Martha – finding oneself in the other (Fonagy, 1999).

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Abstract

This article developed from the therapeutic case study that I wrote for NZAP membership in 2006. It follows my work with Martha, an adult woman, over the course of four years of individual therapy. Issues of loss and bereavement permeated the therapy, most obviously for the client but also for me. I struggled with times when the client's life experience, as spoken in session, was very close to my own; so close that I felt my ability to remain separate and able to think was in danger of being compromised. It seems to me these are issues that all of us must struggle with at times, and merit further discussion.

Introduction

I first met Martha, a post-graduate student, when she requested counselling[1] from the Student Health Service, where I work. This was her second request for counselling, her previous counsellor having left the year before. Her main presenting issue was the same; procrastination around working on her thesis. She presented as a very obese woman of 29, dressed casually in leggings and sweatshirt, who appeared younger than her years. Martha lives an isolated life, in an enmeshed relationship with her mother, a woman with little apparent capacity for attunement or reflective function. Martha's experience of connection fills her with anxiety: on the one hand, fear of abandonment; on the other, fear of enmeshment, 'losing oneself in the other', as will be shown in this paper. In contrast, Fonagy (1999) states, regarding optimal conditions for development:

> If the caregiver's reflective capacity has enabled her accurately to picture the child's intentional stance, then he will have an opportunity to "find himself in the other" as a mentalising individual.
>
> The therapeutic relationship provides another opportunity for one to "find himself in the other".

Client History

Martha is the second youngest of five. The youngest of her three elder siblings was born seven years before Martha; she has a sister who is four years younger. Her mother was 16 when she first became pregnant, and 'had' to marry Martha's 21-year-old father.

Her mother, a life time smoker and also very obese, suffers from chronic respiratory problems, requiring home oxygen and regular hospitalisation. At age fifty six, she can barely manage self-care, with no prospect of her health improving.

Martha was the only sibling at home until recently. Just before we started meeting, over a seemingly trivial argument between Martha and her father, her parents 'suddenly' decided to separate, after 40 years of marriage, and the family home was sold. Her mother and grandfather now live together in a flat. Martha struggles to live separately and sees her mother almost every day. It is clear that this is both to do with her mother's emotional manipulation, and Martha's isolated life and need for her mother.

When Martha and her father argued, her mother took Martha's side. This is not an isolated instance: throughout the marriage, the primary relationship has been between Martha and her mother.

Martha described being a quiet child, who, knowing that her mother was very busy with four other children, would play alone. At eight, she was overweight, and was told to reduce by her doctor, but without good dietary advice.

Making friends has always been hard for Martha and she has never had an adult intimate relationship.

She was always academically able, coming first in her class at school, but negating this by stressing how unimportant the school was. Her parents were proud, but had no real idea of her achievement. On leaving school she took a professional degree, requiring an intern year in Auckland, to gain registration; remarkably she did move there, but lasted one week only. She feels deeply ashamed about this, but the move away from home was beyond her then.

On returning to Dunedin, Martha started a further Arts degree. She felt like she "slept walked" through it, and that they awarded her a First Class degree out of pity. She was awarded a three year scholarship to write a post-graduate thesis, and started this the year before we began meeting. She also supplements her scholarship with part-time clerical work.

Dynamic formulation and diagnostic impression

Much of this history was gathered in our first session, and in my notes I see that I have written 'did not appear depressed'. Martha's bright, articulate and talkative presentation belies the huge discrepancy between her emotional/psychological/social immaturity and, to paraphrase Marvin in *The Hitchhiker's Guide to the Galaxy*, (1979), her 'brain the size of a planet'. It seems clear now that her 'non-depressed' presentation was a Winnicottian 'false self' (Winnicott, 1960), the only face she felt able to show the world and hence me.

The discrepancy noted above (between her immense cognitive capacity and emotional immaturity), can be consciously seen as a failure to achieve normal separation/individuation as an adult, specifically separation from her mother. This adult dependent state presumably replicates earlier infantile unresolved separation/individuation, one of Mahler *et al*'s (1975) key developmental tasks. Martha was her mother's 'baby' for her first four years, but on an inconsistent basis; sometimes intrusive, sometimes distancing; but always determined by her mother's needs, not Martha's. These are the conditions for creating Bowlby's (1969) 'anxiously attached/resistant' child.

