OBJECT-RELATIONS THEORY AND PSYCHOTHERAPY

THE PSYCHOTHERAPEUTIC RELATIONSHIP

The previous chapter emphasized that the extent to which the psychoanalytic technique can be "worked" depends on the relationship between the therapist and patient, and that, in the words of Freud, "total success turns out to be entirely dependent on the patient's relation to the physician". We must then examine closely the dynamic personal factors which are the crux of the matter in psychotherapy.

The Personal Relationship of Patient and Therapist: Transference

It is best to approach the deeper discussion of the patient-therapist relationship from the starting-point of Freud's recognition of transference phenomena, for though transference does not cover the whole problem, it is an enormously important part of it. It is one of those problems that have been so thoroughly explored that there is perhaps not much new to be said about it, but we must seek to present it in such a way that it can be integrated with newer views of the therapeutic relationship. I have felt that some writers dealt with transference as if all relationships of every kind were nothing but transference, and that nothing new in the way of relationship could occur. If that were true there could be no progress in psychotherapy. Fairbairn's 'object-relations' view of psychotherapy was certainly that it is a process in which transference relationships, both positive and negative, are worked through until they lead on and give way to a good realistic relationship of whatever kind is possible and appropriate between therapist and patient. Some patients can arrive at a quite good result and end treatment and go away to attribute the result to something other than the therapist's help. They cannot owe him anything. This shows that the results may be good enough for practical purposes, but have not fully resolved the patient's difficulties in human relationships. While
no treatment can reach perfection in results, a really good result should leave the patient able to feel happy in a genuine sense of gratitude and friendly feeling for the therapist, along with a quite realistic appreciation of him as a human being. I can perhaps explain what I mean best by referring to my own case. My analysis with Fairbairn eventuated in a normal friendship between us, expressed by correspondence, usually on psychoanalytical matters, and occasional visits whenever any business took me to Edinburgh. We had a lot in common in psychological and philosophical concerns. I know he respected my understanding of his work, and I respected his integrity, ability, and deeply humane qualities of character. From time to time he expressed views on other matters with which I disagreed, and had his health permitted more vigorous discussion in his later years, I have no doubt we would have discovered, and I think respected, some quite extensive differences of outlook, without our friendship suffering. This seems to me a 'realistic relationship of whatever kind is possible and appropriate between therapist and patient'.

Naturally, not all treatments end in that degree of friendship. Good results can be obtained with patients with whom one would not have much in common outside the therapeutic situation, provided the basic 'human therapeutic relationship' is genuine. In other cases it is simply a matter of lack of opportunity. Nevertheless true feelings of friendship will exist. Recently a patient who had ended her treatment two years earlier, rang to say: 'I thought you would be interested to know that my eldest son has been chosen to play in a Young England Rugby Trial match.' I was very interested, knowing what difficulties this family had encountered and surmounted, and we had a very interesting chat. A successful psychotherapeutic treatment should end by contributing something permanent and intrinsically good in human relationship to the patient's life, even in cases where patient and therapist never see each other again. No doubt all therapists rejoice in the occasional letter from a past patient indicating that they are going on well, and have not forgotten how they have been helped. We are, however, anticipating, and must go back to the beginning and look first at transference.

The factor of personal relationship between analyst and patient was quickly recognized by Freud and incorporated into the body of psychoanalytical teaching under this term of 'transference'. He saw how large a part the patient's emotional reactions to the analyst played in treatment, and one of his major discoveries, valid for all time, was that these included repetitions of what the patient had felt and was still unconsciously feeling towards parents and other important people in his childhood. Some patients largely repress what they are feeling towards their therapist for a long time, and want to maintain a consciously good relationship with him, on the moral level of winning and keeping his approval. Others begin with openly hostile and resistant attitudes bound up with resentments about having to seek help for this kind of illness. Therapists in general find that it is much better when the hostility comes out frankly at the start. In reality patients always feel both ways, and whichever reaction is conscious, the other is unconscious. This repression of part of their feelings is, needless to say, like all repression, itself unconscious and automatic. This is simply a repetition of the early situation as seen in the conformist, and the problem, child.

Sometimes the patient is unaware of feeling anything at all about the analyst, and becomes very resistant to any interpretation of his behaviour designed to help him to become conscious of this emotional reaction. The withdrawn patient hates feeling 'lured' into a personal relationship. One patient said, 'I'd rather hate you than love you', and another, 'Hate is much safer than love.' But if possible they prefer to feel nothing and so long as they can maintain that stance, nothing much happens. Freud saw that the patient 'transfers' on to the therapist repressed and forbidden infantile reactions to parents of both love and hate. He held that the present-day neurosis must be replaced by a transference neurosis, in which all this is felt for the therapist, if a 'cure' is to be achieved. As usual, Freud had taken the first step in the unravelling of a problem of extremely complex proportions. Not everything can be seen at the start. Freud seized on the importance of this personal relationship factor in treatment, but he looked at it more from the point of view of the patient's reactions to the analyst as a substitute parent, than from the point of view of what impact the analyst made on the patient's reactions, as the kind of person he actually was. These two factors are subtly intermixed and analytical treatment has to unravel them, so that ultimately the patient can come to feel objectively without the distortions introduced by transference reactions.

After a time it came to be realized that analysts have counter-transferences to their patients, which should likewise be analysed. They will be in proportion to the incompleteness of the analyst's own analysis. That must at least have gone far enough
to enable him to recognize and work on his own counter-transferences. When I once said to Fairbairn ‘Countertransference must be harmful to a patient’, he replied, ‘You may do more harm to a patient if you are too afraid of countertransference.’ The reason, clearly, is that if a therapist eliminates all personal feeling for a patient (which actually he can only do by repression or by being something of a schizoid intellectual) in the interests of pure scientific objectivity, the patient will be all too justified in feeling that he is dealing with someone who has no genuine interest in him as a person. Patients easily feel that anyway. They will say: ‘You can’t really be concerned about me. I’m only one of a crowd of patients to you. I’m only a name in a list of cases to you. I need something more personal, more human than analysis. I need to feel you care for me, that you are my friend.’ There is naturally a great deal of transference in this. It conceals unsatisfied legitimate longings for parental affection, and these may be disguised in sexual fantasies of intimate relationships with the therapist. There is nothing here that is not always occurring whenever human beings make each other’s acquaintance in everyday living, but the analyst has to separate out what comes from the past and what can genuinely and realistically belong to the present-day meeting of two real human beings, when one is concerned to help the other to find his human reality. This latter only becomes clear as the transference is got rid of (though there is no perfection in human life, and this process can never be absolutely complete).

Repressed sexual fantasies towards therapist and parents can become conscious if the patient feels safe enough with the therapist. Sometimes these can be quite simply pregrenital and infantile, and may then be even more embarrassing to the patient, as in the following two cases. A married woman in her thirties with three children, feeling unequal to her responsibilities, suddenly felt she wanted to run over to me, climb on my lap and curl up and go to sleep, as she used to do with her father. The other, a headmaster in his forties, felt a strong wish to lay his head on my shoulder and have my arms round him, and recalled being held in his father’s arms and laying his head on his father’s shoulder. The experience was so real to him that he could smell the tobacco of his father’s pipe. But are these to be analysed as just ‘early erotic wishes to be outgrown’? Were they not precious memories of a time when the parent–child relationship had been good, a regression under present-day strain to an early security which had been lost? Their revival in the transference was a sign that the parents, from that time onwards, had failed to help the child to go on to a more maturing relationship. The headmaster’s father had in fact become a cold aloof man as his son grew up, and they lost contact. He needed me to be someone with whom he could go back to that point of arrested development to free himself for further growth. This could not be done by a literal recreation of the original father–child physical relationship, but it could be done by an accepting and sympathetic mental understanding of his whole position.

