns us into the accomplice of their psychopathology and dissociates the patient for ever from experiencing himself as a person.

For this particular patient, *experiencing* had to be first a very private and unshareable state before it could become possible for him to relate from this capacity to others both symbolically and sentiently. Here, the basic function of the interpretation was to *neutralize* the transference object-relationship towards enabling the patient to use the setting as the vehicle of his self-sustenance in the analytic situation.

That session emphasized the importance for him of my recognition of his need to be in the crying state without needing help or intervention. It is this avoidance of the intrusion of even *knowing*, that is insight, on the one hand, and facilitation of his presence as a

person, who was to all practical purposes unrelated to me in the transference, that enabled him to arrive at *experiencing something* in himself to which he could neither put a mental construct nor infest with erotic tensions. This is what, temporarily at least, shut up the 'chatter in his head' and shifted him from mentation to *experiencing* in the analytic situation.

This is in marked contrast to the female patient I have reported, where interpretation through transference relationship had provided the symbolic instruments with which to psychically know herself, and learn to be reflective insightfully towards her own experiences and others.

The Dread of Being (the True Self)

Winnicott (1960*a*) has introduced the concepts of true and false self in the psycho-analytic literature. Briefly stated, his argument is that dissociation of a person into a true and false self is the result of the deficiency of primary environmental (maternal) provisions in infant care. The chief characteristics of the false self organization are:

1. Its defensive function is to hide and protect the true self, whatever that might be.
2. The false self has as its main concern a search for conditions which will make it possible for the true self to come into its own.
3. When a false self becomes organized in an individual who has a high intellectual potential, there is a strong tendency for the mind to become the location of the false self.
4. The point of origin of the false self is in a defence against that which is unthinkable, namely the 'exploitation of the true self, which would result in its annihilation'.

Using Winnicott's hypotheses, I would now recount clinical experiences from the analysis of a young female patient of twenty-four, who could tolerate living only through a hectic exploitation of her false self organization, and who had a terrible dread of ever being found and met in her true self–that is, her authentic being as a person.

This girl, with an inordinately high IQ, has had a long and chequered 'career' as a patient since she was sixteen. She had been referred to me by a female colleague who had patiently and heroically managed her illness for some three years, and had eventually got so worn down by this patient's violent physical attacks on her

person and clinical setting that she could take no more of it. The patient had been physically unmanageable throughout her treatment and even hospitalization had not helped, because she had charmed the hospital staff with her compliant helpfulness. Her violence was exclusively directed at the person of her analyst and her familial environment. The patient is a hefty, wilful girl, with a diabolical will and cunning. My chief reason for believing that perhaps I could help her better than her female analyst was that physically I felt stronger than her, and knew I could meet her compulsion to test me in that area. I had also staff available to me, should I need them. I mention these details because ordinarily we do not take such factors into consideration with our patients, but they become of fateful importance in the management and treatment of a patient like this.

This girl, who has an extraordinary capacity to talk and think in her relation to others, cannot use language to express herself in the analytic situation. Instead of speech and verbalization, *action* was her sole mechanism of defence. Hence, she could not use the couch either. She simply stood and stared at one with a violent and explosive intensity.

She had no tolerance of interpretations. They created a mad, berserk panic in her and compelled her to thrash about. She had no use for insight either. She wanted only *the truth*: and it had to be the given and not the found truth. If she helped one to understand her predicament, then she felt she had betrayed herself. From this frenzied muddle which was her presence in the room, one had to decide to aim towards some one experience that could be focalized as a point of reference. I decided, quite arbitrarily I confess, to make it her refusal to use the couch and lie down. I knew perfectly well she would react violently against it.

