My Closest Friend: Love and the Search for the Lost Maternal Object

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Abstract

This paper discusses our fundamental need to have an intimate ally, a close friend in the form of an internalised, loving and loveable object. It will explore the origins of loving feelings as they relate to the infant's first love affair with mother and how this translates into relationships in later life. It will be argued that many patients in therapy will be needing to get in touch with the preverbal. It will be suggested that training in an infant observation is useful in gaining the skills to treat the infantile aspects of such patients. Projective identification and countertransference will be discussed, as well as the process of breaking through the false self to recognise the deep suffering that the baby and the small child faced as a result of being raised by a narcissistic parent. It will be suggested that psychotherapists may unconsciously be searching for their lost maternal objects in their patients, hence the need for the therapist to have had sufficient therapy in order to be attuned, but separate.

Introduction

Dream on little one, dream on.
Dream on little one,
dream on,
That's all there are, just dreams.
It isn't't what they promised you,
when you were only one.

Dream on little one,
dream on.
Where's the partner and the kids?
It isn't what they promised you,
when you were twenty one.

Dream on little one,
dream on.
Where's all the joy and love?
It isn't what they promised you,
when you were thirty one.

Dream on little one,
dream on.
Unfold those angel wings,
and fly up to the soft white clouds,
So high above the sun.

Dream on little one,
dream on.
Now you are free from pain.
It's just what Nanna promised you,
When you were only one. (Lugton: 2005)

The poem, with its sad and lost tones, reminds me of how I came to write this paper. I was sitting on some steps in a market in Provence sipping an iced drink in the searing heat, and thinking about an argument I had just had with someone I had imagined was a close friend. I noticed a group of young travellers, about twenty-five of them, mainly men. Some would describe them as gypsies.

They were poor, shabbily dressed, a little dirty and had a desperate edge to them, but they had one thing in common. They all appeared to have a dog, and their dogs were so healthy, seemingly better cared for than their owners were. Somehow these dogs seemed to make their owners complete. Each time the dogs got into a spat, their owners were very protective, as if their dogs were their closest ally, their closest friend, important for their survival. Were their dogs the gypsies' closest friends? Where had the gypsies come from? Where were their families? Did anyone other than their dogs care about them? Had they ever been loved? Looking at them that afternoon made me wonder about the meaning of friendship and love.

What is friendship and what is love?

I have always thought that one's 'closest friend' was the person one would sit on the cliff edge with, if one knew that the end of the world was coming. In other

words, a friend who may or may not be a lover. One's closest friend, often a partner, maybe the person you imagine having a baby with. It could for many, perhaps the gypsies, be a pet. When a cat snuggles up to a person on the bed at night the words "Sweetheart, I love you so much" are uttered as the cat gazes adoringly at its owner, whiskers quivering. The feeling towards her is so gentle, so pleasurable, so safe, so easy. But really, a cat is just like a baby, no words, just unconditional love, dependent attachment.

There is also the idea of God's love: what is that? Unconditional love, what is that? I think any type of love invokes a strong imaginary component, perhaps based on a type of faith. Barrie's most highly successful play *Peter Pan* demonstrates the powerful fantasy element involved in love and childhood friendship (Chaney: 2005: 330-331). Robert Burns (1759 -1796) said "For if the truth were known, love cannot speak, but only thinks and does".

Our first, close friendship or love affair, as we all know, begins with an idealised, symbiotic union with mother, where mother knows everything about the baby and the baby imagines he knows everything about mother. This is truly projective identification and most would agree, love.

Perhaps the best way I can describe unspoken human love and that first experience of idealised love, is to quote something I wrote during an infant observation. I called the particular observation 'Reverie/Maternal Preoccupation'.

> As soon as Matthew was at her shoulder his lips opened and he smiled and looked very pleased. He then nestled under her chin and his lips opened and he laughed, and his eyes rolled up into his head. It reminded me of an orgasm. There was so much pleasure. I laughed and I said, "He looks very happy, he's smiling," and Sarah laughed, and said "Is he? You little devil, you gorgeous one. I'm in love with him." He snuggled in even further and I thought, he'll never go down now, but down he went. "I think I'll put him on his tummy this time," said Sarah, and he lay there eyes wide open with his fingers in a different position over the thumbs. He turned his head and gazed at her. I knew it must be hard for him to know that they would soon be separate (Lugton: 1993).

I feel very touched, moved each time I remember this scene. It is so heartfelt, mostly unspoken as Burns observed.