The Analyst as Projection Screen and as Real Object

The early view of the analyst as simply a ‘projection screen’ for the patient’s fantasies has today already been left behind in its stark simple form, but must still be taken into account. The patient has personal needs towards the therapist which are not exhausted by the transfer of infantile eroticism, since he needs his therapist to help him as a real person. When transference analysis succeeds, the patient’s realistic emotional needs towards the analyst emerge, and they are none the less realistic for emerging at first in immature forms, belonging to that level of his unconscious childhood life which the analysis has reached and opened up. Psychotherapy depends ultimately on their satisfaction. The patient’s infantile ego can only grow in a genuine object-relationship. If the therapist persists in being, in reality, a merely objective scientific intelligence with no personal feeling for the patient, he will repeat on the patient the original emotional trauma suffered at the hands of parents, which laid the foundations of the illness. Those who are one of a sibling group will say, ‘I’m only one of a lot of patients to you,’ while others, and not only those who had no siblings, will say, ‘You ought not to have any other patients but me.’ When such reactions have been analysed in terms of the patient’s inner world, I often add a purely realistic comment, ‘If you think you can only feel sure of being loved in the absence of rivals, then you will never feel secure. When you think you have got someone all to yourself, you will really be living in dread of a rival turning up, and if that happens you will feel convinced that the person you are needing will desert you for the other party. You can only feel secure by discovering that you can be valued and cared about as a person in your own right while others are present.’ These patients are seeking a parent–child relationship because what they had in that respect was not adequate to laying the foundations of a strong personality,
They may want it, unconsciously or consciously, in erotic forms, both infantile and oedipal, but if they got that and nothing else, it would keep them in an emotionally immature state. No doubt that is what happens in some marriages where the partners emotionally stagnate.

Yet, if the patient were in reality only 'one of a crowd of patients' to the therapist, how could he be helped to develop a sense of his own reality and worth as a person in his own right. What the patient needs as a basis for recovery can be described in three stages. First, he needs a parent-figure as a protector against gross anxiety. He may recognize or resist this, but either consciously or unconsciously he feels like a drowning man without a lifebelt. The psychotherapist is at first a rescuer to him, from the hopeless losing battle with problems he does not understand. If a good rapport is established, he is likely to say: 'I feel you are the first person who has ever understood me, or taken the trouble to try to.' As one patient put it: 'An analyst is better than prayers.' But such frank dependence is equivalent to one aspect of the parent-child relationship. It is the child's need for a purely supportive, protective, reassuring love as a basis for existence. The second stage involves the analysis of all the ways in which this is interfered with by the legacy of old inadequate relationships with the actual parents and in the family group. This is the transference proper.

Whatever we mean by 'cure' or 'maturing' or becoming able to end treatment, depends on getting beyond that to the third stage. Not that these stages are distinct, separate, and marked off from each other. They are subtly intermingled all through analysis. They are more aspects, often co-existent aspects, than stages, except that the third stage should become more and more predominant towards the end of treatment. Here, the patient begins, at first dimly, to feel that what he really needs is the basically non-erotic love of a stable parent in and through which the child grows up to possess an individuality of his own, a maturing strength of selfhood through which he becomes separate without feeling 'cut off', and the original relationship to parents develops into adult friendship. The three aspects or stages may be summarized as rapport, transference, regrowing or maturing. It is usually over the last issue that the most critical question arises, as the patient begins to work out clearly the transference problems. Has this patient now got enough of a basic ego to be able to go forward to maturity, or are we uncovering an inner emptiness, corresponding to the fact that the original mothering was not good enough to get an adequate ego-development started? This is the most difficult therapeutic problem, and in this case the psychotherapist must be the kind of person who can relate to the patient in a way that enables him to find his own reality and experience a true 'ego-birth and growth' in a way he could not do with his parents. This is something far deeper than questions about the satisfactions or conflicts concerning instinctive needs. They are subordinate aspects of a total self, mature or immature. Here we are concerned with the possession of a meaningful self as distinct from a mere psychic existence which has lost its primary unity. In pursuit of this, the psychotherapist must be able to support the patient with unflagging care and understanding while leaving him free to become his own unique self in an 'on the level' relationship. This he cannot do for the patient unless he has genuine feeling for him, and is not afraid of a truly personal relationship which the patient needs to find with him.

Nevertheless, however adequate the therapist is, it still takes the patient a very long time to accept him as a liberating person, and longer still to experience him as someone with whom the patient can find a true self of his own. There is no evading transference analysis, as all his fears, distrusts, and resentments felt towards parents rise up again, and all his dependent needs countered by fears of involvements with all their restrictive and repressive attitudes are projected on to the analyst. Here the classical psychoanalytic technique is indispensable. The therapist's psychoanalytic insight must guide his intuitive understanding based on experience, to enable him to help the patient to bring his problems to consciousness and face them, both on the oedipal and the schizoid levels. For as frankly oedipal transference phenomena are analysed, the result may well be, not that the patient is straightway released to grow up to a mature adult love, but is rather deprived of a main defence against the ultimate problem, the profound sense of inner emptiness which shows that no very real ego got a start at all. Now the therapist must be the kind of person with whom the patient can find some sense of reality in his own experience of him, and who can at times see something in the patient that he cannot see for himself, because he has never before adequately experienced it. The therapist must now sense, not the patient's repressed conflicts but his unevoked potentialities for personal relationship and creative activity, and enable him to begin to feel 'real'.
All this cannot go on unless the therapist is a 'real' person himself, giving the patient the possibility of a 'real' relationship in the treatment situation, over and above the transference relations. These can come out more openly on the basis of a steadily deepening realistic confidence of the patient in the therapist without which the patient will let out very little, however correct the technique. He must have some firm standing ground in present-day reality if he is to revive, recognize, and work through problems originating in the past, all the more so if these come from the very earliest infancy level. Even then there is no automatic guarantee that the patient can or will use the analyst's help to grow out of his unreality. After all, he is still an individual who can harbour and pursue purposes of his own other than those which led him to treatment. The therapist can do no more than make the possibility of a therapeutic relationship available, and perhaps by being real himself give the patient some reason for feeling that this is the worthwhile goal. He has no power, nor should he have, to force the patient to get well against his will. All through treatment, the patient is constantly discovering that he has what feels to him more important purposes to serve than getting over his illness or solving his personality problems. He may still feel determined to revenge himself on his family, or by transference on the therapist. In that case he will use the analysis to get worse, and will accuse the therapist of destroying everything he had to cling to: beliefs, duties, ideals, hopes, illusions or what-not. Thus he can finally say to the analyst: 'Look at the mess you have made of my life, look what you have done to me.' He may be unprepared to accept the transference elements in this because he wants, not the memory of a dead parent, but a live present person to hit back at. A negative therapeutic reaction enables him to expose the bad parent or even the whole bad family, and the bad analyst all in one.

Hate has its satisfactions in destructiveness even at the ultimate price of self-destruction, for those who feel they cannot ever become constructive. At least it sometimes enables a patient to feel better after he has given up his therapist, though this may not prove to be very firmly based. The path from schizoid and depressive states to reality and maturity of selfhood is like an area sown with land mines. There is hidden explosive material at every step. Traversing this path can never be easy either for therapist or patient. The final result a patient achieves may well be the result he secretly sets out to achieve, in the sense of having unconsciously aimed at all along, and it may be exceedingly difficult to save him from himself by successfully analysing this. If his aim is constructive, he will respond to his therapist in the end, but he must have a 'real' person to respond to. No one will be saved from profound personality disturbance by talking to an impersonal projection screen. In fact, the difficulties the patient encounters within himself are so formidable that he is not likely to be able to overcome them, unless through all the ups and downs of treatment he comes to realize that the therapist is so to be trusted and relied on that it becomes possible and safe to be quite open with him.

Internal Difficulties Operating Against Psychoanalytic Therapy

In Chapter XII, section (3), we glanced briefly at the fact that the deeper psychoanalytic therapy goes the more dependent the patient becomes on an external supporting environment for the time being, so that external factors can easily frustrate our endeavour. We must now look more deeply at the internal obstacles, constituting 'resistance'.

