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# The Teacher's Headache

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## Abstract

This article considers a psychosomatic symptom - migraine - produced in the author while teaching a course on psychoanalysis. Referring to a dream and to case material, the article reflects upon 1. the teaching relationship, 2. migraine headaches, 3. countertransference and 4. the nature of inquiry itself.

## The Teaching Relationship

I have about three or four migraines a year. One particular year, however, I managed to get migraine symptoms on four out of the thirteen Mondays on which I teach an MA course at the University, *Psychoanalytic Perspectives on Education*. Typically I would suspect by the mid-seminar break that a migraine was underway and would then respond by denial, procrastination, or taking medication. The first two of these would lead to a full-blown migraine attack, and the latter to side-stepping it. For the purposes of this article I will leave aside any constitutional bent I have for migraines. Rather, I take this unusual frequency as proof of a psychosomatic element.<sup>1</sup>

The first migraine I can remember occurred was when I was five years old. But I am aware too that by that age I was already familiar with the migraine and how it would happen; my migraines have always been very similar. They begin in the late afternoon and last until the next morning. I don't have distortions of vision - except for sensitivity to bright light - instead I have the typical very painful headache in my left temple, a need to lie down quietly, and, usually, nausea. As I've got older the headaches have become more intense and I now feel washed out the next day. My migraines fit Oliver Sacks' delineation of five stages of the typical migraine.<sup>2</sup> Now and then I will have a twinge or a light

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1 Illnesses and symptoms are designated 'psychosomatic' if (a) the symptoms are accompanied by demonstrable physiological disturbances of function, and (b) the symptoms and the illness as a whole can be interpreted as a manifestation of the patient's personality, conflicts, life-history, etc. (Rycroft, 1968: 133).

2 Initial *excitement*, perhaps accompanied by aura, heightened emotion, or ocular symptoms; *engorgement*, visceral distension and stasis, vascular dilation, etc. and emotional tension; *prostration*, affective apathy and retreat as well as physical nausea, drowsiness, etc; abrupt or gradual *resolution*, vomiting or sudden excess of emotion or more gradual melting away of the symptoms; *rebound*, euphoria and physical well-being (Sacks 1992).

feeling of being touched on my migraine spot without it developing into a migraine.

It shows itself in the therapeutic room too.

Before an initial interview I read the notes made by the receptionist. The new patient had told reception that someone close to her had been sexually abused, but that she didn't know whether she (the new client) would be prepared to talk about this with a therapist. Thus, I was prepared for something. In the course of the first session she said: "When I was fourteen - although I only found out about it years later - my sister was raped by two boys down the road." Immediately I felt that I had been 'hit' on my left temple; I felt a very intense, concentrated cramping there for about five seconds - so strong that I had to rub the spot. I've never experienced this before. "She's communicating something to me," I thought, "But what?" Driving home after the session I again felt a sensation, milder this time, and thought: "Oh-oh, am I getting a headache?" Then I suddenly realised that I had completely forgotten to mention the incident in my notes after the session.

There is much food for thought here. For now I will not try to analyse this acute bodily response. Rather, I pose the question: can we as therapists and teachers use our own pathological 'weak spots'<sup>3</sup> as sensitive transference/countertransference receptors and decoders?

I write here as both psychotherapist and teacher. While a therapist is better trained to venture down the paths I indicate here, in principle they are open to the teacher too. This article tracks the course of my inquiry into four areas: 1. the nature of the teaching relationship, 2. migraine headaches, 3. using this symptom in one's work, and 4. the nature of inquiry itself.

A few words about the course in question. I established it and it has run for four years now. It is structured in such a way that the first half is spent studying Freud and the second considers a range of writers (from Klein to Althusser) and concepts (from transference to interpellation). A wide variety of students have attended the course (e.g. a writer of educational textbooks, an experienced psychotherapist, a sculptor, a science educator, and a couple of budding philosophers). My impression is that the first - Freudian - part is the most intense and stimulating part of the course for both the students and myself. I

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3 I use the term 'weak spot' very loosely to refer to the connection between the domains of psyche and soma: to make some reference to disposition. Oliver Sacks puts it beautifully: "We must interpret situational migraines as if they were palimpsests, in which needs and symbols of the individual are inscribed above, and yet in terms of, the subjacent physiological symptoms" (1992: 223).