Martha continues to attune herself to her mother, rather than the other way round. Her mother's alternating intrusion (but 'named' as 'support') and distancing (experienced as 'rejection') places Martha in an impossible position. Psychologically she experiences two maternal objects; a 'supportive' one and a 'rejecting' one. She internalises the rejecting object to be a bad part of herself: it is her need which is wrong and destructive. The experience of 'support' often feels like enmeshment, and becomes a terrifying precedent for relationships overall.

Eating provides a way to both be with Mum, and be like her in obesity. Intellectually however Martha is very different to her mother. Her academic abilities give her a role in the family; the 'bright one'. Ultimately though, her intellect starts to feel burdensome, as the discrepancy, between what she 'should' be doing, and what she can actually manage, increases.

This conflict becomes starkly apparent at post-graduate level. Her depression escalates; she experiences extreme anxiety to the point of panic; compulsive consumption of food no longer soothes sufficiently, so she starts to cut her own body. Psychologically she is defending against her central conflict with denial and magical thinking; she denies her unconscious knowing that the situation has become untenable: somehow, magically, the thesis will be written without her having to write it.

Denial and magical thinking are immature defences; during the first session I think I was picking this up in my sense of Martha being much younger than her years. A week seemed too long for her to wait for the next session; I was feeling both Martha's actual isolation and a more unconscious awaremess of her anxiety at not being kept in mind. I was in tune with the infant who, not having reached the stage of object constancy, worries that 'out of sight' does mean 'out of mind'.

Diagnostically, Martha fits the criteria for Dysthymic Disorder or, on Axis II, Depressive Personality. Both seem to convey the almost lifelong struggle she has had with low mood. McWilliams (1994) describes the certainty of depressive clients that they are both inherently bad, and that their anger is dangerous, as being diagnostic of Depressive Personality.

As psychotherapy has proceeded I have experienced something characterologically borderline in Martha's personality structure. Her formidable intellect often masks this, but the profound splitting, demonstrated in her idealisation of me and denigration of herself, was an early indicator. Even more strongly I am aware of powerful counter-transferential swings in myself; between a strong want to rescue, more noticeable initially, and an equally potent desire, at times, to reject Martha. McWilliams (1994) expresses how normal and diagnostic these 'internal movements' are when working with borderline clients.

Therapeutic goals

Martha's goal was clear; assistance to complete her thesis. Further goals were evident to both of us; a need to increase her capacity for intimate relationships and hence reduce her social isolation. I also thought that Martha would need to negotiate the developmental stage of separation/individuation from her family.

In order to achieve this, Martha's very limited sense of self would need to develop and mature. All of Erikson's (1951) eight stages of man seemed to apply: there are obvious difficulties with the second and third stages of autonomy and initiative, but also the later stages of industry, identity, intimacy, generativity and ego integrity. And such a limited sense of self inevitably implies failure to master the first stage of basic trust v. mistrust, with Erikson's accompanying virtues of drive and hope. He states:

> ...the amount of trust [depends] on the quality of the maternal relationship. Mothers create a sense of trust [by providing] sensitive care of the baby's individual needs....This forms ... a sense of identity

which will later combine a sense of being 'all right', of being oneself, and of becoming what other people trust one will become.

Initial phase of therapy

Areas of interpersonal difficulty for Martha, throughout our whole therapy, became apparent within the first three months. She struggled with a desire to have a psychiatric diagnosis that would 'explain' her dysfunction. If she could no longer be the 'bright one' in the family, perhaps she could be the 'sick one' and in this regressed, dependent state, get her needs met. Allied with this, there were times when she did not want to see links between her mood state and life events. Early on, she discussed a meeting with her thesis supervisors:

I hate to admit it but I'm very dependent on what [they] think of me.

Why do you hate to admit it? I asked.

Because if external events affect me, it means I can control [my mood]. And there's no reason to feel like this...I was cutting last week in advance of the meeting.

I tried to help her make the links she was reluctant to see.

It's not 'just' a meeting with your supervisors that has you cutting. It's about the whole shebang; the thesis, worrying about dropping out, are you good enough, what will you do otherwise, etc?

