THE CONSTRUCTION AND EXPRESSION OF A GENDERED MIND AND BODY: CONTRIBUTIONS OF A PSYCHOANALYTIC APPROACH

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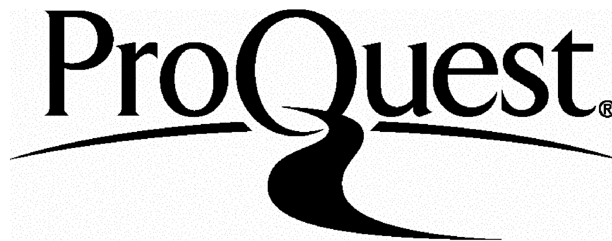

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ABSTRACT

THE CONSTRUCTION OF A GENDERED MIND AND BODY.

Post World War 11 developments in psychoanalytic theory and practice have subsumed discussion about the body, the corporeal to a somatic. Bodily experiences, physical symptoms ranging from eczema to vaginismus to anorexia are seen as manifestations of psychic disturbances: the body acting as the recipient of intra-psychic conflict. This thesis proposes that psychological and physical development are more inter-related with neither the body serving the psyche or the psyche serving the body. To state that there is a relationship between somatic and psychic development is not however to conflate the two. In patients with disturbed body image or with a propensity to physical symptoms with no perceivable organic basis, an examination of the emotional ambience surrounding the physical 'dwelling in' development of the self yields interesting and clinically useful material.

This thesis argues that the physical development of girls needs to be problematised much as gender conscious psychoanalysis has problematised the psychic development of girls and the construction of femininity. It looks at the importance of the maternal body image and the unconscious transmission of body insecurity from mother to daughter as well as the purposeful messages a mother passes on to a daughter about her body. It sets the necessarily ambivalent and pained ambience around the body between mothers and daughters in the context of the particular social milieu of late twentieth Western culture.

The method of inquiry has been an in depth study of the physical aspects of the transference countertransference. An examination of the subjective physical states aroused in the psychotherapist in the countertransference yields extends the understanding both of body disturbances, their derivation and tenacity as well as makes links between physical and psychic development without collapsing one into the other with important clinical implications.

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CHAPTER 1 Methods, Techniques, Theory

1. PSYCHOANALYSIS IN A TIME OF EATING PROBLEMS

Freud's psychoanalysis was a sumptuous affair. The cases that he and Breuer first wrote about in Studies on Hysteria (1895) are stories in which mysterious physical paralyses with no explicable organic basis are unravelled and subsequently treated, restoring to the patient enigmatically lost aspects of themselves.

It was Freud's great contribution to link an understanding of Body and Mind, Psyche and Soma and to insist against the general current of 19th century medicine that hysteria was both a psychical and physical event. For Freud this was not just a theoretical proposition. It is clear from his writing and from his reminiscences that Freud's great empathy for his patients led him to try to enter into their symptomatology: to get the measure of it so that his interpretations, his understanding of the meaning of the symptom, the hysterical phenomenon could come from an engagement with that hysteria.

By the post second world war period, psychoanalysis, cleaned up and sanitised in the States and masquerading as ego psychology, and in Britain, in its Kleinian invocation, becoming much a mentalist discourse, loses its sensual understanding. It becomes curiously dislocated from the body. To be sure bodily distress, particularly sexual, is discussed but this becomes in terms of symbols rather than through an active engagement with what bodily states feel like and engender. Although analysts who work with children, notably Winnicott, capture in their writing something tactile and sensual about the relationship between psyche and soma, this is rare and British and North American analysis rushes forward at a fast mentalist clip, subsuming physical symptoms, physical practices, unusual or ritualised sexual practices into a schema where what is important to psychoanalysis is theories of the mind and the elevation of

meaning and symbol at the expense of the body as the means of understanding and communicating with patients.

So how then has psychoanalysis dealt with a rush of symptoms which cluster around eating? Anorexia - the refusal to eat; Bulimia - uncontrollable eating followed by purging; Compulsive eating - eating without regard to physiological hunger? How has it addressed patients with eating problems?

With notable exceptions and to the detriment of many who suffer with such distress, psychoanalysis has tended to see the eating problem as subsidiary to, rather than centrally expressive of, the psychological life of the individual. It has either trivialised the problem or expected it to go away with the right doses of interpretation directed not so much at the eating per se as at the problem the eating is assumed to disguise. Until recently for example a psychoanalytic reading of compulsive eating would call for the interpretation of unresolved oedipal feelings[1] or of anorexia nervosa as a refusal to accept female sexuality. Such interpretations lost much of their validity because they bypassed listening to the patient in favour of relying upon a construct: the woman is fat therefore she wants the father's child. The woman is thin, she refused a female rounded body therefore she is pre-oedipally arrested. Absurd and crude as such interpretations sound, they encapsulate the kind of understandings that were previously available.