(1) The hysterical defence of substituting a body problem for a personality problem is usually easier for the therapist to detect than for the patient to relinquish. The patient mentioned on pages 310-21, the middle-aged deeply regressed woman, succumbed to a serious infection during a particularly important period of treatment and had to stay in bed and have massive doses of antibiotics. At that time she grew quite calm in her state of mind, only to find that her extremely disturbed condition began to return as she got over her physical illness. There is still in some medical quarters the tendency to treat the hysterical as merely 'attention seeking' and as a wilful nuisance. Certainly hysterics can be extremely irritating, but they are 'attention seeking' in the sense that a drowning man is 'attention seeking'. When it comes to conversion symptoms, physical pain can cover and defend against far worse mental pain which is going to emerge if the physical pain is lost. Unless the patient feels the therapist can really help ultimately with the mental pain, he cannot give up easily the physical pain which is far easier to bear, and more accepted by other people. Professor Bonamy Dobree, in a broadcast talk on Kipling, spoke of the poet's interest in mental breakdown and his knowledge of inner mental hells which have 'to be experienced to be appreciated'. He referred to the charge that Kipling was 'callous about physical pain' but replied that he knew it was as nothing
compared with spiritual agony, this he [Kipling] states unequivocally in the *Hymn to Physical Pain*:

"Dread Mother of Forgetfulness
Who, when Thy reign begins,
Wipest away the Soul's distress,
And memory of her sins..."

"Wherefore we praise Thee in the deep
And on our beds we pray
For Thy return; that Thou may'st keep
The pains of Hell at bay."

This is the situation the psychotherapist often faces in the patient, and the phrase 'memory of her sins' reminds us of the part Freud saw that guilt, often of a deep unconscious kind, played in this self-punishing hysterical defence against something much harder to bear. This situation often arises towards the end of treatment, as in the same case of the deeply regressed woman, especially when the patient has produced a marked improvement which in fact hides a deep and as yet untapped problem. Through fear of approaching this hidden danger, the patient may first produce a 'flight into health' and then find himself in the dilemma of ending treatment with an unsolved problem on his hands which might well be triggered off by the separation anxiety of losing his therapist, or else going on and facing the analysis of what he is afraid of. In this situation he may well try to do neither, but fall back on a relapse into hysterical conversion symptoms to sidetrack the treatment from the main issue. Since the ultimate issue is always the patient's need for a personal relationship which will enable him to grow a real self, the last and deepest problems are always some version of one or other of the two final fears, the fear of having no relationship at all and losing one's ego in a vacuum; and the fear of entering into a relationship and feeling that one's weak ego will be overwhelmed. In this dilemma, hysterical conversion symptoms have the special value of diverting attention for the time being away from the problems of human relationship, on to some bodily symptom.

An elderly woman known to me developed eczema all over her body following the death of her husband. For more than a year medical treatments secured no more than improvements, followed always by relapse. She was then cured by a kindly elderly woman herbalist who personally massaged a wonderful ointment into her for an hour twice a week. She was 'cured' so effectively that the eczema never returned. This was due, no doubt, not to the wonderful ointment, but to the 'mothering', albeit of an infantile order of soothing attention to her body by someone in whom she rapidly acquired great faith and trust, in her loneliness and distress. Nevertheless, an analyst would be thankful to produce so permanent a result so quickly. Her bereavement had laid bare a deep-seated infantile insecurity in her which had been hidden by her dependence on her husband. As she certainly had no faith that medical treatment would provide an answer to that problem, she could not give up her eczema by which she cried out through her body for 'mothering attention'. The patient cannot give up the illness unless something better can be put in its place. What kind of 'something better' can the psychotherapist give? Certainly not a cold, impersonal scientific technique of investigation, or as in the case of behaviour therapy, of 'symptom elimination'. Certainly for the elderly woman one would prescribe the motherly herbalist rather than psychoanalysis; whereas for anyone young enough to want radical changes in personality, the psychotherapist must provide a kind of personal relationship that enables the basic psyche to grow out of ego-weakness into ego-strength.

(2) A further and extremely stubborn obstacle to psychotherapy, though in fact it is the same obstacle viewed in a deeper way, is what Fairbairn called 'the libidinal cathexis of the bad object' (1952a, p. 72). In 'Analysis Terminable and Interminable', Freud (1937, p. 332) describes psychotherapy as supporting the patient's ego against the quantitative strength of his innate instincts. He says:

The quantitative factor of instinctual strength in the past opposed the efforts of the patient's ego to defend itself, and now that analysis has been called in to help, that same factor sets a limit to the efficiency of this new attempt. If the instincts are excessively strong the ego fails in its task... The power of analysis is not infinite... it is limited... We shall achieve our therapeutic purpose only when we can give a greater measure of analytical help to the patient's ego.

We have moved far today from this simple instinct theory and the biological and therapeutic pessimism it would force on us. We would today be evading our responsibilities as therapists if we told a patient that we could not help him because his instincts are too strong. The actual impulses and emotions with which we deal in patients are not in themselves fixed innate biological factors. They are reactions of an ego, though a weakened ego, to persons and situations encountered in the process
of living, and in psychotherapy to the situation created by the therapist. They are appropriate to the way the ego perceives the object, and express the ego's relation to the object. In analysis, this is a mixture of transference factors and of what the analyst is in reality. Change the object, either in reality or in the patient's perception, and the impulses and emotions change.

Supposing the analyst to be adequate as a real person to the therapeutic situation, then what he must analyze is his patient's ties to his internal bad objects in his inner world. It is the patient's internal bad object world, not his instincts, that are the cause of trouble. The turbulent impulses and emotions of the neurotic are not fixed inborn instincts, they are personal reactions of a weak infantile ego at the mercy of and yet unable to give up the frightening and frustrating figures in the deep unconscious. They would die down if these internal persecutors were got rid of.

But that is just the problem. The infantile ego cannot just give them up, for in that internal world it feels like being left with nobody at all. Psychoanalysis is not reinforcement of instinct-control. As Fairbairn says aptly, it is more like exorcism, the casting out of devils from the inner unconscious world, devils who can often be seen clearly enough in the patient's dreams. Yet it is not strictly speaking like exorcism, but is a subtle process. Where lies the difficulty? One might think that patients would be only too glad to let go their devils, but nothing is further from the truth. Thus a spinster in her late fifties was still dreaming of her father thrashing her and said, 'If that were happening, at least I wouldn't be an aging woman living alone.' A man of thirty, who in real life could not bring himself to leave a home in which he was violent unhappy, dreamed

... of being on a muck-heap frantically raking to find something valuable. A cyclist went by and called to him to come away and join him, but he stayed on his muck-heap.

'Mucky' was one of his epithets for his mother. He couldn't give up his muck-heap that he was still trying to get something valuable out of. Yet another patient said, 'My husband and father are devils but I never give up my devils.' Patients cling tenaciously to their *external* bad objects because they represent *internal* bad objects whom they feel incapable of leaving. To part with internalized bad parent figures sets up two kinds of fear-reaction; it plays on repressed death-wishes against the bad parent in childhood, arouses the unconscious feeling of having now destroyed this bad parent in the inner world, lead-

ing to guilt and self-punishment; it also creates the uncon-scious feeling of being now for the first time in life left utterly alone, bringing with it the fear of ego-loss, of depersonalization, of dying, unless and until they are replaced by someone better. Bad parents are better than none. Both a depressed and a schizoid reaction can follow the loss of internal bad objects as the following case shows with great clarity.