But close friendship and love in adult life is different from that between a mother and her baby. It is no longer idealised with the friendly, loving feelings far more complex. Adult friendship involves a degree of separateness and the subtle

negotiation and balancing of love and hate. Even though one may imagine that one's partner knows everything about one, it is not the case, nor is it necessary. One should be able to retain something for oneself, to be one's own closest friend, in order to negotiate one's travel into, and throughout, adulthood. The ability to have become somewhat separate by adulthood is crucial to healthy relating as my discussion about development a little later will illustrate.

I think the concept of respect is also relevant to friendship and love. Respect is a type of empathy, an ability to genuinely value another, and there is also more agreement on what respect is, hence it is more quantifiable. Many people who have not received empathic attunement early in their lives, are very sensitive to disrespect (Winnicott: 1996: 3-13) .

Being in love is something different again, and too big a subject for this paper. However, I recall Julianne Moore the actress as saying, "to be in love is to be in a permanent state of anxiety", possibly because as D. H. Lawrence said, "the great emotions like love are unspoken" (Steele: 2004: 158). However, the unspoken can lead to misassumptions often involving phantasy, hence anxiety.

In the end love is more likely to be an idiosyncratic concept, particular to each person and each situation. Oscar Wilde in particular is a great illustrator of this point. I think the words that have made most sense to me lately as to why loving, adult friendships are important, were beautifully scripted in the film *Shall We Dance.* Susan Sarandon, playing the role of the wife at risk of losing her husband, talks to a private detective about marriage and adult love. She says:

> We marry because we need a witness to our lives. You need to know that your life will not go unnoticed, because your partner will notice it. Your life will not go unwitnessed because your partner will say "I will witness it. I will be your witness."

This is not idealised love, but something much more realistic and sustainable. The psychoanalytic literature is in general agreement that the infant who experiences his mother as his closest ally, a person who would love him and protect him, witness his life unconditionally, has a greater chance of moving to the point of mature relating which involves the capacity to form friendships and to love and be loved.

When Mother is not good enough

It is frightening, and I think disturbing, to realise that there are many infants being raised by parents who cannot empathise with their children, who cannot truly

acknowledge the existence of the other, and therefore, are unable to love them in a way that allows for healthy psychological development. I would describe them as superficial, perhaps "false self" parents who, for reasons of their own, cannot be a loving and loveable witness to the development of their children. The repercussions of this may be many (Anthony: 1983; Hopkins: 1987; Brown: 2002).

In very general terms, the child may go on to being a compliant child, more often than not empathising with mother, not empathising with himself, often accommodating to the environment, rather than being part of it and finding himself in it. Winnicott's "false self" may emerge, with the child forever on the look out for other people's feelings, rather than exploring his own. This is when feelings may be converted into symptoms such as psoriasis or something akin to that, the bleeding burning skin (Bick: 1968).

The Winnicottian concepts of "true and false self" are useful. They invoke the concept of a split at the very heart of being. Winnicott says:

> The true self is the theoretical position from which the spontaneous gesture and the personal idea emerge. The spontaneous gesture is the true self in action. Only the true self can be creative and only the true self can be real . . . . The true self comes from the aliveness of body tissues and the working of body functions including the heart's action and breathing. It is closely linked with the idea of Primary Process and is, at the beginning, essentially not reactive to external stimuli but primary (Winnicott: 1962; Winnicott, 1990:148).

Christopher Bollas has extended this concept by stating: "We use the structure of the mother's imagining and handling of our self to objectify and manage our true self" (1987:51).

Winnicott explains how the the "false self" at one extreme sets up as real a defensive structure whose function is to hide and protect the true self. Where the mother repeatedly fails to meet her infant's gesture, the true self doesn't become integrated in subsequent development but, in a sense, must never be found, for that would mean a total sense of annihilation of being. She substitutes her own gesture, which is to be given sense by compliance of the infant. This compliance on the part of the infant is the earliest stage of the false self (1990:145).

Michael Fordham, a Jungian analyst, describes things differently, probably because he calls the early self the "primary" self, and sees the infant from the beginning as a person, separate from mother. He says:

> At times the fear of the meeting between expectation and object is not satisfactory. The infant becomes distressed, consequently tries to defend himself

> against his distress, and ego development is impaired. At times the rage and fear are so great that the infant erects defences of the self which protect him from disintegration (1947:169).

Whichever language you are comfortable with, these are powerful words. Winnicott and Fordham have clearly described something that I am familiar with in many transferences. For a patient to be so disconnected from himself is a personal tragedy.

So what happens next? Do we all need a safe internal maternal object? The answer is, of course we do!