expect the students to take Freud seriously as a thinker; sometimes they arrive with simplistic, dismissive prejudices about his work. I don't let flip, careless statements pass by and I encourage students to consider even Freud's most outlandish-sounding notions: thanatos, penis-envy and castration-anxiety, the primal horde. I try not to be a zealous defender of a doctrine which is immune to criticism, but rather insist that criticism involves serious reflection. By the end of the Freud section I have been satisfied each year that I have succeeded in getting students, not to be Freudians, but to take his ideas seriously in all their intellectual and personal difficulty, and even to enjoy them. To be able to move on to the question, "Why do I dismiss/accept this so readily?" After much wrestling each week with Freud (and with me) one student said: "I've made friends with Freud." I find that I am far less concerned that students be as earnest about the authors and ideas in the second part of the course. Perhaps this is because that material just isn't as challenging or because I let up, my main task having been accomplished. But in any event in the latter part of the course the classes lose their edginess and, perhaps, some creative tension too. So it will be clear to readers how much of myself is invested in Freud's work. (Why this might be so is a question for another day.)

Frieda Fromm-Reichmann (1937) articulated the classic psychoanalytic position; migraine, she said, is the bodily expression of unconscious hostility to consciously beloved persons. The difficulty here for me in trying to understand my own migraines is that the destructiveness she speaks of *is not experienced as anger* - it is unconscious; how is one to verify its existence? Nevertheless, if we can entertain her explanation, perhaps we will see what it is in my class that would generate such unconscious rage and set in motion the migraine solution; and, extrapolating outwards, get a glimpse of something which is a feature of pedagogic encounters generally.

To this end, I have undertaken some self-analysis, therapy, supervision, and reading between then and now. One day when out walking I recalled a vivid dream I had had in early 1994, the first year of the course in question.

**Dream.** I am a junior member of staff at a university/psychotherapy centre and I have arranged for Freud to be awarded an honorary doctorate. Everyone is in the hall next door where Freud is giving a lecture; I am not there because I am to organise things in this room where he will be awarded the degree. The doctoral gown is hanging on a rack and I am rather disappointed with its colour: dull orange-mustard instead of, say, bright scarlet. The procession begins to fill up the hall. I am on stage with the other members of staff. With a start I realise that I'm wearing short pants, but

figure that people won't notice because I'm not in the front row. Freud and the other dignitaries walk slowly in. He is very old, like in the photographs of him in London. Suddenly he trips on the carpet and falls heavily - I know that he has broken his hip and that it is a fatal injury. He bellows in agony. Everyone stands watching quietly as the paramedics attend to Freud. He is given an oxygen mask (which looks like a plastic bag over his face) and placed on a stretcher. As he is taken out he smiles and waves weakly to us. I am devastated and wake weeping.

So, an unconscious phantasy that Freud's work needs resuscitation - indeed he needs the paramedics! - and also a fear that my small efforts to keep him alive in my classes are in vain. The other face of idealization too, destructive envy. There is a lot more to think about here, but what struck me as I remembered this dream was the difference in attitude between myself and the rest of the dream's audience. I was the keeper of the flame, the loyal disciple, whereas for the others Freud was one old-time writer among many: they were respectful seeing him dying, I was absolutely desolate. Perhaps this is something like what happened in my class. It is as though I was a Talmudic scholar while the students *seemed* intrigued but nonchalant by comparison. (I emphasize 'seemed', a different picture emerges later). To me the students were reluctant and, thus, I became unconsciously resentful.

And this is where the conflict became intense and intolerable. I was their teacher and (I now realise) for me a teacher has a triple responsibility: to hold the group<sup>4</sup>, to provide some of the excitement, and to model intellectual rigor. The problem with this phantasy of the ideal teacher, of course, is that this teacher can't be himself - I *had* to be enthusiastic and positive. But in this particular class it became too difficult because of my suspicions about the attitudes of the students and because of my particular attachment to the central figure of the course itself, Freud. Sacks describes the case of a migrainous nun: "Irritability, anger, sulking, etc. were not permissible in the convent, but migraine was" (1992: 167). The same was true of my classroom. As Bruno Bettelheim said:

It is not even enough to do the right thing at the right moment, it must be done with emotions that belong to the act. Again and again in our work we have found that what counted was not so much the hard facts as the feelings and attitudes that went with them. (1950: 7)

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4 'Holding' here refers to Winnicott's (1965) notion of 'the holding environment.' See also Wilfred Bion (1962) on projective identification where the therapist 'contains' the patient's projection which is in turn designated 'contained.'