A spinster in her middle fifties, who had had an unusually bad mother, was physically very vigorous but emotionally very vulnerable and given to violent outbursts of rage. She was constantly dreaming of the hate-relationship between her and her mother, and would project her into any woman who invited such projection, often with catastrophic results in her daily work. After a very long analysis, she passed slowly into a phase in which she began to lose her physical energy, and then half-way through one session she suddenly fell silent for a long time, and then said quietly: 'It's safe now. She's gone. This is the turning point. I'm going to get better now.' She left feeling definitely better, but turned up for the next session quite mark-edly depressed. She was surprised when I said that I had expected this. She had at last let go and got rid of the bad mother inside and now felt all alone because she had lost her. She felt cut off from her friends, I suggested that I myself, and the very good friend she lived with, and an excellent friend she had made about a year previously, were not yet installed adequately in her deeper feelings, in her unconscious where she had been tied to mother for so long. As we talked about this her depression lifted, and for two or three weeks she emerged into an entirely new personality. She lost her hate and temper outbursts, and her loud raucous voice, and her 'queer' intolerances of ordinary things, and became as her friend said 'a normal, more healthy-minded, and also a gentler and more lovable person, much easier to live with'; though she also felt physically weak, like a small child facing the big world. Then she seemed to come to a standstill, and was unwell, miserable, and discouraged. Though she did not lose the gains made, she seemed unable to make any further progress. Then one night her friend was out later than she had expected, and she began to fear that she was dead. In telling me about this, she realized that she had begun to have ideas that those she loved would die, and she developed an unreasonable dislike for her friend's aged mother, about whom she said, rather oddly, 'I shall have to go on fearing her till I die.' I put it to her that she was showing clear signs of feeling guilty as if she had murdered her mother in fantasy to get rid of
her, that no doubt death-wishes against her mother from childhood had been activated, and that now she was feeling that she must be punished by being unable to get any benefit from her new freedom; she must remain ill and weak, her own loved friends must be taken from her, and that in her unrealistic reaction to her friend's mother she had in fact put herself back in her own bad mother's power, this time decreeing that herself must be the one to die first. Only with the bringing out of this depressive guilt, as well as the first schizoid reaction, was she set free to enjoy a steady recovery of physical health as well as mental stability.

The major source of resistance to psychotherapy is the extreme tenacity of our libidinal attachments to parents whatever they are like. This state of affairs is perpetuated by repression in the unconscious inner world, where they remain as subtly all-pervasive bad figures generating a restrictive, oppressive, persecutory, inhibiting family environment in which the child cannot find his real self, yet from which he has no means of escape. There are only three things he can do, fight desperately, suffer passively, or fly, i.e. withdraw into himself, break off all object-relationships, and experience the 'unthinkable anxiety' of utter isolation in which he will lose his ego. Then, when he gets over negative transference, i.e. the fear of meeting his bad parents again in his therapist, his fear of losing them remains so great that he will regard the analyst as someone who is going to rob him of his parents, even though it is also true that he looks to the analyst to rescue him from them. He will then face an awful period in which, if he loses his internal bad objects while not yet feeling sure enough that his therapist will adequately replace them, he will feel that he is falling between two stools, or as one patient vividly expressed it, 'plunging into a mental abyss of black emptiness'. It takes the patient a very long time really to feel that the therapist can be and is a better parent with respect to giving him a relationship in which he can become his own true self. Long after he is consciously and intellectually persuaded that this is so, the child deep within cannot feel it. In this uncertainty, even accepting the therapist's help may still feel like a fundamental disloyalty to parents and arouse guilt, or else he will go back to negative transference and feel he encounters his smothering internal bad objects all over again in his therapist.

Thus one patient who had made great progress began to come up against the smothering of his spontaneity in the early family set-up. He dreamed that he was watching a mother and small son, and the mother was saying, 'Everything you know belongs to me, I gave it to you.' He was so furious that he pushed the mother over, and the dream ended suddenly. Here was the smothering mother and in his next session it was clear that he felt he had come up against her in me. He had dreamed:

I was driving an old car I had years ago and came to a place where I wanted to get up to some bridge over to where I was going. I could go up in a lift, but there was a side road up a steep hill that I could get up by and I decided to go up that way.

I commented, 'It looks as if you decided not to accept help but to get up by your own way, to do it yourself.' He said, 'I'm claustrophobic in lifts. There is a very closed-in one where I work and often I can't go in.' I told him that I thought he was feeling claustrophobic in relation to me, that he was feeling I was like the mother in the previous dream, putting her knowledge into the son and then possessing him, and this was how he had felt about his own mother who had brought him up on a very marked social conformity pattern. He said, 'Yes, she was always on at me to behave nicely, to be generous, or you never knew what people would be thinking about you. I often feel when people are talking to me that they are pushing things into me. When you were saying something just now I was trying not to listen, and then had to repeat your words over again to myself before I could bring myself to attend to their meaning.'

But even when this kind of problem is got over, the fear of having no roots in a family past can dictate the defence and justification of parents against all outsiders. As one patient said, 'I sometimes feel this business is against my parents, that they haven't brought me up properly which I deny (though in fact she had recently been saying exactly that), and secondly that it's pulling me away from them, which I don't want.' She had for the moment forgotten that it was in defiance of her parents' opposition that she had sought treatment of her own accord to achieve greater independence of them. Fairbairn wrote:

The resistance can only really be overcome when the transference situation has developed to a point at which the analyst has become such a good object to the patient that the latter is prepared to risk the release of bad objects from the unconscious. (1943, p. 33a.)

And again:

It is only through the appeal of a good object that the libido can be induced to surrender its bad objects... It may well be that a conviction of the analyst's 'love' (in the sense of Agape not Eros) on the
part of the patient is no unimportant factor in promoting a successful therapeutic result. At any rate, such a result would appear to be compromised unless the analyst provokes himself an unfailing good object (in reality) to his patients. (Ibid., p. 336.)

J. C. Flugel wrote in 1945:

Though the negative phase of the transference is unavoidable and also essential for a ‘deep analysis’, it is the positive phase which is the ultimate stepping-stone to therapeutic success, for it is only by means of the projection of the more positive aspects of the super-ego on to the analyst that the patient can face the task of becoming aware of his own repressed impulses and inner conflicts. He needs the help, understanding and security afforded by the analyst before he can venture to relax the control exercised by his own super-ego. This is well brought out by Fairbairn in ‘The Repression and Return of Bad Objects’. (Flugel, 1945.)

This, however, falls short of Fairbairn’s position while it supports it. The patient’s superego may not contain the ‘more positive aspects’ Flugel refers to, and the patient may need to find them for the first time in the analyst. It is curiously artificial to say that the patient can only be helped by the analyst if he projects some part of himself on to the analyst. Object-relations theory calls for the analyst to be a good-object in reality, in himself, just as the mother has to be a good-object in reality to the baby. Flugel’s simpler statement is more realistic, that the patient ‘needs the help, understanding and security afforded by the analyst’ who will have to provide that particular kind of parental love that the patient’s parents failed to provide at first, i.e. in Fairbairn’s words, to care for him ‘for his own sake and as a person in his own right’. The therapist must be more than just a projection of good elements in the patient’s own superego. He must, in his own reality as a person, bring something new that the patient has not experienced before.

(9) The view of psychotherapy here maintained is that the patient cannot be weaned from, and become independent of, internalized bad parental objects, and so cannot become healthy and mature, unless he can consolidate a good relationship to his therapist as a real good-object; since otherwise he would feel left without any object-relationships, the ultimate terror that the withdrawn schizophrenic person is always dreadting. Here emerges the third fundamental obstacle to psychotherapy in practice, namely the severe difficulties patients have about entering into any relationships at all with real human beings in their outer world, even though such relationships are what they most deeply need. Thus they both seek and resist a real good-object relationship with the therapist. In the depressive position their trouble is the ambivalence of their reactions. They cannot love him without finding that hate and aggression surge up as well. But the deeper and more difficult problem is their reaction in the schizoid position. Here their need of love-objects is so starved and intensified, and their basic attitude to people is so greedy, hungry, and devouring, so that they feel destructive, that they are afraid to need and want and love anyone. This is further complicated by the fact that all this arose because they had reasons to fear their unsatisfactory human environment at the outset, and also, as Melanie Klein has shown, by ‘projective identification’, they feel that their objects have exactly the same destructive attitudes to them. Hence, for a complex of reasons, they retreat into a cold, aloof, unfeeling detachment. Real relationships are felt as too dangerous to be risked, however much this feeling is masked by a superficially co-operative attitude. Genuine rapport is gained only to be lost again, and they become ‘cut off’ through fears of being destroyed or absorbed, if they risk too genuine and spontaneous a response of trust.