The lost maternal object and loneliness

I believe that everyone, in these very narcissistic times, needs more than ever, a safe, reliable, and emotionally attuned, maternal figure. If it has not been internalised in infancy, I think there can be a lifelong search to fill the void. People who have an insecure attachment style may not be able to adapt to change, especially separation, as well as those with a more secure attachment style (Ainsworth: 1989).

Divorce, for example, may evoke powerful feelings. Dells and Phillips in *The Passion Paradox* state:

> Romantic loss reawakens the primal fear of abandonment. Babies instinctively feel abandonment because their physical survival depends on having a constant caretaker. In a sense, we are all like babies when we feel abandoned, only our fears centre on emotional survival needs. The anguish of romantic rejection tells us something about the strength of these needs (1990:97).

The principal message that many patients convey, both verbally and non-verbally, is being lonely: not something easily described, but just a sense of a deep inner aloneness. We can be naive about the inevitability of loneliness: the fact that unlike when one is a baby, as an adult it is normal to sometimes feel, or be, lonely.

David Schnarch, in *A Passionate Marriage,* says:

> Eventually we must grapple with the immutable separateness of being human. Loneliness is a basic condition of our existence. It is part of understanding and appreciating intimacy and, when correctly handled deepens and extends our humanity (1997:402).

Clark Moustakas, in his book *Loneliness*, writes "To love is to be lonely". He says:

> We confuse existential loneliness and loneliness anxiety. Loneliness anxiety is our common but necessary fear of being alone, our normal neurosis, our alienation from ourselves. It surfaces in the pervasive 'never be lonely' themes in modern society and what we now call 'fears of abandonment' (1961:101).

The psychologist Eric Fromm (1941) says that intimacy is the way that we escape from "the prison of our separateness" (quoted in Schnarch: 1997: 403). Fromm presumed an acceptance of existential loneliness, rather than a denial of it. His understanding is that the healthy person acquires the ability to manage the feelings of being alone. A person who has not been able to find their true self in life, who has not internalised a comforting maternal object, can actually feel traumatised if they do not have a partner.

I am reminded of a patient; I shall call him John. John came to see me after spending four years in bed. He called his condition "chronic fatigue syndrome". Others might call his state of mind adult, anaclitic depression. During the initial stages of John's therapy he would text me confirming an appointment or to let me know something about his life. I replied once or twice, although reluctantly, and then I began to wonder why he did this. Finally, about two months into the therapy, I plucked up the courage to say that I was wondering what the text messaging was about. He smiled and said he didn't really know. He needed to do it for some reason, but he couldn't find the words to explain it. I said that the text messages were held in my phone and I wondered whether it was his way of always being with me, reminding me that he existed so I would not forget him. Perhaps it was something to do with his Dad.

He thought about this and said "Yes, I think you might be right". His eyes were very moist, but he was not able to let the tears flow. My eyes were moist as well. I felt connected with him.

John then talked more openly about his childhood. When he was one, his father, who was a postman, was gaoled for taking cash out of envelopes, ostensibly to feed his family. He went to gaol for nine months. John, again, could not find the words to explain his loss. When he was four his father had tried to kill himself with a shotgun. He succeeded in damaging his chest and shoulder, and made two large holes in the living room and dining room walls. All John can remember is coming home and finding his grandfather plastering up the holes. Shortly after that, his mother left the house with the children. John reconnected with his father much later and they are now friends. After that session the therapy took a

leap forward. I think prior to that, John had been frightened that I would not be able hold him in my mind, remember him, especially when I did not speak.

Repercussions at various developmental stages

The DSM-IV is relevant to this discussion. It states that the Dependent Personality Disorder is among the most frequently reported personality disorders encountered in mental health clinics. Two of the symptoms are

> 6) Feels uncomfortable or helpless when alone because of exaggerated fears of being unable to care for himself or herself.
>
> (7) Urgently seeks another relationship as a source of care and support when a close relationship ends (DSM-IV: 669).

It is not surprising that a person might develop these symptoms, if he or she has been in a fused, dependent position with a mother who, consciously or unconsciously, wants her child to remain a child rather than mature.

So at which points are those who have had an experience like John, for example, at risk of not being able to contain a lonely or alone state of mind, not able to feel that someone is alongside them, and in adulthood, urgently need a real life partner? In other words, at risk of developing dependent traits, or worse still, a personality disorder.

Oral Phase: For the developing infant, object constancy is generally reached at eight months, when, if mother goes out of the room, the infant has the capacity to hold onto an image of her in his mind: the depressive position, holding the good and the bad breast alongside one another (Klein: 1940: 347).