(I should say again that I really don't expect my students to become devoted Freudians. Actually, I'm not put off by the student who remains sceptical. It is something other than agreement and disagreement that I find hard to tolerate.)

To get back to the problem of teaching. M. Robert Gardner's work is useful here. He has been a teacher of psychoanalysis for many years and he speaks about the affliction of the "true teacher": the paradox of the "furore to teach."

What is a furor to teach? It's a menace. It's a menace to teachers, to students, and to innocent bystanders. Teachers possessed by that furor are in trouble. Teachers devoid of that furor - if such can be called teachers - are in more trouble. Teachers are damned if they have it and damned if they don't. (1994: 3)

Appoint any energetic man or woman to the teacher's job and in short order that teacher will regard as indispensable whatever he or she chooses to teach and whatever method by which he or she chooses to teach it. (4)

Without the furor to teach, true teachers are most unlikely to move themselves or their students. But the line between helpful furor and harmful is full of lost edges and, consequently, of lost teachers and students. (6)

And then Gardner says something which rings true for my feelings with regard to my own teaching of Freud. He says:

I have found myself subject to the fullest furor to teach when consumed by the notion that *I know something . . . that my students not only need urgently to learn but are able to learn only from me* (1994: 9, my italics).

This is the knot as I see it thus far. Full of the furore to teach I put a lot of myself and my narcissism into the teaching of Freud. Students, naturally, responded with various and varying degrees of interest or lack of interest, antagonism, irreverence, industry, and slothfulness. Now comes the kicker; because of the furore to teach and my ideas about what it is to be a good teacher, I tried to engage enthusiastically while a part of myself, it seems, was hurt and furious at any signs of lack of interest or apathy mixed in with the students' response.

An earlier version of this article, presented to psychotherapist colleagues, ended at this point and with a speculation about developing my personal experience into a theory about hate in the teaching relationship, along the lines

of D W Winnicott's (1947) *Hate in the Countertransference*.<sup>5</sup> Could it be, I asked rhetorically, that in the apparently selfless and charitable act of teaching there is a built in hatred of others and of self? Or in Jacques Lacan's words:

We place no trust in altruistic feeling, we who lay bare the aggressivity that underlies the activity of the philanthropist, the idealist, the pedagogue, and even the reformer. (1949: 7)

In Winnicott's well-known article he said that there is good reason for the therapist to hate the psychotic patient, just as there is good reason for the mother to hate her baby. Surely it is plausible to build a similar case with regard to teacher and students? Students wear the teacher out physically, emotionally and mentally; students are ruthless and expect the teacher to satisfy all their desires; students have to be loved unconditionally, even their poor work and bad behaviour; students suck one teacher dry and then move on to the next one; students sexually excite the teacher who cannot act out these feelings; students resist Teacher A's strenuous efforts, but sing the praises of Teacher B to Teacher A; the teacher envies the students' freedom to be serious or not; and so on. Like the therapist and the mother, the teacher must learn how to hate the student. More of that later.

Expressed as a syllogism my thinking at this point went as follows. Teaching contains within it the teacher's hatred of the students; migraine headaches are produced by the non-expression of unconscious hateful and rageful feelings; therefore, it was the unconscious nature of my hatred as a teacher for my students which produced my migraine headaches. The strain of trying to adopt a false self<sup>6</sup> and not retaliate was too great, and I fell ill. (Consciously, of course, this is all most unreasonable.) This model throws light on the pedagogic relation - the teacher is, among other things, hateful - and it is also wholly in line with classic psychoanalytic theories about migraine; two good reasons to feel self-satisfied.

## Migraine

What does the psychoanalytic literature say about the dynamics of migraine? Fromm-Reichmann, as we have seen, spoke of her migraine patients as

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5 I knowingly elide here any differences between aggression, hostility, anger, and hatred. See Akhtar, Kramer, and Parens (eds.) (1995) *The Birth of Hatred*.