Part of the problem, of course, is that psychotherapists were unable to listen to a patients despair about her or his eating or not eating or her or his obsession about food and their body without immediately translating the language of food and eating into something else, almost before it has been grappled with and discovered in its own terms. The vitality that had informed Freud and the early psychoanalytic pioneers and which gave birth to the practice of interpreting the unconscious, has become both reified and ossified. Instead of interpretation being part of a **process** of understanding and engagement with the lived experience of the patient, it now became a **thing**, a set of a

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[1] See for example C. Philip Wilson, C.C. Hogan and I.L.Mintz Fear of Being Fat: The Treatment of Anorexia Nervosa and Bulimia Jason Aronson New Jersey 1983

priori formulations handed to the patient which could leave her or him painfully marooned with his or her pain.

This diversion of the patient's experience around food as though it were only valid as a metaphor is intriguing. It is as though the actuality and the materiality of food and by inference the materiality of the body, flesh, digestion, evacuation, and its processes are somehow disturbing unseemly – an unfit subject for analysis.

Perhaps thinking about such processes engenders discomfort in the therapist. Perhaps imagining oneself into the experience of an individual whose eating is disordered or chaotic is disturbing or incomprehensible. Perhaps entering into a dialogue about the eating practices of an individual is too private, more private than the revelation of a patient's sexual life.

But perhaps above all such considerations, discourse about eating is often not engaged with by practitioners because of the pain it arouses both in the analysand and analyst. Perhaps what is exposed is so devastating, so excruciating, so pitiful that it becomes almost too much to bear. The eating or non-eating experiences of the patient and their manifold experiences of their bodies can't be engaged with because, quite simply, it hurts too much. In place of engagement then, interpretation - which is really nothing more than a particular kind of conjecture - is substituted. The patient and her or his symptom is 'read' as text; the body becomes an almost literary construction as opposed to the problematic place in which the individual lives and breathes.

Paradoxically, this reading of the patient's body as text or the reading of the symptoms of anorexia, bulimia or compulsive eating as symbol, was born out of the work done in the 1970's on eating problems by gender conscious psychoanalytic clinicians engaging with patients with eating problems. The rapid explosion of such problems spawned the dissemination of the understandings gathered from patients whose eating was disordered, chaotic or disturbing to themselves. The rich and graphic plethora of

meanings[2] were so arresting and evocative that they soon entered the cultural landscape. It wasn't long before they then found their way into the Academy, where those in cultural studies playing with themes coalescing around gender, the body, disguise and revelation seized on them as a new literary form[3]. It wasn't long before this reading then fed back into psychoanalysis itself, unwittingly, further devaluing thinking about the patient's actual experience deflecting it instead into seeing the action as entirely symbolic and *reading* the action of eating or not eating and the surface of the body as performative.

In the psychotherapeutic world of the very early 1970's, it became both imperative and impossible to ignore the place of eating problems in the psychological life of many individual women. It was as though there was an unacknowledged or a secret epidemic eating (*sic*) at the bodies, hearts and minds of women of all ages. Indeed so unrecognised was this epidemic and yet so widespread that it was almost as though it were an aspect of being female, part of what initiates one into adult femininity[4]. Women in psychotherapy were seeing took it for granted that they should be obsessed about their body size and distressed about their eating. It was simply a fact of life. Worse than that even, they felt helpless in the face of such preoccupations, making talking about them at any depth, pointless. The only solution was to find a magical cure.

When instead of concurring with such a stance therapists paid attention to what they said about their eating and their bodies, it was as though they were listening to something between a code and a patois: a shortcut language used to explain something both intimate and social about how they conceived of their bodies, the meaning of food in their daily lives and a way to communicate about emotions. "I'm fat" was not simply a statement about body size and the relationship between adipose tissue and muscle. Rather there was to be understood by it the myriad of culturally endowed meanings of

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[2] See for example Susie Orbach *Fat is a Feminist Issue*, Paddington Press 1978, *Fat is a Feminist Issue 2* Arrow Books 1983, *Hunger Strike* Faber & Faber 1986

[3] See for example Maud Ellman *The Hunger Artists* Virago London 1995

[4] Now with a body distressed adult population raising children, combined with the relentless assault from the beauty industry we see the penetration of this aspect of the construction of femininity in girls much earlier.

the term fat. Women weren't meant to question it, *why or how* they believed what they believed, they weren't supposed to see the obsession with food as a way in which femininity is constructed in our culture, and they weren't, in the first instance, to understand it as anything but a negative judgement. Simultaneously "I'm fat" stood for the expression of often profound emotional distress. "I'm fat" could never be accompanied by "I'm feeling good, content, well." It might mean, "I'm full of self hate" it might mean "I'm miserable", it might mean "I'm needy", it might mean "I'm in difficulty."