How must it be for an infant who has not had the empathic, loyal, trusting experience? How do they manage this? Probably not well. If he has not been allowed to be a little separate, does he get thrown again and again into the "paranoid-schizoid" position, not having the internalised mother-infant couple to contain his anxiety? The false self may by this time be emerging (Winnicott: 1990: 145).

Anal Phase: For the anal infant control is the central issue. For the first time, the young child may be able to do a poo in the potty, a very real gift to mummy. What happens if mother is not attuned to the toddler's struggle and delight at finally being able to control this part of his body? He will need to sense the congratulatory empathy of the mother, a shared joy. I suggest that the mother who feels that her child belongs to her or in phantasy, is part of her, may enviously

attack anything which does not involve her and belongs to her toddler. Often patients who are stuck at this stage may be quite withholding, secretive, for fear that they will be intruded on, have things stolen from them.

Oedipal Phase: For the oedipal child, a myriad of sexual issues are beginning to surface where parental attunement and empathy are again critical. The process of falling in love with his mother, and in fantasy, killing of his father, finds the little boy desperate to find his own identity with much confusion and conflict about "Is this OK?". If the parents cannot tolerate his outbursts of rage, again he may be left floundering, reverting back to only pleasing his parents, rather than having his own little identity, with the false self further developing.

These oedipally fixated patients can become enraged, particularly in groups, when for example, a woman fancies someone else. They may also develop fetishes, for example, with the little boy identifying too much with his mother and cross dressing. I suggest that gender difficulties may also emerge where the child may not be able to tolerate difference and will prefer to be with someone who is the same. This can be revisited in the genital phase.

Genital Phase: During the genital phase, when oedipal issues arise again, the adolescent begins to slowly participate in small acts of sexual behaviour. The adolescent girl may be in a constant, exhausting battle with her mother. Some say the task of adolescents is to murder both the parent of the opposite sex and the marriage, but of course, if they do, it is disastrous. There is a lot of pushing and pulling and the parent with low self esteem can find the process close to annihilating.

Hormonal adolescents face head on the task of finding their own identity, struggling to separate from their parents. The narcissistic parent may need, wittingly or unwittingly, to inhibit their child's need and rightful destiny to become a sexual being. They don't know how to handle the young person who is becoming sexual. The child who has previously been so accepted and so loved and loveable, feels unable to repress the sexual aspects of themselves and at the same time feels a pressure to remain a child. The adolescent can feel a type of stuckness, a pull from the parents to be a child, an impulse from himself to become an adult. This feeling of impasse may generate an unbearable sense of being alone and lonely. Suicidal ideation or actual suicide may follow.

Adulthood and Marriage: The marriage of an adult child is a time where it is sometimes hard for narcissistic parents to set aside their own phantasies about who their child should be with, and to respond positively to their child's choice of a partner.

Unwittingly, the child may make an unconscious choice to be with a partner who is similar to the parent who is most problematic. After which there may be a struggle, often for many years, to convert their partner into what they think they need. This is an unconscious attempt to change the internalised object they remember from childhood. Again, a search for the lost maternal object.

Becoming a parent: As I have discussed previously (1994), the main danger lies in the parent overcompensating for what she believes she did not have as a child (Clulow: 1982). Alternatively, a mother may feel great anger towards her baby if she is expected to idealise her baby. If this is not understood, her repressed rage and murderous phantasies may contribute to a post-natal depression. In either case, she may enviously attack her relationship with her baby to avoid the baby having more than she had herself. This is often a time that mothers or couples present for help, as intuitively they fear that they may not do a good enough job. With support, however, they often are good enough mothers and parents (Clulow: 1982).

Menopause/Retirement: Unfortunately, this period often comes alongside the couple's parents dying, or friends developing terminal illnesses and becoming vulnerable. It can be a threatening constellation of events when one or both partners may develop a depression and neither can contain the other as they formerly did. It is not surprising that without a solid, internalised, comforting, maternal object, fifty-year-olds can develop a very serious, almost psychotic depression, especially if they have a tendency to be melancholy. I think this is also the stage where there is the danger of an affair, a desperate need to feel love or be in love, as time is running out: mid life crisis time. In many instances an affair could be described as an erotomaniac defence against retapped early anxiety and depression, even anaclitic depression (Spitz: 1965). The experience of the loved object turning away, or being experienced as lost, leaves the other vulnerable to seeking love, touch and warmth elsewhere. Again, an example of a search for the lost maternal object (Lugton: 2004).

Whatever its origins, the wish to be in an idealised "in love" state of mind, similar to that with mother, can lead to sexual acting out and serious consequences. So often the fifty-year-old, menopausal woman may get entangled with a dark, smouldering charismatic, Darcy type, the narcissist who may turn out to be a rigid, controlling and dominating nightmare - a baby in adult clothing. This baby in adult clothing has a powerful, familiar pull, as he represents the narcissistic parent (Reich: 1986).