Martha found it hard to let people know about her difficulties and needs directly. She related her tendency to walk out of arguments and then expect to be followed. If Martha were the 12-18 months infant of Mahler *et al*'s (1975) 'rapprochement' stage of development, this behaviour would be completely appropriate; as an apparently adult woman in her 20s, it generally stimulated frustration in others. In session, I wondered if she could try to state her wants more directly, and suggested this 'passive-aggressive' communication could actually be counter-productive.

Martha responded that I was wrong and became tearful. However, with me, she was able to try something different. Rather than just leaving (wanting me to follow?) she opened up more, admitting that she knew there was something childish about this communication style. She went further.

The final straw leading to my moving out was Dad saying that I'm a child who knows nothing of the real world.

Martha then disclosed that she and her father have never communicated directly other than through bickering, and that "Mum always gets in the way". The pathological need of Martha's mother to keep her young, at home and therefore 'Mum's eternal child', became clearer. Martha stated that when she was happy, her mother was down and vice versa. Very tellingly she said,

I've never seen her so happy as when I was at EPS (Emergency Psychiatric Service); she hardly needed any oxygen.

Part of Martha's low self esteem, and hence difficulty with being confident enough to make an independent life, has been her weight. Her obesity is the first thing that one notices. She was very aware that she comfort eats. I felt an urge to give her books about how dieting makes one fat, as if one book could fix her lifelong problem. Supervision was very helpful in managing 'my' want to do something about Martha's obesity; my supervisor spoke of how Martha would continue to use food, as long as she had nothing else.

I asked about the cutting, disclosed at assessment; Martha said she had self-harmed at about age fourteen, but not again until the recent crisis. In agreement with Favazza (1998), I understood Martha's self-harm to be 'a morbid form of self-help...[providing] rapid... relief from distressing symptoms such as mounting anxiety' and its 'effects [to be] tension release, ... satisfaction from self-punishment ... and relief from feelings of depression, loneliness, loss and alienation.'

Middle phase of therapy

In the initial phase of therapy the fundamental resistances and conflicts have been identified: the bulk of the therapy is the continual examination and re-examination of the identified conflicts, within the holding function of the therapeutic alliance.

Although Martha's enmeshment with her mother is always strong, her mother's hospital admissions epitomised the problem. Martha would spend hours sitting beside her mother's bedside and everything else would be jettisoned. Often I felt frustrated with Martha and her mother at these times, by this pathological 'dance' that Martha said she wanted to end but colluded with constantly.

I also had had my own experience of my mother becoming very ill and dying the previous year. The memory of the hours I spent sitting at my mother's

bedside was strongly with me, as Martha spoke. I remembered 'my' sense of helplessness in the face of my mother's pain and my want to do 'anything' to try to manage this. When Martha related her week between sessions, 'living' at the hospital, the identification felt so great that I struggled with using my irritation with Martha's 'dance' as important counter-transference information. What was mine and what was hers felt, at times, confused.

A sense of confusion was a common experience for Martha within her family where the underlying dysfunction was becoming more apparent. Perhaps, therefore, I shouldn't have been surprised when Martha disclosed, some three months on, that she had been sexually abused.

She was talking about her wish for 'everything' to be different. I responded by saying:

> *I think saying 'everything' is a defence against the pain you might feel if you get into the details. I think you need relationships, aside from your family.*

She responded with:

> *People cause pain... I'll only be hurt.*

She spoke very slowly about memories of something occurring when she was four, "an older boy". "One of your brothers?" I asked, and she agreed; Luke, seven years older than she, was the perpetrator. Martha had never told anybody before. "Perhaps it was just kids playing around." The memories, however, were clearly of masturbation and oral stimulation.

I said that at four, and eleven, this was not 'just kids playing about'. I said that Luke should not have done this, that there may be a link with her depression and it was brave of her to talk of it. Martha's need for her 'fat' as a defence against emotional intimacy became clearer now.

We also began to explore the cutting. Nobody had ever seen her cuts, and following Levenkron's (1998) model, I asked if Martha wanted to show them to me, which she did. I think there was something soothing for her in at last 'exposing' this most private behaviour to another person. This was also valuable for me as it indicated a clear demarcation between her mother, who knew nothing of her cuts, and myself. This was a 'healthy' secret between us.