These feelings were so entrenched that to ask what "I'm fat" meant would be both to breach something taken for granted, perhaps even to seem to expose an ignorance on the part of the therapist that could engender distrust and looks from the patient. On the other hand, disconcerting as such a question might be it would be ultimately useful and potentially libertory by allowing for a different kind of language, rather than the repetitive refrain of fat and thin, eating and not eating. Querying "I'm fat" might allow women to express through words rather than through concealed actions something more direct about their experience.

Psychotherapists who asked the question and refused to accede to the negative aspect of the statement "I'm fat" or indeed to accede to the positive attribution "I've lost weight" was expected to evoke, realised they were up against a formidable taboo. It was as though they were asking the individual to re-orientate themselves in some profound way.

But being located in psychoanalysis, a discipline so used to deconstructing what it hears, and being concerned that we needed to do more than simply accede, made it reasonable to ask and to want to know what the individual meaning(s) of "I'm fat" could be and why the idiom of food and body size was so ubiquitous, so unquestioned and so powerful in the lives of the women. In order to comprehend that, not just at the level of symbol, psychotherapists needed to enter into the experience of food and of eating for the women troubled by it. They needed to know, smell, feel, connect with the texture of their eating and non eating episodes: the binges and the purges, the evacuation of what

had been taken in but couldn't be held inside, there experience preparing food for others and food for themselves[5].

But deeper than the details of the preparation was the emotional distress that made the preparing of food for others and feeling content that they ate, one kind of act, while preparing food for oneself and ingesting the food are quite another. How it was that eating was fused with guilt when performed by the women herself but could bring pleasure when she prepared it for others. Therapists needed to understand why, what and how it felt for an individual to be gravitating towards food when not physically hungry or refusing it when starving. What was going on, physically and psychically when this was occurring?

Before interpretation could be of any value it was imperative that the details of what an individual felt like before she started a binge, while she was eating compulsively, after she finished eating or conversely if she felt unable to eat, needed to emerge, to be held in front of us, not concealed, so that it could be, as-it-were, ruminated over and digested. In this way not only the physicality of the experience could be understood[6] but more significantly, so that the experience for the individual could become a *lived* rather than a split off experience, one of which they could dare to be conscious rather than one of which because of shame, self disgust and lack of awareness they had little awareness.

One of the achievements of psychotherapy is to make available to the individual the incorporation[7] of that which is a trouble to one but is elusive. Through the recognition of something that has been dismembered, disregarded or split off either because of repression, shame or extreme hurt, the individual has the possibility to occupy a new psychic space. That which has been discarded is accommodated to revitalising the individual and transforming their self experience. Thus it is with eating problems. By not being afraid to enter into the details of an individuals eating or non eating or bingeing and vomiting, by demonstrating that what may feel initially verboten for them

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[6] So that the divide between the psyche and the soma could be (temporarily) dissolved in the therapy
[7] By which is meant the taking into oneself **both** psychically and physically

- only possible of being enacted rather than held in mind, observed and thought about - the therapist is able to help the individual enter a conversation with herself about the eating, non-eating, bingeing, purging, a conversation which has the possibility of enabling the individual to connect up with her symptom and in the course of time to make creative links between that which has previously been rendered as somatic.

By endeavouring to enter into the experience with the individual, therapists are not so much trying to help them confront the actual ingestion of large quantities of food. The job is rather to help us both find a stance of acceptance and curiosity towards the actions. With that established even if it is hard for the individual to believe that she can establish an empathy towards what she regards as so shameful, the therapeutic dyad can then go on to recognise what the eating or not eating might be about. It's not, that eating is devoid of the symbolic: how could it be? But a focus on the symbolic without recourse to actual engagement with the experience of food and eating, fullness and emptiness, for the individual cannot render the experience but symbolic. It can only lead the individual who suffers with an eating problem stranded in the symbolic or the prosaic - both positions are devoid of the texture of a lived experience, the very thing that is required to be restored to the individual if they are to have a life that is not defined by an eating problem.