6 For Winnicott a 'False Self' relates to the environment "on the basis of compliance" (1960: 149). He says that the False Self may exist at any of five levels ranging from health to deep pathology. Winnicott also makes a point which is relevant to the issue of relationship which I am about to discuss: "*It is not possible to state what takes place by reference to the infant alone*" (145).

suffering from “unresolved ambivalence; they could not stand to be aware of their hostility against beloved persons; therefore they unconsciously tried to keep the hostility repressed, and finally expressed it by the physical symptoms of migraines” (1937: 26). While the average person “feels conscious anger against an adversary,” “the migraine patient . . . represses his hostility against consciously beloved persons” (28).

R.E. Money-Kyrle understood migraine as a defence against seeing something about oneself, for example, envy. Interestingly, he spoke of a patient “losing the ability to have migraine” (1963: 491). In other words, migraine is not something that attacks one, but something that one does.

Melitta Sperling said that “repression of rage and of the impulse to kill serves to protect both the object in the outer world and the patient himself. At the same time, the gratification of the impulse is achieved unconsciously in the symptom” (1952: 161). One of her patients reported beginning to develop a migraine on the way to analysis, but then the headache stopped. “So,” said the analyst, “you decided to let me live” (1964: 554). Sperling noticed that a manic-depressive pattern alternates with the migraines. It occurs to me that perhaps the migraine is a temporary alternative to depression.<sup>7</sup>

The writings of our psychoanalytic predecessors, then, suggest that “each migraine attack represents a repetitive unconscious killing of the frustrating object. There is no conscious awareness of this, no guilt feeling, and no depression” (Sperling, 1964: 550). The migraine is “a specific and early acquired attitude of the patient towards dealing with overwhelmingly strong destructive impulses” (556). A narcissistic injury, in Sperling’s view, produces destructive impulses which have a few possible means of expression: 1. attacking the object, 2. attacking the self (depression), and 3. somatic expression. This destructiveness, then, threatens to destroy the object relation, but the psychosomatic solution not only retains the object in reality, “but the tie is strengthened by the illness”. In short, through secondary gains, “it pays to be sick.” “By the very fact that he is sick, [the patient] can indulge himself and be indulged by others” (555). She puts it succinctly:

The onset of migraine in certain types of personalities . . . occurs in a situation which provokes intense rage *and at the same time does not permit the discharge of this rage in overt behaviour.* (1964: 551, my emphasis)

<sup>7</sup> Sacks confirms this. Not all migraine sufferers fit the stereotype of the obsessive “migraine personality,” neither are migraineurs particularly neurotic. “In many cases . . . the migraines may replace a neurotic structure, constituting an alternative to neurotic desperation and assuagement” (1992: 172).

I have found this most illuminating on the subject of my pedagogy. However, this formulation - let us now call it Model A - does not ring quite true. It smacks of premature theorization with regard to my migraine. For one thing, as its focus is only on the teacher's internal world, Model A is theoretically unsatisfactory in terms of explaining the pedagogic *relationship*. Model A addresses the teacher's countertransference but ignores the student's transference - the student's efforts to re-enact in the pedagogic setting relationships which have been learned in early childhood.

Sometimes we need to be hit over the head, as it were, before we can see something which was before our eyes all along. Migraine for me occurs in relationship with others.

In a co-therapy session Rebecca - a vivacious young woman, paraplegic after an accident which occurred after her marriage - was confronting her husband yet again: "Why don't we have sex any more? I'm still interested." Yet again, her husband hung his head, saying little. Then a sudden change; he raised his head, looked directly at his wife, and out poured a stream of cruel, cold truth-telling. "I'll tell you why. You think you're normal, but you're not. You won't hear this, but you're disabled. You just lie there, I have to do all the work. Do you know what it's like having sex with a handicapped person? It's not fun, I can tell you." Glancing at the therapists, "She's dead weight." "You're hard work, Reb, you're hard work." And so on for some considerable time. Then a tearful silence broken eventually by Rebecca in her characteristic up-beat, appealing voice, "Yes, but that's just an excuse, we can try can't we?" The session came to an end, and as the couple left the room I was struck by a powerful and debilitating migraine.