Increasingly, Martha's need for human contact became apparent. In desperation, she said

Perhaps I'm just not meant to have friends, like not be an astronaut.

I challenged this and interpreted her terrible fear of relationship but her desperate longing for just that. This was obvious in our relationship where the inadequacy of meeting once weekly was clear. Although there was nothing I could do at the time about this, I commented that she needed to come more often and I wanted to meet that need.

This statement of what Martha needed (even when its provision within the Service was impossible) was important, as it counterposed Martha's certainty that she must be an unwanted burden against my declared wish to see her more often. It also modelled that needs must first be identified for there to be any possibility of them being met.

We did manage to change to twice weekly sessions, a year after starting to meet, as Martha received funding under the Accident Compensation Corporation (ACC) for sexual abuse counselling, in my private practice. Initially there seemed clear indications that attending more frquently was beneficial; but after two months, it seemed that a 'taste' of more only emphasised her sense of deprivation.

There continued to be regular crises around Martha's thesis, usually precipitated by her supervisors needing to see signs of progress. Her mother and grandfather moved into a flat together, further out of town. Initially this helped Martha spend less time with them, but she quickly reverted to old patterns.

Martha dreamed that her mother had died and there were so many obstacles she was unable to reach her. Some weeks later Martha disclosed that she had wanted to reach her mother in the dream, so that she (Martha) could kill herself. This led to her sharing her certainty that she 'would' kill herself when her mother died. I allowed this expression, much as it alarmed me, and empathised with the emptiness in her life. At the same time I proposed an alternative future, where it would undoubtedly be terrible when Mum died, but not necessarily catastrophic.

Progress fluctuated. Martha would get excited, when, for instance, she managed to find a fitting bathing suit and restarted swimming. She started using *Xenical* for weight loss and described throwing out her crisps, a symbolic act similar to a smoker discarding their cigarettes.

Her mother's role in keeping Martha fat became clear; at the same time as helping pay for the Xenical, she would encourage Martha to have fish and chips saying, "one time can't hurt". Her support for, and undermining of, any

move by Martha to make change is mirrored by the different parts of Martha also struggling with the same dilemma.

We reached our first major break. I took five weeks leave and, on my return, everything had been "fine". I later realised, that she had needed to be 'good,' so I would return. Eventually Martha disclosed that she had managed the break by resorting to cutting herself again.

The New Year also meant that two years of Martha's scholarship funding had gone. The thesis was the unspoken 'pink elephant' in the room: it became clearer that Martha wanted it done without having to actually write it. I openly challenged this magical thinking. She would talk of the impossibility of doing everything (study, work, family, exercise, diet, making friends) and eventually, with assistance in supervision, I confronted her with the paradoxical thought that perhaps the thesis was beyond her. She responded to such challenging by stating that she wanted to persist, but the difficulties continued.

In May 2005 her supervisors threatened to 'pull the plug'. After an initial collapse Martha responded well and designed an impressive plan to make progress. At the same time her 'child' face was to the fore, "it's not fair", but I had to challenge this. There was nothing unfair in her supervisors' normal expectations of progress.

Throughout this period Martha was often feeling hopeless but I was able to maintain hope; at such times I think my fantasy was that of the rescuing 'good mother', McWilliams' (1994) 'complementary counter-transference' to the unconscious belief of depressive clients, that only unconditional love will cure them. At other times I felt equally hopeless; my 'concordant counter-transference' (McWilliams, 1994) to Martha's hopelessness. Martha's projective identification of her hopelessness was so powerful at these moments, that any hope for her had to be delegated to my supervisor to hold.

There were, however, some signs of greater maturity. She began to talk of her parents in much less polarised terms, Mum no longer a 'saint', Dad not just an 'ogre'. She realised freedom from depression didn't mean continuous happiness. Counterpoised to this was Martha's want to have some actual experience of joy. These thoughts felt like indications of Martha moving towards Klein's (1946) depressive position, with more ability to tolerate ambivalent feelings.