This difficulty is shown by a female patient who alternated between response and withdrawal. In the earlier stages of her analysis she was fully conscious of feeling guilty of disloyalty to the family and especially mother if she let the therapist help her to any independence of them. Long after she had ceased to feel conscious of this, traces of it would reappear in her dreams whenever negative phases alternated with positive ones in her sessions. After a period of much more definite responsive trust in me during which she had begun to feel that her treatment really was supportive while she was at work and between sessions, she suddenly cut herself off again. She commented, ‘I lost you almost as soon as I left last time, and have felt to be struggling alone all the week.’ She then reported a dream:

I was with my family and I just wandered out, left them and went off alone, and I got lost. I knew they were angry with me for leaving them, but I could not find my way back to them.

Here is the real schizoid predicament. When she had relinquished her original unsatisfactory objects in their mentally internalized form (in real life she still had responsibilities to an aged mother, and a sister), she still could not commit herself steadily to a growth-promoting relationship with the
therapist, and wandered in an empty no-man's-land in her
dream world.

The more radical difficulty of not being able to accept a
therapeutic relationship at all, in spite of a conscious need of it,
is shown by a male patient who was exceptionally rigid in his
detachment. As he came into one session he observed: 'I feel an
uprising of tension but the thought occurs, "I'm old but you're
older still." One becomes less physically attractive as one grows
older, and less likely to be loved. As I grow older there are
fewer people by whom I can be loved in a paternal way. One's
props get less. I feel angry but if I were aggressive you'd resent
it, it would become a personal matter between us. It's only
because between analyst and patient there's no personal
relationship between us that I can let things out at all.' I explained
that he wanted but was afraid to see me as a real human being
who could have a genuine concern for him. He would only see
me as an impersonal professional object called 'an analyst' lest
the therapeutic relationship should become emotionally alive
and real, when he would have to face all his deeply disturbing
difficulties about personal relationships. This was an effective
defence which halted real progress in treatment, so that he
made only superficial improvement. I reminded him that he
once said that he could only talk at all if he lay on the couch
where he could not see me, and could talk to the wall. In that
situation, nothing of any emotional significance would be likely
to emerge and he would be safe from anxiety attacks. He
replied, 'I find any personal relationship with anyone impos-
sible. I don't really know what it means. I want a personal
relationship but am too proud to ask for it, too independent.'

The Therapist as a Real Good Object

If the patient cannot part with his bad psychic objects in his
inner world because of guilt and the risk of ego-loss, in what
sense must the therapist become a real good object whose 'love'
helps him out of this dilemma towards finding his own true
self? Gitelson, in a paper on 'The Emotional Position of the
Analyst in the Psycho-Analytical Situation' (1952) wrote that:

Recent developments in the psychotherapeutic functions of psycho-
analysis ... have pointed to the importance of the analyst as a real
object.

His paper, however, was confined to dealing largely with
countertransference, the fact that 'the analyst may bring into

the analytical situation interfering emotional factors'. To off-set
these he held that the qualified analyst brings to the patient
... intellectually sublimated curiosity ... Object-attitudes includ-
ing empathic compassion which is distinguishable from sympa-
thetic identification, and helpfulness which is distinguishable from
omnipotence or masochism ... Finally, an emotionally 'open'
and flexible (personality) in a spontaneous state of continuing self-
analysis. (1952, pp. 3-4.)

This, however, does not carry us far enough. Gitelson rightly
says that

The analyst as a mere screen does not exist in life. He cannot deny
his personality nor its operation in the analytical situation as a
significant factor. (p. 7)

'Helpfulness distinguishable from omnipotence and masochism'
is definitely required but 'sympathy distinguishable from sympa-
thetic identification' raises far subtler questions, and here
Gitelson appears to retreat from the full implications of the
analyst as a real person in the therapeutic relationship. Home,
in 'The Concept of Mind' (1956, pp. 43-4), writes:

In discovering that the symptom had meaning, and basing his treat-
ment on this hypothesis, Freud took the psychoanalytic study of
neurosis out of the world of science into the world of the humanities,
because a meaning is not the product of causes but the creation of a
subject.

By science he means the impersonal study of dead facts, explain-
ing them in terms of causes, and by the humanities he means
the personal study of living subjects in terms of meanings and
reasons. He holds, and I believe rightly, that the only way we
can know 'living subjects' is by identification.

This gives us an understanding of the object (i.e. the live object or
living subject) and particularly of how it is feeling and therefore of
how it will behave.

Provided perception is accurate and 'refined by the withdrawal
of projections', 'cognition through identification gives us
accurate information and information which can be obtained
in no other way'. It is 'this mode of cognition which is used
by the analyst in analysis'. In that case, denying that the
analyst's 'empathic compassion' is the same thing as 'sympa-
thetic identification', Gitelson denies the only means by which
an analyst can 'know' his patient at all in a truly personal sense. Gitelson's argument should logically have concluded with the affirmation of the psychotherapeutic relationship as a fully personal relationship, but he drew back from that when he wrote:

This is far from saying, however, that his [the analyst's] personality is the chief instrument of the therapy which we call psychoanalysis. . . . It is of primary importance for the analyst to conduct himself so that the analytical process proceeds on the basis of what the patient brings to it. (1952, p. 7.)

It is, of course, easy to see that what he seeks safeguards against is the danger of the therapist becoming bogged down in a neurotic emotional involvement with the patient. This can only be avoided by the maturity of the therapist, not by maintaining a theory of the therapeutic relationship which denies its fully personal nature. The personalities of parents are the chief instruments in bringing up the child. What the patient brings to analysis is, at bottom, behind all his defences, a need for a relationship with someone who in loco parentis will enable him to grow, a need which must be met by what the therapist brings to the analysis. Gitelson almost but not quite reaches this point when he concludes that the

... sustaining psychotherapeutic factor in the conduct of an analysis, the real ego-support that the patient needs, resides in the actuality of the analyst's own reality-testing attitudes. (p. 8.)

And

One can reveal as much of oneself as is needed to foster and support the patient's discovery of the reality of the actual inter-personal situation. (p. 7.)

But he still does not give a definite statement of the nature of the specific element in 'the reality of the actual inter-personal situation' which meets the patient's need. One does not usually have to 'reveal much of oneself' for example, as a private individual; the analyst's personal interests, activities, friendships, family life, history, are not as such essential to the patient. What does concern the patient, and it is the only thing about the therapist that does really concern him, however much other things may crop up accidentally or incidentally, is whether the therapist as a real human being has a genuine capacity to value, care about, understand, see, and treat the patient as a person in his own right. Obviously any given therapist

will find that he has more natural affinity with some patients than with others, but if he can truly and humanly care and understand, then he can be therapeutic. This disinterested personal 'love' (agape not eros) is the true parental love, which does not regard the child as a nuisance, or as a piece of clay to be moulded, or as there to fit in merely with the parents' convenience or to fulfil their ambitions for themselves, or what not. It is the capacity to respect and to be concerned about the other person's reality in himself and apart from oneself, and to find true satisfaction in helping the other person to find and be his own properly fulfilled nature. It is a matter of being a sufficiently real person to the patient to give him a chance of becoming a real person himself, and not an assemblage of defences, or a role, or a conforming mask, or a mass of unresolved tension. If the patient cannot meet with personal reality in the therapist, he cannot give up his struggle to keep going a spurious reality by means of internal bad-object relations and external forced effort.