It is clear from the preceding discussion that many of the transferences that present themselves in the consulting room are not only difficult to understand but difficult to tolerate and manage (Joseph: 1985); hence the requirement that therapists are appropriately trained and suitable for engagement with infantile aspects of their patients.

Training

Psychotherapy is a co-operate, conciliatory relationship where the therapist, ideally, needs to be in a state of mind where he or she can suspend critical judgement, at the same time being aware of what is at play in their own superego. This attitude creates a space in which the therapist has more chance of creatively engaging with the conflicts and suffering that patients bravely bring. Most clients feel critical of themselves, feel guilty and ashamed and may have difficulty putting the issues into words.

So many of our patents have been traumatised during the first year and so often are in that early traumatised state of mind in our presence (Hopkins: 1987). As such, we have nothing to go on except our experience of being in the room with them. Often this is a silent time, when much is being communicated and needs to be held, digested and understood. Sometimes it will be the first time in his life that the patient will have felt listened to and understood.

One of the most useful training experiences to prepare oneself for working with infantile transferences is to undertake an infant observation based on the Esther Bick method (Bick: 1964; Tuters: 1988).

Learning through infant observation

The merit of using aspects of the method of infant observation in the therapy setting with adults has been discussed widely (Bick: 1964; Covington: 1991; Dowling & Rothstein: 1989; Freud: 1975; Harris: 1987; Henry: 1984; Miller,Rustin & Shuttleworth,:1989; Tuters: 1988).

The experience of completing a five-year infant/child observation was critical to the development of my skills as a therapist. It both fascinated and frightened me. It also taught me just how sensitive an infant is to his mother's engagement with him, and how important this is in one's start to life. Fortunately, the mother I worked with was mature and used to babies, Matthew being her third.

I emphasise that the infant observation training experience is very different from bringing up one's own children. The observer needs to be separate, and aware of that separateness (Coulter: 1991). Critical is the fact that because the first year of an infant observation is without language, it is usually only the mother who is attuned to her baby's communications. As such, it teaches the observer a great deal. This is when the mother is truly a witness to her infant's life and the observer is a witness to the mother's and infant's lives.

The "infant observation" method is simply the way observers are taught to watch and listen. As therapists we are also observers. Rather than observing a mother and her infant the therapist is observing the therapy dyad: the therapy/mother and the patient. Not an easy task. I think if this can be achieved there may be more of a chance of the patient internalising the therapist as a "good enough mother" (Winnicott: 1986:13n). The goal is to try to develop the capacity to look inward and outward simultaneously. This state of mind is described by Bion as "binocular vision".(Grindberg: 1971: 35) It is a way of seeing the struggles to prevent the session from being clouded and distorted through preconception. We must try to listen as Freud suggested, with "an evenly suspended or poised attention" (Laplanche: 1988: 43) so that we are optimally available to respond to both conscious and unconscious communications from our patients, at the same time being aware both of our own and the patient's state of mind. Similar descriptions of this process include "quasi telepathic" and "coenesthetic", "receptive" or "empathic listening" (Nathanson: 1988).

Projective identification

Many of the unconscious communications of infant and mother proceed via the processes of "projective identification" and "projection". Klein (1932, 1957) first introduced the term "projective identification", describing it as an unconscious defensive process by which human beings, in phantasy, can rid themselves of unwanted painful feelings. Bion (1967) extended Klein's usage, describing "projective identification" as a communicative process by which the infant (patient) can project all of his feelings, bad and good, into the mother (therapist), to help her make sense of his needs. The mother (therapist) unconsciously identifies with what is being projected and may be induced to think, feel or behave differently.

Bion and Winnicott viewed projective identification as an essential form of two-way communication which can induce identification both of infant with mother and mother with infant. Bion describes this complementary state of mind as

the infant being contained by the container/mother and believes that it is the precursor to the infant being able to think, another goal of therapy (Grindberg: 1971: 52-53). As such, it is critical for normal development.

In the therapy setting, when the infant/patient is anxious, he may project the anxious part of himself into the therapist/mother, who may identify with the anxiety. The next stage of projective identification involves the sensitive therapist/mother processing the projections for the patient. She can then respond in her own way, her own creativity at play, so that the patient's projections can, in time, be converted into a more acceptable form, the last stage of "projective identification" (Ogden: 1979, 1982). Gordon (1965) and Jureidini (1990), both Australians, provide useful discussions of projective identification.