At times, I was very moved Martha's clear appreciation of me. Once she informed me that her younger sister Ellen and her abusive boyfriend David had asked for my name for a (fraudulent) ACC claim. When their request was

put to her, Martha said she felt both possessive and protective of me. I stated clearly that I would not see either Ellen or David; Martha was my client and she came first. In my mind at the time I was thinking, "Martha is 'my' baby". I did not speak to Martha in these terms, but in demonstrating so clearly that there was no question about where my priorities lay, I think I passed a 'test' that Martha had been, at least unconsciously, setting for me.

Martha's wanting to protect me from David felt like a verification of her achieving Klein's depressive position; the stage where the infant begins to experience anxiety that the mother (therapist) has been harmed by his/her aggressive attacks. Martha's aggression was not overtly stated but certainly expressed in her constant resistance ("yes but") to any of my support towards change. This had lead to a feeling of guilt and a want to make reparation.

Such hints of greater maturity felt important because family crises in my life meant that, soon after, Martha was forced to face the inevitable disappointment of being in a relationship, when I had to cancel a session at short notice. During the following session no mention was made of this, but Martha commented that I was looking tired. I wondered if she thought I was too tired to be present with her. She said she had wanted to ask if I was all right, but wasn't sure if it was okay. I assured her that I was fine and available. Reflecting on this later, I wonder whether Martha had wanted to express anger as well as concern, at my sudden non-appearance, but was not confident to do so. I can see now that my assurance that I was "fine" limited the possibility for her to express all her feelings about the cancellation.

This was a very stressful period: my sister was critically ill in hospital and my mind was frequently elsewhere. I wonder if I was rather anxious about giving Martha the chance to explore her feelings further; unsure that I was strong enough to bear her anger, and perhaps her unconscious knowing that 'someone else' came first with me.

Events accelerated as the year progressed. Her mother's health worsened and Martha's distress became more overt. She spoke of feeling desperate, but "nobody knows it". She was cutting more often. I expressed my anxiety that she might really hurt herself and offered psychiatric care, but she declined it. Suddenly both Mum and Granddad were admitted to rest homes. Martha, 'freed' from their demands, collapsed into crisis.

This culminated in Martha's being briefly admitted to a psychiatric ward, for the first time, and she presented to her therapy session feeling suicidal. Her mother was in the Intensive Care Unit (ICU) and Martha sobbed that she thought her mother was going to die. I was very concerned about her mental

state and arranged to take her to EPS: this involved cancelling my next client and driving Martha in my car.

Reflecting later on these events, I can see that something very powerful was being communicated by Martha: another 'test' was being set for me. At the time I felt that I was the only one who could save her and that I needed to prove this with heroic measures.

Martha's mother was most present for her when Martha was ill, most obviously (as documented on page 11), in seeming to come to life when Martha was unwell enough to need EPS. Although consciously recognising this old relationship pattern, and telling Martha that she could still have me, even when well, I think that in reality, I recreated her familiar dynamic of 'clear dysfunction leading to greater attention'.

Martha had never felt that she was first with anyone. I put her first, above my other client, and momentarily passed her 'test'. Unfortunately and unsurprisingly, Martha could not truly internalise this demonstration of my regard, any more than her frantic consumption of food could really fill her up.

On reflection I feel as though I was 'forced' into actions far beyond my normal practice; that Martha, although intellectually knowing she is not an infant in her mother's care, still longs for a relationship of that degree of intensity. She projected this longing so powerfully that I found myself responding in unusual ways: this is the essence of projective identification, as Ogden (quoted in McWilliams, 1994) states:

> In projective identification, not only does the patient view the therapist in a distorted way that is determined by the patient's past object relations; in addition, pressure is exerted on the therapist to experience himself in a way that is congruent with the patient's unconscious fantasy.

The uselessness of my rescue attempt became clear at EPS, when Martha refused their help by 'running away', and I found her, at her mother's bedside in the ICU. Martha pouted and said she wasn't leaving: I could only ascertain that she was safe and reinforce our usual appointment time for the following week.

Martha did survive this crisis, and necessary further support was provided by the public mental health services. This was a relief for me: I had been feeling burdened for some time by the responsibility of being Martha's only 'functional' mother. She started attending an outpatient group programme and made the mature decision to defer her thesis.

The importance of such 'preparatory' steps became starkly clear when Martha rang me on Christmas Day to say that her mother had died. This coincided with my annual long leave. I was very anxious about Martha, but had to feel confident to leave her care to the hospital group programme.