For months we battled over this issue of not using the couch. I tried out every interpretation, and she mocked and rejected them all. Eventually, one day I said to her that I can see that so long as she is *in action*, she is not existing in her own being and person. But if she were to lie down she would then be vulnerable, because she would be present in her being and thus could be damaged and annihilated. 'By what?' she asked menacingly. To which I replied that I did not know by what, but I knew what I said was true of her behaviour. We bickered and battled over this for a few more weeks. Eventually, to prove me wrong, she agreed to try lying down and did. It was a bizarre sight indeed. I can only describe it by the

absurd statement that what I could see was a person standing up in a horizontal position. Of course, she did not stay on the couch for more than a minute, and was up on her feet and lunging about all over the room.

In the next session, however, she arrived tearful and chastened in mood. After asking her usual silly and provocative questions, for the first time she volunteered to tell me a dream. Her exact words were: 'I had the same ghastly dream again. You know it.' She would not accept that I did not know the dream for the simple reason that she had not told it to me yet. She said that was irrelevant. If I really cared and tried I would be able to know the dream. A few more weeks passed battling around this. Then one day she told me the dream while she was lying down on the couch, which she had been doing fitfully now and then. The dream was: 'All my teeth were rotting and falling away. In fact if I had not awakened myself, all of me would have rotted.' She has had this dream recurrently since childhood and never told it before to any one of her three previous therapists. She asked me what it meant, and hastened to add: 'Oh, don't tell me!' Then she asked again what it meant. I said that so far as I could tell, *she had an anxiety dream about the dream she cannot dream.* She was thoughtfully silent, and remarked: 'I know–you mean I cannot dream about me in the other world, where I am perfect and everything is perfect'. This was the first time she had mentioned 'the other world' where she is a perfect being. She added further: 'I see what you mean about not being able to use the couch and that annihilation lark. It is the same as my not being able to sleep properly in my bed. If I dreamt the real dream, then it would not be all in my own possession; some of it will always be the dream's, even if it is my own dream. Me in the other world has to be all in my keeping. Only thus it can be kept perfect.'

Suddenly she was up and laughing in her maniacal way where one cannot tell whether she is shrieking or laughing. And she said: 'You think it is all mad, don't you.' I agreed with her that to me it all sounded very mad, but I also knew it was very real and meaningful to her. She accepted that gracefully.

In the following months she talked a little more about her two 'me's'–the 'me in this world' and the 'me in the other world'. How she is always trying to arrange her 'me in this world' to become something where her 'perfect me in the other world' could live from, but it never works. Something always goes wrong. So it never starts. Living for this girl is a terrible anguish and ordeal. Her only

respite from herself is when she is acting for others. One thing, however, is now quite clear–that to bring her 'perfect me in the other world' into the clinical situation is to take the risk of annihilation. Hence all she can communicate is the terror and dread of that eventuality. And yet she insists it must happen one day if 'I am to really live. It cannot go on for ever like this.' May be she will have to kill her 'me in this world' in the end, she says; which in her case is not an idle hysterical threat. It could go that way (cf. Winnicott, 1960*b*).

Conclusions

I have given three clinical examples of how patients *use* the analyst as an object in the clinical situation. These examples are perhaps extreme cases. Of course, there are endless variations of such *use* of the analyst that mix these modalities in different proportions. I would like now to discuss briefly each *use of* the analyst described in the case material.

In the case of the girl whose dream was about her mother's unconscious and its impact on her developmental process and maturation, it is clear that the child had been able to internalize the experience and the corresponding object-relationship. Only she could not bring all her later developmental and socio-sexual experiences to bear upon this experience and modify, correct and enlarge it. It stayed dissociated and hidden in a very special way, and the essential task she had set herself and the analyst was the rediscovery and resolution of this internalized and dissociated relation to her mother. Here, the emphasis in the transference-neurosis was on *knowing* and that freeing of both imagination and intellectual capacities which alone enables a person to cognize themselves meaningfully. The crucial task for the analyst was to provide through interpretations those links which facilitated the process of symbolization, as in the dream, and thus enabling the repressed material to become both sentient and remembered personal experiential data. Here, insight is the aim as well as the vehicle of integration in a person.