Here the pain, rage, humiliation, sweetness, desperation, frustration, fear, horror, and heartbreak in the room became too great for me to handle. Taken aback, I identified with everything, it seemed: his feelings about living with a paraplegic spouse, her hurt at hearing herself described in this way, and his desperation at her denial. Stunned into silence by the suddenness and the sheer magnitude of this emotional load, I was unable to relieve it. (Interestingly, while I got a migraine for my troubles, their relationship began to improve shortly afterwards.)

This ties in with another weakness in Model A which is that I have in fact never been a complete stranger to my anger. It is true that the teacher-role discourages the acknowledgment of angry feelings towards one's charges, but, nevertheless, I have often felt angry with a student. Sometimes it's hate, yes, but at other times it's other emotional circumstances which can produce



migraine. During the period when I was pondering this question it happened that a small and not uncommon therapeutic incident caught my attention and enabled me to disrupt the initial explanatory model.

Sitting with a patient I remarked, "I wonder whether being the responsible oldest son in a large family has something to do with your only feeling good when you are helping your friend with a problem." As I said this he glanced very briefly at me out of the corner of his eyes. Immediately I felt a tightening in the migraine spot on my left temple.

This type of interaction must have happened many times inside and outside the therapy room, but for once I was able to notice it and think about it. What did his glance suggest? He is angry with what I have just said; it is wrong, unwelcome, or mis-timed. Although he is not about to let me or himself know that he is angry with me, he communicates it nonetheless. As Freud said in the case of Dora:

He that has eyes to see and ears to hear may convince himself that no mortal can keep a secret. If his lips are silent, he chatters with his finger-tips; betrayal oozes out of him at every pore. (1905[1901]: 77-78)

What happened in the little incident with my patient? It may be, of course, that my detection of his anger produced an equal and opposite anger in myself, anger which because it was unconscious could not be expressed and therefore became a migrainous symptom. This explanation is in line with Model A.

But this might be quite wrong. Is it not equally plausible for an angry signal to produce a fearful, self-protective response? What I now think occurred is the product of my strenuous *post hoc* picking apart and piecing together of what was but a momentary spark of quite banal human interaction. Here is an alternative analysis of that instant:

I made the interpretation.

The patient briefly, and probably largely unconsciously, felt angered, his glance showing this for he who has eyes to see.

I only just picked up on the anger but, because of the unconscious nature of the perception, was quite unable to adopt either a fight or flight response, so froze.<sup>8</sup>

I felt pressure in/on my temple.

In the case of the young woman telling me about the rape of her sister, it might be that her hostility produced an unconscious fearful response in me. (This interpretation fits with her distinctly psychopathic tendencies which revealed themselves as the therapy progressed.)

Let us call this Model B. Although one can never *know* about such things, this thought has enabled me to move beyond the confines of Model A.

Based shakily, it is true, on an  $n = 1$ , it occurs to me now that migraine is a psychosomatic response to unsuccessfully repressed material in an intersubjective context.

I have found Sacks's comprehensive *Migraine* (1992) a most useful read. On the incidence of migraine: "A substantial minority, perhaps one-tenth, of the population experience fairly common and readily-recognised cephalgic migraines" (120). He notes the variety of symptom occurrence in migraine - headache, nausea, aura, lethargy, *et al.* occurring in a variety of permutations - as well as the variability of duration and level of the nervous system which is affected. Migraines lie "in the middle range - between the vegetative disturbances and the cortical disturbances" (109). Sacks reviews the vast array of external and physiological stimuli which may produce migraine. "Migraine is conspicuously a psychophysiological event" (1992: 110). I do not concern myself with "circumstantial" migraines in this article, but rather with "situational" migraines; what is important for our purposes is the *psychosomatic* nature of migraine. Migraine, says Sacks, is an "eloquent and effective . . . oblique expression of feelings which are denied direct or adequate expression in other ways" (226). He speaks of chronic migraine sufferers (of which I am not one) as being "caught in a malignant emotional 'bind'" (1992: 165).

Perhaps Sacks is right when he asserts that "migraine may be summoned to serve an endless variety of emotional ends . . . . If they are the commonest of psychosomatic reactions, it is because they are the most versatile" (1992: 166).<sup>9</sup>

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8 Sacks speculates that migraines are instances of the "passive, parasympathetically-toned, protective reflexes such as many animals employ to environmental or internal threats - cold, heat, exhaustion, pain, illness, and enemies. All such reflexes, like migraine, we have seen to be distinguished by regression and inertia, *in contrast to fight-flight responses*" (1992: 226, emphasis added).