Countertransference

The process of projective identification is linked with countertransference. Racker (1968) provides a comprehensive discussion on the subtleties of countertransference including the terms "complementary" and "concordant".

Countertransference is composed of the feelings that appear to come from nowhere and may well be what the client is unconsciously communicating to the therapist. Part of one's response will also be due to one's own personality, defence mechanisms, psychopathology; and all psychotherapists have that, whether they want to admit it or not (Guntrip: 1986).

Countertransference is one of those terms about which there is much disagreement (Laplanche and Pontalis: 1988; Rycroft: 1985; Hinshelwood: 1991). Perhaps that is why David Malan in his text *Individual Psychotherapy and the Science of Psychodynamics* refers to countertransference only once (Malan: 1982: 85). My understanding of countertransference is again influenced by Melanie Klein (1932, 1957, 1991). I prefer to think of it as almost all of the unconscious reactions, including thoughts and feelings, that one has when one is with a patient. As such, the therapist is like a "tabula rasa" or empty plate, whose major function is to be the container (Bion: 1967, 1970) for the unconscious projected feelings and parts of the patient's self and object world. The process that then occurs is a resonance from unconscious to unconscious.

Countertransference is similar to an internal reflective mirror that can help the therapist make working hypotheses about the unconscious relationship between therapist and patient and what may have occurred between the patient and his primary care-giver, often mother. For example, if the patient's experience

as an infant was that when he or she cried, mother would leave the room, the patient may imagine that will happen if he cries in front of the therapist: that the therapist will not be able to bear any difficult feelings and leave the room, at least emotionally. A therapist who can stay in the room, rather than be propelled by the patient's projections of a deserting mother, will represent a mother who can tolerate the infant's cry. The therapist who uses countertransference to inform her of the patient's internal object-relations may be able think about her countertransference and thereby contain a patient's projections. She will then will be able to process what the patient is communicating to her and feed it back to the patient in the form of an interpretation. I emphasise the 'may', because sometimes therapists are unable to think, especially in the presence of borderline or psychotic aspects of their patients. Hence the importance of supervision.

Crudely, you could say that what the therapist is feeling is a guide to what the patient is feeling. Those who object to this interpretation of countertransference are, I think quite rightly concerned about those parts of the countertransference which are made up of reactions of the therapist which, as I mentioned above, come, for example, from his own psychopathology. Freud stressed that no therapist can go further than his own complexes or resistances permit. Consequently to enable the countertransference to be a more valid guide to what is going on with the client one does need to have submitted to a personal analysis, to assess one's own ego defences (Freud: 1968; McGuire: 1974).

Empathy

Perhaps within all of this, as Nathanson (1988) suggests, useful terms are empathy or empathic listening. Many therapists believe that they are empathic, and it is often only after years of working in this field that they come to recognise how, unconsciously, they themselves defend against authentic empathy, possibly to avoid being retraumatised themselves. It is only in a genuinely empathic, respectful, loving space that patients can slowly begin to digest interpretations perhaps about their inability to describe their feelings and their own capacity for empathy.

Over time, as patients learn that perhaps their mothers were not good enough, they can allow themselves to become more separate and empathise with themselves, at the same time slowly beginning to internalise the therapist. As the true self is accessed they begin to have a feeling of being less alone. They may even believe that they have found a friend. It is at this point in the therapy and in the transference that the patient may begin to have many

phantasies or dreams about the therapist being a real friend. With appropriate boundaries the grief involved in knowing that this can never be so can be worked with. Their capacity to grieve and to sob sometimes uncontrollably, often becomes evident when they cry for themselves rather than others. Whilst this can be extremely painful, it can also feel like a great relief and they may say things like "I don't feel myself" or "I feel strange, suspended". This is the "me, not me" idea that Winnicott talks about, transitionally and often perilously balanced between false self and true self (1986:130). This often the time when patients get in touch with the psychotic aspects of themselves, where breakdown may occur and good containment is critical. On the more positive side, by understanding why they nearly went mad as babies, patients become more compassionate and less blaming of themselves. Many patients are beset by guilt and shame, perhaps the most destructive of feelings, because their mothers could not empathise with them. They were left in the dark with the only explanation being that it was their fault, often carrying their mothers' shame as well.

Case study and assessment

I had been seeing a patient for some time twice a week. I shall call her Janet. She, like John, was depressed, with a sense of not knowing whether she really existed for anyone. She repeatedly said that she had never existed for her mother and was always sensitive to not existing in her relationships. Janet often talked about killing herself. She would then have truly ceased to exist. It was hard for me to hold her through these times and the transference was terrifying for both of us. After a session when my patient was trying to recover from her husband's premature death from cancer and four years later, her twenty-five-year-old son's murder in Africa, I found myself writing the poem "Dream on little one, dream on". Adult life for her was far removed from her childhood dreams.