In the second example of the male patient, the emphasis was quite different. He needed a respite from the continuous defensive exploitation of his mind in order to *experience* his affects. One can here talk of automatic defence. The anxiety affects were not allowed to develop in the service of the ego. The ego prematurely anticipated potential anxiety-situations and defended itself with stereotyped and archaic

defences. Such patients dread any sort of experience of helplessness, and all their clinging is a way of rejecting both the object and their own instinctual needs. Hence the role of the analyst in the clinical setting was to curtail interpretative work because it merely reinforced the patient's own style of self-defence. Only by this dosage of refusal to supplement the patient's intellectual defensive organization was it possible to sponsor that basic trust in the clinical situation where he could take the risk of being undefended and sentiently be a person in his affectivity. No true object-relation is involved in this *use* of the analyst by the patient. The analyst is a living and responsive part of the total environment that the patient has put himself in the care of. To introduce the bias of object-relationship in the transference interpretation in this climate of the *use* of the analyst is to distort the true dynamics of the analytic situation in terms of the bias of our theories, and regardless of the need of the patient and his psychic reality.

The third case cited is more difficult to discuss in terms of the accredited analytic theory of technique because she has been unable to use the analytic situation in any meaningful way. Here, the crux of the clinical situation lies in finding ways of enabling a patient to tolerate their violent rejection of the analytic process, and helping them to discover how they defend the exposure of their inner reality, which they both hide and cling to with a fetishistic and fanatical fervour. Though they demand cure almost with the intensity of a craving, they regard participation in the therapeutic process as a betrayal of their true self (to use Winnicott's phrase). Freud had always emphasized that in the clinical situation what is most important and relevant is not *what* a patient hides but *how* he hides it. No human being can or ever does reveal the whole of their inner reality and truth. The question is whether their *privacy* constitutes a relatedness to their true self or a paranoid and aggressive exclusion of others from any link with it. If it is the latter, then the patient brings his or her needfulness as a *challenge* to the analytic task. The need and compulsion to be found out is here tantamount to what Winnicott (1956*a*) has described as the element of hope in the antisocial tendency, and it has to be met as such (Milner, 1969). I have given material from the third case merely to indicate the limiting point of analytic process and situation.

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Infantile Neurosis as a False-Self Organization

In analytic writings, in spite of Freud's monumental case-history of the Wolf-man (1918*b*), the concept of infantile neurosis has not received the attention it deserves. Nagera has discussed this issue lucidly in his book, *Early Childhood Disturbances, The Infantile Neurosis and The Adult Disturbances* (1966). (Also see Greenacre (1954*b*).) It is my inference from my clinical work that we can distinguish three varieties of infantile neurosis in the personalities of the adult patients we treat. The first type is what I should call the 'average infantile neurosis'. Here, the strains and stresses that are inevitable in any human development as an infant and child cohere into a potential intra-psychic structure. This leads to average development, and one encounters it in persons who are by and large well adapted to life and manageably neurotic. Then there is the second type, in which the cumulative traumata disable the child from achieving that internalization of the experiences that leads to a structured potential infantile neurosis. Instead, the whole issue is, as it were, postponed into the future to be later elaborated and given structure. In this category come the cases that are called schizoid or borderline. In my experience these cases have a good prognosis, though they are extremely taxing for the therapist. But they do reach us in an open and undecided internal psychic state.

The third type is the one I shall discuss in this paper. Here the ego of the child has prematurely and precociously brought the traumata of early childhood under its omnipotence and created an intra-psychic structure in the nature of infantile neurosis which is a false-self organization, and which will henceforth set up a rigidity of split-existence and defensive exploitation of pregenital instincts and archaic mental functioning, most commonly met with in obsessional neurosis. I consider Freud's Wolf-man to be the classic example of such a case. I shall draw attention to one comment of

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