Current progress and thoughts on termination

At the time of writing, it is over two years since the death of Martha's mother's, and recently her other main attachment figure, her grandfather, also died. Two major developments mark this later time of therapy. Martha's physical health has worsened, with the diagnosis of obesity-related complaints; high blood pressure, Type II diabetes, and renal damage. At times her only response to these serious health problems has been one of passive suicidality, and a fantasy of rejoining Mum "in heaven".

Latterly her isolation, her despair, and anxiety about ACC funding running out, has led to her dangerously overdosing on prescribed medication. This move, from suicidal thinking to acting, has been extremely worrying: the holding provided by therapy (now in once weekly sessions only) and the daily outpatient group programme has seemed inadequate.

We are still living with the anxiety about further ACC funding but after a serious crisis around Christmas, Martha seems to have found some stability within herself, although how long this will last neither she nor I know.

It is still very hard to imagine a planned termination at the right time for Martha. She worries now about getting better for fear of losing the therapeutic relationship, despite my stating that she can grow up and still keep me, for as long as she needs.

Discussion

Bowlby (1969) described the importance of the primary caregiver providing a secure base for the child, from which exploration could be made in confidence that 'safety' could be returned to. As Karen (1994) puts it, 'secure attachment' between mother and infant [is] of crucial importance to the child's psychological development and mothering [that is] warm, sensitive, responsive and dependable... [is] the key ingredient".

Martha was her mother's 'baby' until the age of four. One would assume that this was a likely foundation for focussed maternal attention, but her lifelong dysfunction suggests something other. The key words are 'sensitive and responsive'; crucial to this is the parental ability to reflect on the child's state of mind and put the child's needs first. Considering her mother's

enmeshment with Martha as an adult, it can be hypothesised that in the past she was similarly providing for her own needs, and that their attachment was at best insecure and at worst pathological. Martha's infant role is likely to have been to provide a secure base for her mother, a frightening reversal for a dependent infant/toddler. It can also be assumed that Erikson's second stage of autonomy verus shame and doubt, and Mahler et al's (1975) separation/ individuation phase would be discouraged by Mum, who would feel anxiety at her toddler's attempts at independence and respond with explicit or implied disappointment, and withdrawal of love and attention.

Such an enmeshed relationship between mother and child needs to be disrupted by the father; that 'third person', so necessary to the introduction of the concept of the world containing 'others'. Martha's father's inability to 'fight' for his relationship with her, is probably a consequence of his own dysfunction. However, it was understood by Martha that she was too unimportant for him to try. The only real 'attention' she received from a male, as she was growing up, was the sexually abusive contact from her elder brother.

Fairbairn (1941) states: "development ... is essentially a *process whereby infantile dependence ... gradually gives way to mature dependence.*" (italics in the original). Martha realises that her idea of friendship is similar to the infantile dependence she experienced with her mother. She knows intellectually that this is an unrealistic goal for adult relationships. In the therapeutic relationship, she has been encouraged to try something different: she has been enabled to try to 'find herself' in/through me.

Martha has become more able to manage my failures (e.g. cancelling sessions) by letting me know, rather than by totally denigrating me and the therapy. Winnicott (1955-56) says that 'The patient makes use of the analyst's failures', crucially by the analyst not defending themselves but allowing the patient to experience and express anger.

Martha's sexual trauma should be seen in the context of her lack of Winnicott's 'good enough mothering' (Winnicott, 1960), epitomised perhaps by the parents' blindness to Luke's sexualised and abusive behaviour. Mitchell and Black (1995) sum up Winnicott's view of 'trauma' as being:

> Not just... something dramatically negative, frightening and noxious (e.g. precocious sexual stimulation); it is... the failure to sustain something positive – the... conditions for healthy psychic development.

Such abuse seldom occurs in isolation but more often within the context of the 'dysfunctional family experience', well described by Alexander (1992) in her article linking attachment theory to sexual abuse.

Conclusion

Guntrip (1961) states, summarising Fairbairn, that 'the root cause of all personality disturbance ... is the unconscious persistence within the adult ... of too strong an element of infantile dependence ... The human child ... does not always grow up to be psychically adult.'