A month later I received an email from her which had a kindly sense to it. She asked for a change of time which I was able to do, and she said "Thank you" in the most genuine way. I told her of my experience of her gratitude and she cried and said "Yes". In that moment, she felt as if we were really close and she did feel grateful. This had occurred two weeks after she had shouted at me "Why do I always get blamed? You are attacking me". I was able to tolerate her murderous feelings, her attempt to murder my existence. I think my being able to withstand the intensity of Janet's murderous and self-murderous attacks may have been what Bion would have called surviving "catastrophic change" (Grindberg et al.: 1971: 17-18) and the turning point that effected the change

in her. She said later "I was never able to scream at my mother and I have never been able to do it to anyone". Whilst it was horrible when she was doing it, it had led her to realise that you can be very angry with someone, but they may still care and not disappear. I was very moved and reassured because I had hated her shouting at me and I had a nightmare afterwards. Reading 'Hate in the Countertransference', Winnicott's seminal paper (1987:194-204), helped me to contain my own raging countertransference. A day later I came upon a poem by Mary Elizabeth Coleridge (1861-1907):

Affection

The earth that made the rose,
She also is thy mother, and not I.
The flame wherewith thy maiden spirit glows
Was lighted at no hearth that I sit by.
I am as far below as heaven above thee.
Were I thine angel, more I could not love thee.

Bid me defend thee!
Thy danger over-human strength shall lend me,
A hand of iron and a heart of steel,
To strike, to wound, to slay, and not to feel.
But if you chide me,
I am a weak, defenceless child beside thee.

Janet and John highlighted some of the things to look for during assessment. Amongst other things, I look out for the capacity for empathy. A useful idea to play with is, "Could I imagine this person being my mother or father?" I think the clearest sign of a person who has not received empathic attunement is one who cannot empathise as mother couldn't and may find parenthood difficult. Early in Janet's therapy I worked for three months with a broken ankle encased in a huge cast. Little was ever said about it. Denial, or lack of empathy, but worth wondering about.

Listen to your body. It may pick up something often preverbal. In the first session with John the hair stood up on the back of my neck. I think my physical response reflected his fear as a small boy, his lack of containment, even a feeling of going mad (Wiener: 1994). In general, the psychotic patient tends to be more concerned with the authenticity of the heart not the words, particularly during a first meeting with the therapist Look out for discrepancies even lies.

The narcissistic personality, on the face of it, is constructed to suit the needs of others but in fact they often have to keep secrets in an effort to maintain their power. John lied consistently throughout the initial stages of therapy, laughing as he did so. Perhaps he was enjoying teasing me, shades of contempt? My feelings of disquiet were palpable.

The therapist's search for the lost maternal object

And now for perhaps the most challenging part of my paper. We know a great deal about what we, as psychotherapists, are to our patients. We have compassion for our patients. We enter their worlds and share their suffering. Some would say that we love them. We believe that we respect them.

We are, as we know, never in reality our patients' closest friends, but I think we are pivotal, transitional friends. We provide a space in which they may feel less alone, in an effort to help them find themselves in their struggle, to help them grieve for their lost maternal and paternal objects.

But what are they to us? Someone once said "Scratch the back of any therapist and you will find a depressed mother". I reframe that to say that a therapist/ mother who has suffered so much herself may have little left for her patient, and may not, temporarily, have the capacity for empathy. Sad for both her and her patient, as mutual attunement is critical at this time. So what about the neglected symbolic infants in us?

Much has been written about the way we can project our infantile needs into our patients and have them cared for vicariously through the process of that contact. Alternatively, we may in part want our patients to be our babies. I have noticed how many therapists begin their training just after their children have left home.

As I mentioned above, an addictive aspect of this work is the fact that one of the things we get from patients, even when they are in the negative transference, is respect and a type of love. It is often at times when clients do not treat us with respect by not paying an account, for example, that we may feel abused, used, perhaps a revisiting of the early trauma, when attunement by our mothers or fahers was not present. A bit like not getting a drug hit.

I would like to suggest that many patients have difficulty finding words for something, perhaps an early, powerful and pre-verbal trauma. I think this is sometimes matched by the difficulty the therapist has in being able to

genuinely empathise with the deep suffering of the patient, preferring to fall back on theoretical interpretations, however well-intentioned. How to be able to understand this preverbal period is an important task for us all and I think it promotes a loving transference. I am not certain that we can create this unless we have completed an infant observation.