9 Sacks lists six uses of migraine: recuperative, regressive, encapsulative, dissociative, aggressive, and self-punitive (1992: 213-216).

## Countertransference

Psychosomatic psychopathology in the therapist must be the subject of ongoing analysis and self-analysis. Quite obviously, I must continue my efforts to transform my migraine responses. But I now wish to talk about the possibility of productively employing a psychosomatic response such as migraine in the therapy room and the classroom. This brings me to countertransference, and the definition I wish to use is that of Joseph Sandler: countertransference is “a compromise between [the therapist’s] own tendencies or propensities and the role-relationship which the patient is unconsciously seeking to establish” (1976, 47). Let’s be clear here. Countertransference, Sander is saying, does not belong to either the patient or to the therapist; it is a joint production, the nature of which depends on what each unconsciously brings to the interaction. The patient tries to get the therapist to behave in a particular way (a role), and the therapist responds in a way which is dependant on his or her own characteristics (‘stuff’). To generalise (unless we cling to the spurious notion of the completely analysed therapist) the tendencies or propensities of the therapist necessarily include his or her own pathological bits. These must and do get activated at times by the patient. And, what is more, these activated symptoms are signs which have meaning.

But we therapists are trained to recognise positive and negative transferences. Also, it is increasingly becoming accepted among psychotherapists that countertransference can be a useful tool. Why is it that in the examples cited in this article I was knocked out of kilter in the way I was? It is not the case, I believe, that I am generally poor at coping with transference and countertransference. Much of my work involves listening with my third ear<sup>10</sup> Rather, in these particular instances I was caught unawares: blindsided, mugged, if you like. It is as though there is a bandwidth of unconscious communication which I detect only preconsciously, psychosomatically. The unconscious can by definition not be observed, but its effects can seep through because repression is never complete.

The powerful disavowed feelings sneaked up on me precisely because they had been imperfectly repressed. Unexpectedly and indirectly semi-expressed, I not-quite-noticed them out of the corner of my eye - like a phantom. It is important not to limit this failed repression to the patient alone. I would reconstruct a quote from Sacks (1992: 26) as follows: *Migraine is an eloquent and effective oblique expression of feelings arising between me and someone else which are denied direct or adequate expression in other ways.*

<sup>10</sup> Theodor Reik (1948), *Listening with the Third Ear*.

Winnicott (1948) speaks of 'impingements' as another's interruptions to our going-on-being - like when a ringing telephone disturbs one's sleep. In the instances I have given, though, it is like being woken by a telephone which *has been* ringing but, by the time one wakes, is silent. Startled awake, what's going on! As Sacks says, migraines "represent disorders of *arousal*" (109). There is a retuning of mood and autonomic status over the course of the migraine. That is its function - to return me to a condition of going-on-being where I can work. Think of a spinning top. A small tap in the wrong direction causes chaos in the movements of the toy; it must come to complete rest before it can resume going-on-being.<sup>11</sup>

In order to be able to deal with such affective situations one needs to be able to have enough distance to be able to perceive what is going on. Then there will be the possibility that one can help oneself as well as help the patient.

Here is an example:

During a session I developed a sensitivity in my migraine spot following the patient's description of a powerful dream he has had since childhood. The dream is of the huge planet earth whirring very fast only inches from his face and body; it is an overwhelming dream of awe and insignificance. A little later in the session he described an old symptom of his - a difficulty breathing, a snatching at breath. He had subsequently found out that it is a medical condition, but one brought on by 'stress,' he said. (In my words, it is a psychosomatic expression at a physical weak spot of some emotional difficulty.) It is less debilitating for him these days, he continued, because 1. he relieves it by taking a few deep breaths, and 2. he realises that he's stressed, something that he has been unable to recognise in himself although others do notice it. I silently put all this together with my own self-work and then commented: "It has meaning, then, and you're learning to read it."