The urgency and reality of the need felt by one patient in this matter was vividly expressed in a dream:

I'm looking for Christ on the seashore. He rose up as if out of the sea and I admired his tall magnificent figure. Then I went with Him to a cave and became conscious of ghosts there and fled in stark terror. But He stayed and I mustered up courage and went back in with Him. Then the cave was a house and as He and I went upstairs, He said, 'You proved to have greater courage than I had,' and I felt I detected some weakness in Him.

The patient associated the admired tall figure of Christ with his athletic father and then said: 'I also associate Him somehow with you. I've got the idea that somehow you may inveigle me into courage to face ghosts and then let me down. Mother was a menacing figure. Father was weak, mute before her onslaughts. He once said it wasn't a good thing to have one parent constantly dominating the other in front of a child, but he never showed any anger at all.'

Here is the patient oscillating between the old fear that father lets him down if he tries to stand up to his violent-tempered mother, and the new wavering hope that the therapist will not let him down in facing the 'ghost' of the angry mother within. In a later dream he encountered the ghost of mother coming out of a room, while a figure representing myself stood by him. He was gradually internalizing me as a reliable parent-figure in his inner world around whom he could reorganize his security as a person. It was such phenomena that suggested to
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Fairbairn the parallel between the analyst and the exorcist casting out the ghosts or devils who haunt the patient in his inner world; though the analyst does not in fact 'cast out' these internal bad objects, but gives the patient a sound personal relationship in which his ego can grow secure enough not to need them any longer.

The psychotherapist naturally does not seek to play the role of a Christ or Saviour, or indeed to play any role, least of all the 'role' of a professional therapist. But without him, the patient cannot either cope alone with his disturbed state of mind or give up his internal bad objects and be left with no one. His only hope lies in his internal bad objects being replaced by the internalization of a good therapist, i.e. the therapist who gives him a relationship which at one and the same time supports and leaves him free to develop his own nature. By then, the therapist will have become a non-possessive good parent-substitute with whom the patient will have outgrown the dependencies and fears of childhood, and achieved the kind of mature satisfactory relationship which is not lost or damaged by his ending treatment to live his own proper life, akin to the grown-up child leaving home.

The centrality of the personal relationship factor in psychotherapy has been steadily gaining recognition now for some time. Speaking of psychotherapy at the Sixth International Congress of Psychotherapy, Laing (1965) said, 'We live on the hope that authentic meeting between human beings can occur.' Only when the therapist finds the person behind the patient's defences, and perhaps the patient finds the person behind the therapist's defences, does true psychotherapy happen. This relationship factor has sometimes beencrudely expressed as 'loving the patient better' but we need to be careful what is meant by that. Certainly if we simply hate patients, are on the defensive against them, and want to make them get better quickly to get rid of them, we shall do no real good, and may even encourage them to maintain a hate-rela- relation as a defence against a real solution. On the other hand, uninform- sympath for the patient, however genuine, would only draw him into in- terminable dependence which gets nowhere. Moreover, since it is a main part of the patient's problem that he is afraid of a relationship to anyone, it may still be a problem to the therapist that he could be afraid of a relation with the patient. All that Gitelson said about 'continuing self-analysis' is highly relevant. This personal relationship factor is what makes psychotherapy the most difficult of all therapeutic procedures, and makes many favour more impersonal objective 'scientific' methods. It is possible to carry out diagnostic labelling and prescription for the control and suppression of symptoms on the basis of a knowledge of medicine. Psychotherapy can only be carried out on the basis of a knowledge of oneself and of the patient as a person.

Psychotherapy can only be carried on by those who are prepared to be exposed to all the subtle reactions that go on between two human beings who meet on an emotional rather than on an intellectual plane; and who are prepared to accept awareness of these reactions as essential to treatment. The emotional plane is that of the patient's suffering, his loneliness, his insecurity as an ego and his anxiety about life. The psychotherapist is not a deus ex machina, an authority diagnosing and prescribing from some position outside the patient's personal world. The psychotherapist must be primarily a human being who has faced and sufficiently understood himself to be worthy to be admitted into the patient's private pain and sorrow. He will understand the patient's inner life, not because he has a theory (though if it is a good one, it helps) but because he can feel with and for the patient; and he knows, not just theoretically but in his own experience, what the patient is passing through. Sharing in the same humanity with the patient, he is able to identify with him in order to know him. Only that enables the patient no longer to feel alone. Neither love nor insight alone cures. Fairbairn pointed out that deep insight only develops inside a good therapeutic relationship. That is because the patient cannot stand it if he feels alone. What is therapeutic, when it is achieved, is 'the moment of real meeting' of two persons as a new transforming experience for one of them, which is, as Laing said (1965), 'Not what happened before [i.e. transference] but what has never happened before [i.e. a new experience of relationship]. Thus a patient who had had a paranoid-schizophrenic breakdown, suddenly said to me, after two-and-a-half years of analysis: 'I feel safe with you now. I haven't done liherto.'

But this meeting of two people is far from easy. Transference analysis is the slow and painful experience of clearing the ground of left-overs from past experience, both in transference and countertransference, so that therapist and patient can at last meet 'mentally face to face' and know that they know each other as two human beings. This is without doubt the most important kind of relationship of which human beings are capable and it is not to be confused with erotic 'falling in
love’. People can and do fall passionately in love sexually and later discover that there is no genuine relationship between them as persons. In that case, the sexual passion generally fades out into disillusionment. Neither does this deep and truly personal relationship necessarily involve sexual love. It can exist between people of the same or of different sexes; sexual relationship cannot be truly satisfactory without it, but it can and does exist where a sexual relationship is not appropriate or desired and does not exist. It is the fundamental purely ‘human personal’ relationship. It cannot exist fully between parent and child because the child is as yet immature and not capable of ‘equal’ relationship. But I would say that its ideal realization is to be found where the child grown adult and the parent remaining young enough in spirit, achieve a deep mutual affectionate understanding of each other. This I regard also as ideally the goal of psychotherapy, which is basically a relationship of the parent-child type at the start. We shall see in the next section how profound an interpretation of this Winnicott gives.

Most psychotherapeutic sessions are experiences of transient flashes of reality amidst a lot of unreality. Real psychotherapy does much for the maturing of the therapist as well as the patient. The patient’s need dominates the situation, but the therapist cannot meet it and remain a stagnating human being. He cannot pretend or play roles. If he does, the patient cannot find him and nothing happens. Psychotherapy is a progress out of fantasy into reality, a process of transcending the transference. The extent to which Freud regarded sex as the basic factor in object relations has, I am convinced, introduced misunderstandings and unnecessary complications into psychotherapy, and also exerts a dangerously misleading influence in current popular culture. Unless the term ‘sex’ is used with such a wide connotation that it loses all specific meaning, it cannot be said to be the essence of meaningful personal relationship. It must be seen as biologically innate need that can only find real fulfillment as part of a truly personal relationship.

I must add that I feel suspicious of ‘active stratagem’ technique. It looks too like experimenting on the patient, who is then treated as an object not a person. The surest guide is simply to keep asking oneself: ‘What is this patient’s genuine need at this moment, whether he realizes it or not?’ In what way can I help him to understand it and how can I meet it to help him forward?’ Once patients know that they can reveal their need and be sure of a response of understanding and accept-

ance, of a kind they have to find in childhood, then through many ups and downs the genuine meeting of two human beings as persons begins to occur. That is the only thing that is ever really therapeutic, enabling the patient to feel real in himself.