Fairbairn once said, "I can't think what would motivate any of us to become psychotherapists if we did not have any problems of our own" (Guntrip: 1986: 448). Kernberg (1980) and more recently, Neville Symington (1993) also emphasise the need for therapists to have the deepest parts of themselves looked at, empathised with, and thus potentially able to be managed. If the lost and long-suffering babies in us are not attended to, surely it makes sense that we may search for that in those closest to us, and that may be our patients. I think there are times when our patients reassure us, feed us, providing sustenance for our hungry narcissistic selves. If this is more than temporary, an ongoing need, then we may be repeating the experience they had with their own mothers, hence the danger of therapy "interminable" (Freud: 1937).

All I am suggesting is that we need to be aware of our own vulnerability, respect it, and find our own authentic true selves in the myriad of projective processes. We also need to be attended to by getting mothering, love and friendship from other parts of our lives, rather than relying on our patients for sustenance, relying on them to be our mothers. Otherwise, every time we connect with something in the patient that resonates with our early lives we may be retraumatised and be at risk of exhaustion and inevitable burnout.

One of my supervisors once said to me "To be a therapist you need a very passionate partner". Not all of us are in that position, so we have to make do. We will sometimes make narcissistic object choices when choosing partners and that will certainly not feed us (Reich: 1942). I have been fascinated by how many therapists choose partners (patients) who resonate with the long-suffering infant in the therapist, the partner often being pitied rather than the therapist pitying herself. As a result we have two adults with deeply denied suffering parts of themselves trying to have an adult relationship. Twins without parental objects present and internally available: potential catastrophe.

Our lives, like those of our patients, are never ideal, but we have our supervisors, we have intimate friendships and we have or own therapists. It is important for our survival to make the best use of them.

Conclusion

What I have argued is that, in the end, we are alone with our experiences of life, our knowledge of life, and our insights about ourselves. Some of us are surrounded by many people, some prefer to be more solitary, the extrovert influenced more by the external world, the introvert more persuaded by his or her internal world.

The patient, more often than not, comes to therapy with an unconscious need for someone else to make his or her life complete: the "witness to their life" idea. By the end of the therapy there may be much more of a sense of living alongside oneself, in the knowledge that intimacy with another is a choice rather than a need, sometimes a desperate need. In today's world with the couple state seemingly so much "under fire", many people will find themselves single, if only towards the end of their lives. Those that seem content are those who have a sense of an accessible inner optimism with good internal objects guiding them along the way.

Whatever we choose to do, to rely on our own inner world or on the environment, the only truly close friend is our own authentic self. The self-love or self-respect we manage to develop is something which cannot be taken away. It belongs to us. Ideally it is real, it is palpable, it is alive and creative.

When a patient can honestly say "My closest friend is me", I think we are getting somewhere. Rather than being depressed they could be better described as unhappy, a state of mind that can be comforted. In my experience it is hard to comfort a depressed person.

I am reminded of a verse from a poem, "The Love Song of J. Alfred Prufrock" by T. S. Eliot. For me, his words capture the most fundamental element inherent in any psychotherapy session: courage.

> And indeed there will be time
> To wonder, "Do I dare?" and, "Do I dare?"
> Time to turn back and descend the stair. . . .
> Do I dare
> Disturb the universe?
> In a minute there is time
> For decisions and revisions which a minute will reverse (Eliot: 1930).

As a psychotherapist you will not only descend the stairs with your patients through their various stages of development, you will invariably disturb their

universe and also your own. Through this process, as with T. S. Eliot, we often unwittingly expose much of ourselves, both consciously and unconsciously. Without a capacity to be vulnerable ourselves, I think there is less potential for creativity in the therapeutic relationship, more of a risk that it will be a vicarious experience for the therapist.

You may, as I have said, be experienced as your patient's closest friend during this process and you will dare to love them, hate them, fight with them and make up. Most of all you will stay with them, explore, tolerate not knowing where each moment may take you, allowing yourself to oscillate between yes, no, yes, no. The people who ask, often so desperately, for our assistance, need to know that we have the capacity to survive all of this, often because their mothers could not. Their mothers were their lost maternal objects, the often blank register. Patients need us, albeit temporarily, to be a witness to their lives. Often they will reclaim hope, find their true selves and leave us. They may want us then to be a friend in the outside world but we need to be able to say goodbye: they will be sad and so will we. As my poem suggests, our work will indeed be done.

Little one
I sit beside you little one
To hear your memories good and bad.
They often can't be told in words
But simply felt and heard
I sit beside you little one
Until our work is done (Lugton: 2005)

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