Remarkably, as this discussion progressed, so my migrainous sensation lessened, then disappeared, accompanied by a sense of well-being. My patient too reported feeling calm at the end of the session. I understand it as follows. Initially I was unconsciously possessed by the helplessness and destructiveness of my patient. Just as he was unaware of his 'stressful' feelings, so I did not experience the feeling, rather a substitute: a migrainous sensation. Able to

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11 This image fits with the developing cybernetic model of psychosomatics: 'psychobiological disregulation' which integrates developmental biology, developmental psychology, and the biomedical sciences with relational models of psychoanalysis. For a review see Graeme Taylor (1992).

reconstruct this in my mind I could offer the affirmative intervention<sup>12</sup> which, small as it was, provided relief by promising some hope to each of us and by allowing me some analytic distance from my own helplessness (and my destructiveness). Our exchange functioned affirmatively for myself too with regard to my own psychosomatic situation. (Harold Searles [1975] has written movingly about the patient as therapist to the analyst.)

A question raises its head: could this not all simply be a projection on my part and have nothing to do with my patient? Thomas Ogden has made the distinction between projection and projective identification clear. Projection is like the first stage of projective identification, viz. "the fantasy of projecting a part of oneself into another person and of that part taking over the person from within" (1979: 358). Experientially, though, projection is different to projective identification. In projection one feels psychological distance from the object, while in projective identification, one feels "profoundly connected" with the object (359). In the case in point I would say that I identified with my patient's projection of his helplessness and the destructive part which threatened to obliterate him.

We have dealt a lot with hatred in this article. Winnicott, that most maternal of therapists, insisted that hate be acknowledged by the mother in order for child to feel real.

What happens is that after a while a child [here of a broken home or without parents] gains hope, and then he starts to test out the environment he has found, and to seek proof of his guardians' ability to hate objectively. It seems that he can believe in being loved only after reaching being hated. (1947: 199).

Meeting hate with consistent love is worse than no help. In his book *The Art of Hating* (1991) Gerald Schoenewolf says that the way to hate well is as follows: 1. distinguish between 'subjective' and 'objective hate,'<sup>13</sup> 2. risk verbalizing the hate, and 3. bear the consequences of that verbalization. Subjective hate belongs to the mother (teacher, therapist) and needs to be resolved through self-analysis, supervision, or further therapy. On the other hand, "hate *that is justified* in the present setting has to be sorted out and kept in storage and available for eventual interpretation" (Winnicott 1947: 196). "Objective

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<sup>12</sup> An affirmative intervention is, according to Bjørn Killingmo, "a communication which removes doubt about the experience of reality and thereby re-establishes a feeling of identity . . . . Affirmation and interpretation address different experiential modes" (1995: 503).

<sup>13</sup> Let us leave aside for now the myriad of philosophical problems inherent in the word 'objective.'

hating resolves the conflicts that breed hate and transforms hate into its alternative feeling state, love" (Schoenewolf 1991: xii).

There are many ways to deal with hate. To hate well—thereby transforming subjective hate to objective hate—one can use: questions, commands, explanations, puzzles, out-silencing the patient, out-crazing the patient, or one can use what Hyman Spotnitz (1976) calls the "toxoid" response. This is like immunization where individuals are injected with a mild case of the disease – "carefully 'treated' to destroy their toxicity and to stimulate the formation of antibodies" against the disease proper (1976: 50). Here is an example of employing the toxoid response in the classroom.

A year after the semester of the high incidence of migraines in my masters class, I taught the course again – this time more self-aware about my own phantasies. One day during a discussion with the students about the progress of the course I figured out how to express my hatred. "Sometimes I catch myself lecturing and advertising as though I need to convince the class of something. I'm not sure what it's about but I really don't like feeling like a used car salesman. How does it seem to you?" A student spoke up: "It doesn't feel to me that you're trying to sell me something, but I do have some anxiety about how vast the field is and whether I'll ever get on top of things."

Others joined in expressing their worries. It became apparent that my furore to teach was making the students more anxious, and that I was misreading their anxieties as reluctance. Needless to say, the flow of the class was set in motion again without my having to resort to migraine.

Although my learning experience is far from over, there may be a lesson here about a potential therapeutic ability. My own weak spot may be tamed in the sense that its (transferential) meaning will be accessible enough so that as a therapist I can illuminate or contain something for myself and the patient and simultaneously stop the migraine. Further, it may be that the migraine symptom will become such a refined tool that its waxing and waning can be used to measure the extent of repression and denial or insight and relief in both the teacher (therapist) and the student (patient). Countertransference is a deep pool.