It seems that in the last hundred years, the schizoid element in human experience has become more obtrusive and recognizable, perhaps because this is a century of cultural transition in which human beings tend to become spiritually displaced persons. The rise of the psychological novel from the work of Henry James is a symptom of this. Recently a radio reviewer of a book on ‘Loneliness’ said: ‘Loneliness has always been with us but it is only recently that we have become aware of it.’ Our age has become more generally aware of the isolation of the individual within himself, and the tenuous nature of his relationships with other isolated individuals. Existential thinking is another symptom of this, with its stress on life as rooted in anxiety, and on the personal encounter as the important fact in human life. Without that we are only sub-human, and apart from it our anxiety cannot be dealt with. What existentialism is in thought, psychotherapy seeks to cope with in practice; they are parallel manifestations of our need to overcome our alienation from ourselves, from one another, and from our whole outer world, so that humans no longer hide away inside themselves, insecure and only half alive in an internal fantasy world that binds them to the past, but become able to emerge into real personal relationships and live a whole life.

It follows from this that a psychotherapist is not a therapeutic good object merely by virtue of being a good technician or analyst. The technique of psychoanalysis as such does not cure. It is not endowed with any mystic healing power. It is simply a method of psychodynamic science for investigating the unconscious, an instrument of research. It plays an essential part in psychotherapy but is not itself the therapeutic factor. It is a way of helping unconscious mental experience to become conscious, by providing a patient with an opportunity to talk to someone with complete freedom to say anything and everything without encountering disapproval or retaliation; so that he can bring the unconscious operations of his personality to conscious awareness, and discover himself to himself in self-expression, aided by the therapist’s experience and insight. But what is to be done with what becomes conscious? Abreaction, ‘talking out’, ‘acting out’ gives some temporary relief to pent up feeling, and temporary security is experienced in an ad hoc good
relationship, but this does not of itself lead to permanent changes. Thus the analytical technique is more an instrument of research and of temporary relief than of radical therapy.

The analyst's interpretations will be given to the patient as suggestions for him to respond to, not as dogmatic or authoritative pronouncements for him to accept blindly. It is the sustenance of this analytical process in the continuing relationship of therapist and patient on an emotional, personal level, that enables the patient to deal with what is made conscious. It is only the kind of self-knowledge that is arrived at as living insight, which is felt, experienced, in the medium of a good personal relationship, that has therapeutic value. Insight, integration, individuation, and personal relationship are but distinguishable aspects of one and the same thing, which is called 'mental health' from the psychiatric point of view and 'peace' or 'salvation' from the religious point of view. Whatever terminology different interests use, the therapeutic change can only come about in, and as a direct result of, a good relationship. This is true in real life. The best chance of progressively modifying the bad objects internalized in infancy and repressed, lies in the child experiencing increasingly good relationship to parents in the post-infancy period, before the whole mental make-up consolidates. That is the cue for psychotherapy.

As a radical process, it has a better chance in childhood than in adulthood, but either way the maturing of personality takes place by natural growth and development on the basis of the right kind of parental love. In infancy, parental love has an erotic element and is expressed in physical handling in bodily contact and care. This physical relationship is profoundly necessary to the child, especially in the earliest preverbal period. As the child grows up, this erotic factor will have done its work of giving an elementary sense of security, and is reduced to minor proportions, so that ultimately the child can transfer its erotic response and become capable of marriage. Parental love changes into a non-erotic, non-possessive, non-dominating affection which supports the child in his development of separate and independent personality. He is backed up and encouraged to think, feel, and act for himself, to explore, experiment, take risks, use and develop his own powers and is helped to 'be himself'. This kind of parental love, appropriate to latency and adolescence, leads finally to the replacing of the early erotic attachments which are dependent in the child and supporting in the parent, by mature relationships of adult mutual respect, equality and affection in friendship. Then the grown-up child is free without anxiety or guilt to enter an erotic relationship with an extra-familial partner, and to form other important personal relationships in which there is a genuine meeting of kindred spirits without the erotic element, and further to exercise an active and spontaneous personality free from inhibiting fears. This kind of parental love, which the Greeks called *agape* as distinct from *eros*, is the kind of love the psychotherapist must give his patient because he did not get it from his parents in an adequate way.

*Winnicott's View of the Basic Psychotherapeutic Relationship*

In Chapter IX I sought to relate the work of Winnicott to the developing phases of psychoanalytic theory. His work on the mother-infant relationship from the very beginning, as the indispensable medium in which the psyche of the infant begins to realize its latent possibilities of ego-growth and the achievement of true selfhood, is an advance beyond the work of both Melanie Klein and Fairbairn. It is an advance beyond Klein in that it is fully object-relational. It rescues us from the implicit solipsism and subjectivism of the Kleinian view of the infant's inner world of fantasy as held to be built up primarily by the interplay of entirely innate, subjective forces, the inherited life and death instincts. I have devoted Chapter XV to the closer consideration of the Kleinian metapsychology. It is sufficient here to say that the objective world in her system is quite secondary. It functions as a projection screen on to which the infant's fantasy can be extruded thence to be introjected again so that the object world can never be experienced in its own right. In Winnicott's work, on the other hand, the all-important primary object, the breast and the breast mother, is a real object directly influencing the infant, and entirely responsible for the infant's security. Only the mother who is capable of 'primary maternal preoccupation' and 'identification' with her baby, is capable of giving it a sound start in ego-development. The mother is not just a projection screen but a real person, so real that the baby's ego will be weak or strong in proportion as the mother's ego-support of the baby is weak or strong. This view plants human personality squarely in the soil of personal 'object-relationships' as the starting-point of all human living, prior to the development of Klein's internal fantasy-world.
Winnicott's work also goes beyond that of Fairbairn, in that Fairbairn's analysis had to take the existence of the ego for granted, in order to trace out the splits it suffers in its early experience of good and bad object-relations. But Winnicott takes us deeper than that to the most elementary experiences in which the first dim and uncertain beginnings of ego-growth occur as a result of the infant's existing in the peculiarly intimate primary mother–infant relationship. If we take all this into account, it is clear that Winnicott's work must have a very large implication for psychotherapy, where the last and deepest problem to be dealt with is always the profound basic ego-weakness of the patient. Winnicott, indeed, has seen this and left us in no doubt about his views on the matter. It is only when theoretical analysis and therapeutic practice are carried back to the very beginning that the implications of the personal nature of the therapeutic relationship emerge in their simplest form and become fully clear. Short-term treatment of the milder neuroses can be carried out successfully with no more than a very straightforward cooperative relationship developing. The earlier the causes of trouble in the patient, the more fundamental his ego-weakness, and the more we move beyond psychoneurosis into the deeper schizoid, borderline and psychotic problems, the more profoundly important does the quality of the therapeutic personal relationship become, until ultimately it faces the question of the possibility of a replacement for the failure of original mothering.

It is at this deep level that Winnicott's most important contribution is made. He distinguished between 'psychoanalysis' for 'oedipal cases', and 'management' for 'pre-oedipal cases' where initial good enough mothering cannot be taken for granted. When Winnicott first made this distinction I could not feel happy about its being made in such a clear-cut form, at least in the one respect that analysis cannot be excluded from the treatment of pre-oedipal cases. Even with respect to the earliest experiences, the patient needs interpretation of the experience, if he is to gain insight and integrate the experience in the context of the therapist–patient relationship. But Winnicott does not make the distinction rigidly. In his paper on 'The Aims of Psychoanalytical Treatment' (1962), he says:

As we come to gain confidence in the standard technique through our use of it in suitable cases, we like to feel that we can tackle the borderline case without deviating, and I see no reason why the attempt should not be made.

But he makes an important qualification which highlights the personal relationship aspect of treatment. He speaks of analysts who

... deal with more primitive mental mechanisms; by interpreting part-object retaliations, projections and introjections, hypochondriacal and paranoid anxieties, attacks on linkages, thinking disturbances, etc., etc., they extend the field of operation and the range of the cases they can tackle. This is research analysis, and the danger is only that the patient's needs in terms of infantile dependence may be lost in the course of the analyst's performance. (Op. cit., p. 169; my italics.)