In this work with Martha I have tried to understand her inhibited development as a 'psychic adult'. The thoughts of various theorists have assisted my ongoing internal processing during the course of therapy. However, regardless of modality, we understand that it is the relationship that heals. Fairbairn (Guntrip, 1961) states it thus:

> ...the really decisive factor is the relationship of the patient to the analyst, and it is upon this relationship that the other factors depend for their very effectiveness...since in the absence of a therapeutic relationship with the analyst they simply do not occur...

I endeavour to provide a secure base from which Martha is enabled to explore the world and ' find herself'. This process is still tentative: Martha 'darts away', in Mahler *et al*'s (1975) words, and then needs to return for 'refuelling'. Often she resists the demand to become psychically adult. It is too hard: she longs to return to the 'womb' of home and Mum.

I can do little except keep being present, reliable and non-defensive; a good object for Martha to internalise, and a secure base to struggle, safely, against. In time the therapy will hopefully provide what food does not, a fullness that really satisfies, and this relationship will act as a precursor for new and different emotional experiences with others in the wider world.

References

Adams, D. (1979). *The hitchhiker's guide to the galaxy*. London: Pan, 1961; repr. Picador, 2005.

Alexander, P.C. (1992). Application of attachment theory to the study of sexual abuse. *Journal of Counselling and Clinical Psychology, 60* (2), 185-195.

Bowlby, J. (1969). *Attachment and Loss Volume 1: Attachment*. London: The Hogarth Press and The Institute of Psychoanalysis.

Erikson, E. (1951). *Childhood and Society*. London: Imago and Hogarth.

Fairbairn, W.R.D. (1941). A revised psychopathology of the psychoses and psychoneuroses. In *Psychoanalytic Studies of the Personality* (p. 34). London: Tavistock and Routledge & Kegan Paul, 1952.

Favazza, A.R. (1998). The coming of age of self-mutilation. *The Journal of Nervous and Mental Disease, 186* (5), 259-268.

Fonagy, P. (1999). Transgenerational consistencies of attachment: A new theory. Paper to the *Developmental and Psychoanalytic Discussion Group, American Psychoanalytic Association Meeting, Washington DC, 13 May 1999.*

Guntrip, H (1961). *Personality structure and human interaction: The developing synthesis of psychodynamic theory*. London: The Hogarth Press and The Institute of Psychoanalysis; repr. 1973.

Karen, R. (1994). *Becoming attached: First relationships and how they shape our capacity to love*. Oxford: Oxford University Press.

Klein, M. (1946). Notes on some schizoid mechanisms. In *Envy and gratitude and other works 1946-1963* (pp. 14-16). The Hogarth Press, 1975; repr. Virago Press, London, 1988.

Levenkron, S. (1998). *Cutting: Understanding and overcoming self-mutilation.* New York: Norton.

Mahler, M.S., Pine, F. and Bergman, A. (1975). *The psychological birth of the human infant*. New York: Basic Books.

McWilliams, N. (1994). *Psychoanalytic diagnosis: understanding personality structure in the clinical process*. New York: The Guilford Press.

Mitchell, S.A. and Black, M.J. (1995). *Freud and beyond.* New York: Basic Books.

Winnicott, D.W. (1955-56). Clinical varieties of transference. In *Through paediatrics to psychoanalysis* (p. 298). London: Karnac and Hogarth, 1975.

Winnicott, D.W. (1960). Ego distortion in terms of true and false self. In *The maturational processes and the facilitating environment* (p. 140 and pp. 145-6). London: Karnac and Hogarth, 1966.

Endnotes

The service provided at Student Health is termed 'counselling' and the practitioners, regardless of training or modality, are counsellors

[1] If Martha were the infant of 12-18 months in age, of Mahler's normal developmental stage of 'rapprochement', this expectation would be completely appropriate. As an apparently adult woman in her 20s it unsurprisingly stimulated frustration in others.

[2] Levenkron regularly looks at his clients' cuts in session.

[3] A new short term person, but I can see now that I was recreating 'this' client's difficulty of always acquiescing to others' demands.

[4] I use my cellphone for contact at my private practice; hence Martha's being able to call me on Christmas Day. She has seldom abused this facility.