There is an old joke that goes:

A man goes to a doctor and says, "Everything's wrong with me, but I don't know what it is. I touch my head and it hurts. I touch my chest and it hurts.

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I touch my leg and it hurts. What's the problem?" The doctor examines him and says, "Your finger's broken."

Sometimes I think our work as therapists is a bit like this, except in our case the patients do have hurts and we are the ones with broken fingers. The head, chest, and leg come to stand for what the patient brings to the therapy, and the hand with its broken finger represents the flawed person of the therapist. Now the joke is at the expense of psychotherapy and the paradox of the therapist's own psychopathology.

### The Nature of Inquiry

Is it necessary to add a note of modesty here? Far from a solution to what Freud called "the mysterious leap from the mind to the body," this article is simply an account of how my thinking has developed with regard to my own psychosomatic experience.

I walk a fine line here in that I might be seen to reveal more of my own psychopathology than is seemly, but how else could I have demonstrated my point? I've shown quite enough of myself here and it may be unwise to go further in public. The psychoanalyst Rivka Eifermann (1987) has written about how a friend called her "crazy" for discussing her self-analysis before an audience. (Where is the line between collegial discussion and acting out?)

In writing this article I have found it useful to borrow some methodological considerations from Jane Gallop's *Knot a Love Story*. To paraphrase her, I wager 1. that I am not a paranoid or a hypochondriac, and 2. that the incidents I describe are representative of a range of pedagogical and psychotherapeutic experience. Gallop introduces the term "infantile pedagogy" by which she means that "teaching in general is informed by largely unconscious reactivations of powerful childhood pedagogical configurations, which of course, in their specific forms vary with the individual" (1992: 6).

I fear that, if I tie up more threads of my narrative, what remains of its spontaneity and openness will be compromised. Let me summarize this work-in-progress for now: certain emotions, when imperfectly repressed and thus indirectly expressed in the classroom or in the therapy room, function as impingements to my going-on-being and produce migrainous symptoms in me. I have ventured to suggest that this says something not only about myself, my students, and my patients, but also about migraines, pedagogy, and psychotherapy. Stated as three aphorisms:

*The world of the classroom is full of hate, but very few teachers know how to hate well.*<sup>14</sup>

*The migraine is both an intersubjective event and an encounter with a poltergeist.*

*Countertransference is feeling another's pains with one's own broken finger.*

I said at the start that I have tried to use my psychosomatic response to a teaching situation in order to learn more about four things: the nature of the pedagogic relationship, migraine attacks, actually using this symptom in psychotherapy work and teaching, and the inquiry. A few thoughts on the last of these.

In the process of developing a question (Why am I getting migraines in this class?) into a line of inquiry and then into a research article I have for many months alternated between floundering aimlessly and grabbing onto passing debris (personal experience of migraine, pedagogy, and psychotherapy, as well as reading in these literatures). That process has been one of intuitive leaps, serendipitous happenings, rational thought, as well as the creative activity of writing.

When a story is too neat in construction, too smooth in the telling, we may suspect over-intellectualization. Indeed, the Nobel Prize-winning biologist P. B. Medawar once famously asked whether the scientific paper is not a "fraud" because "it misrepresents the process of thought that accompanied or gave rise to the work that is described in the paper" (1963: 228). So in this article I have tried to convey the development of my thinking, but the result does gloss over the backtracking, the leaps, the pauses—there is a limit to how much one should test the goodwill of one's audience!

There is no way to do research, i.e. what we call "research methodologies" are stories told after the fact to try to make rational a substantially irrational process.

I have found that conducting research is a bit like going for a swim: floating, getting out of one's depth, diving below, treading water, swimming strongly. This is not like swimming in a river which has a source and a mouth: hypothesis, experimentation, results. Rather, it is like swimming in a large pool. There is no beginning or end, just water and endless shoreline. One gets in, moves around in the water, and after a while one gets out. I do so now with a final aphorism *à la* Winnicott:<sup>15</sup>

*There is no such thing as a research method.*

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<sup>14</sup> Adapted from Gerald Schoenewolf: "The world is full of hate, but very few people know how to hate well" (1991: xi).

<sup>15</sup> "There is no such thing as a baby" (1952: 99).



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