With this mention of the 'patient's needs in terms of infantile dependence' the ultimate psychotherapeutic problem is raised, that of how to start off the growth of an ego which has not yet properly begun to be. Winnicott bases his view of psychotherapy at this depth, on his view of the nature of the infant–mother relation. I shall summarize this briefly before quoting his own words. The mother is being there for the baby in such a way that he can feel in touch with, share in, partake in her psychic state of secure being, even before he can distinguish between her and himself. Here, at the very beginning, the foundations of ego-security are laid in a situation experienced by the mother as her state of 'primary maternal pre-occupation' with the baby, and by the baby as 'primary identification' with the mother. The baby must be able to feed actively at the 'male' breast (cf. Chapter IX) that is doing something for him or else he must protest at deprivation; but he can sleep without anxiety at the 'female' breast that is simply 'being there' for him, and there is the beginning of the secure sense of 'in-beingness', of ego-identity, that as he grows the baby can take for granted and does not have to worry over and work hard to maintain. Only the mother can provide this experience at first, while the task of the father lies in 'doing' all that is necessary to protect and support the mother–infant pair in their very special and formative relationship. In psychotherapy at the deepest level, this situation has to be recovered, with the analyst meeting the patient's need for both mother and father. Thus one female patient in her late fifties, herself a grandmother, but who had been severely schizoid all her life, said, after a very long analysis, 'I don't want analysis now. I just want to be here and to be quiet, and know that you are there and let it sink in.' Shortly after that she brought a dream:

I opened a steel drawer and inside was a very tiny naked baby staring with wide open eyes as if looking at nothing.
Suddenly she saw a filing cabinet in the corner of my room and said, 'The steel drawer was like that.' Thus her unconscious fantasy and experience was of coming to birth out of me, and of bringing her tiny infant self to me, simply to get a start in feeling secure and real. 'Analysing' is a male function, an intellectual activity of interpretation, but based on the female function of intuitive knowing experienced, as Home reminds us, through identification. Ultimately 'being there for the patient' in a stable and not a neurotic state, is the female, maternal, and properly therapeutic function, which enables the patient to feel real and find his own proper self.

Winnicott writes:

There is something about the mother of a baby, something which makes her particularly suited to the protection of her infant in this stage of vulnerability, and which makes her able to contribute positively to the baby's positive needs. The mother is able to fulfill this role if she feels secure ... (Her) capacity does not rest on knowledge but comes from a feeling attitude which she acquires as pregnancy advances, and which she gradually loses as the infant grows up out of her. (1965a, p. 3.)

We notice in the expectant mother an increasing identification with the infant. ... The predominant feature may be a willingness as well as an ability on the part of the mother to drain interest from her own self on to the baby. I have referred to this aspect of a mother's attitude as 'primary maternal preoccupation'. In my view this is the thing that gives the mother her special ability to do the right thing. She knows what the baby could be feeling like. No one else knows. Doctors and nurses may know a lot about psychology, and of course they know all about body health and disease. But they do not know what a baby feels like from minute to minute because they are outside this area of experience. (1965a, p. 15.)

In this passage Winnicott draws a clear and absolute distinction between intuitive knowing or knowing by identification, by emotional or personal rapport, and intellectual or scientific knowing. The qualified doctor or nurse approaches the baby as a scientist, from outside observation, and with intellectual knowledge, a kind of knowing that was described in Chapter IX as 'male element knowing'. This is valuable when it is a matter of dealing with the baby's bodily health, but it is useless for 'knowing from minute to minute what the baby could be feeling like'. This 'mother's knowing' comes through an emotional 'feeling at one with' the baby, and as Home main-
of infantile terror, isolation, and the evaporation of his ego into a feeling of nothingness. He must keep as constant and close contact with him as is humanly possible, especially if the patient's human environment is not as supportive as one might wish. He must see the patient through into the ultimate acceptance of a therapeutic regression from which he must be mentally nursed to a rebirth and regrowth of a real self. The therapist is utterly indispensable to him at that stage.

This is well illustrated by the case of the deeply regressed woman mentioned in this and the previous chapter. Some concluding remarks on that case may now be made. As mentioned on page 321, after many vicissitudes, she began to relive the basic trauma of her primary maternal deprivation and her sense of utter isolation at heart. Her husband had a very adequate grasp of all that was implied in this and we were able to work together to meet her need for a belated maternal security. But there were times when it was inevitable that she was left alone in the house, and I was kept informed of these. They were dangerous occasions for her, and I did all I could to contact her on the telephone at these times. Her state of mind was invariably like that of a person alone and lost on an empty plain without landmarks. On various occasions she said such things as: 'Till the phone went and I realized it was you, I've been sitting here paralysed, unable to move, with a queer feeling as if there's nobody else in the whole world except me.' Again, 'I can't stop sobbing and I feel I can't hear a single sound anywhere except the sound of my own crying.' Yet again, 'I'm so glad you've rung. I knew you would but I felt so afraid something would stop you, and this terrible loneliness would never be broken. I've had hard work not to panic. Yet when I heard the phone go I felt terrified that it would be someone I didn't know.' Her husband said to me, 'I've given up being a husband just now and I'm simply being a mother.' Gradually the neglected and isolated infant in her deep unconscious must have been reached and contacted, reassured, and given a new start with a feeling of security, for she began slowly to drop her resistance to regressing, accepted her husband's help without resistance, felt more and more overcome with exhaustion and the need to sleep, and found that she could go to bed and drop fast asleep at any time without any sleeping pills, waking after three or four hours to feel much better. At this stage the ordeal of a journey from her home town to Leeds became too much for her. There was one morning in the week when her husband could be free to bring her, and I arranged to see her then. She took no medication at all on those mornings, and would arrive feeling pretty ill, but always by the end of the session felt much better and found that a 'person' was better than a 'pill', a highly important discovery for her, for she had been under heavy medication for years. At her other usual session times, I would ring her and after a short talk she would then go to bed feeling that it was mentally with her, and go to sleep (like the baby in the pram who can't see mother but has no doubt that she is there).

Gradually this must have set going an inner sense of a new security, and this was expressed in a dream. She consciously dreaded mental hospital as a place where she would not be understood. Now she dreamed that she was back in the hospital where the superintendent had been so very understanding. But this time it was a real home; doctors, nurses, and patients (i.e. father, mother, and siblings) were all friendly, and there was a graded scheme of stages through which everyone was getting better, and she herself moved from the first (entry) stage on to the next one. For years her dreams had been frankly persecutory or anxiety-saturated. Now here was the sign of the development of a foundation of inner security on which a new life could slowly be grown. At such times the therapist's involvement with the patient is maximal.

Winnicott, however, says of the mother's 'primary maternal preoccupation' with her baby that it is an extraordinary condition which is almost like an illness, though it is very much a sign of health... It is part of the normal process that the mother recovers her self-interest, and does so at the rate at which the infant can allow her to do so... The normal mother's recovery from her preoccupation with her infant provides a kind of weaning... we can find parallels to all these things if we look at our therapeutic work. (1965, pp. 15-16.)

Thus, the degree of involvement of the psychotherapist with the patient, as with the mother and her child, will change. At first it must be adequate to the patient's need for a stable parent, according to the nature and degree of the illness for which he seeks treatment. If that is successful, it will slowly adapt to the patient's growing need for greater independence and will turn into support for and respect for his development of an individuality of his own. Throughout, psychotherapy is a personal relationship on the basis of which the therapist can make use of his intellectual knowledge gained from psychodynamic research. Our patients are always to some extent isolates hiding
behind defences, in a persisting state of anxiety and insecurity. Their 'cure' can only come about in a therapeutic relationship in which the core of their potential self can be found and communicated with in such a way that it shall not feel threatened, but protected and supported for self-discovery and self-realization. On this basis of a new-found self-possession and ego-strength, he can lose his schizoid fear of human contact and involvement, and find relationships enriching and fulfilling.