When analysts and therapists accede to the statements of an individual about body size, food ingestion or food refusal without exploring them, they are leaving the patient in the pre-symbolic rather as though Anna O's arm were to remain paralysed. The experience of the arm would not be engaged with and the reincorporation of the arm into the body of the person as an arm, rather than a symbol would not be effectuated. Modern psychoanalytic technique seeks to move away from a valorisation of the body as the place in which we solely inscribe and fail to understand the human pain, suffering and struggle involved in eating problems to use psychoanalytic understandings and vision and reading of eating problems and body preoccupations as a window into what is so deeply troublesome and problematic for women today and to restore to psychoanalysis one of its more beautiful endeavours: the attempt to link our psychical and physical

elements and by so doing to give us deep insights into the gendered mind and gendered body.

2. COUNTERTRANSFERENCE

The psychoanalytic therapist has tools for her or his trade just as the neurobiologist, psychologist, palaeontologist and physicist have tools in theirs. In each of these disciplines we have instruments and we have conventions about evidence, about what constitutes a way of understanding that is satisfactory in terms of how our disciplines evaluate its own knowledge bases and increases its understand of what it is we are observing.

We make theories to account for our experience so that we can make sense of what is in our field of view. Theories don't exist waiting to be discovered, rather scientists construct ways of thinking about the relationships that can account for the phenomena they are observing. Morton (1994) is proposing one way of understanding memory and retrieval through a filing system and the heading. Edelman (1987), Rose (1992) and others in neurobiology reject analogies to computer models of storage and retrieval preferring to work within a natural selection model where out of a multitude of neural pathways only a very few may selected for in learning. Both approaches have something to contribute to the development of our understanding of the processes of memory and retrieval. The neurobiologist's interest in learning may well prove to be of interest in the long term to the psychoanalytic therapists' endeavour to understand certain internally structured and persistent responses

There are two things here. Firstly the repetition compulsion (Freud 1914) and secondly of the work on hyperarousal see for example van der Volk, & Greenberg,(1987) The psychologist is concerned with individual perception and cognition while the psychoanalytic worker is concerned with the study of human relationships and the individual's subjective experience of them. The tools of the psychoanalyst are his or her

experience of the therapeutic relationship in which speech, silence, slips of the tongue, dreams, bodily symptoms, defences, dissociated states and feelings serve as evidence of mental states produced in the relational field of the therapeutic interaction.

One of contemporary psychoanalysis's primary tools for elucidating the human psyche as it is constructed in human relationships is via an examination of the thoughts, feelings and actions which arise within the therapeutic milieu. The transference - countertransference is read for what is embedded, enacted and evoked in the relational field between analyst and analysand and thus what it reveals about the relation to self, internal objects and to others. Countertransference forms a particular type of evidence which is scrutinised by the analyst for what it can elucidate about the intra-psychic and interpsychic world of the patient and the experiences that form and modify the intrapsychic world. Countertransference is an instrument continually examined for what it is registering, how it is registering, what the analyst is contributing, what is communicated consciously and unconsciously.

Psychoanalysts have felt defensive about this form of evidence where the analyst's subjectivity is part of the field of study for two main reasons because it appears to transgress our received notions about objectivity and what constitutes a reliable instrument. Firstly many analysts long for what they perceive to be the apparent certainties in the natural sciences. Perhaps behind this desire is a wish for a certainty and clarity we often feel we don't have in the consulting room. But uncertainty is a feature and a motor force in all scientific enquiry. It allows us and forces us to learn in whatever discipline we find ourselves. Care is needed not to confuse mythologised notions of scientific research as detached, objective and certain with the actual practice of scientific research which is disputatious and infused with all the passions of human subjectivity what the French molecular biologist Francois Jacob (1920)calls the difference between night and day science. It might be useful to recall that on looking through Galileo's telescope all one sees is four tiny flecks of light. It takes the complex processes of human culture to turn those flecks of light into evidence for the movement of the moons of Jupiter, evidence which was hotly denied at the time by partisans of an Earth centred universe as being an artefact of the instrument.

I cite this incident, not in an attempt to cloak psychoanalysis in the mantle of established science but to show that under the telescope is human discourse. Much as we might wish it to be true, there is no singular method in which we find out about the world. The optical astronomer cannot make controlled laboratory experiments but does make quantitative measurement of the intensity, wavelength and polarisation properties of the received light. The molecular biologist uses genetic analyses involving controls but no quantitative measurements. The palaeontologist uses reconstructions of fossil material with no measurements or controls, while the botanist develops classification schemes to bring a level of understanding to the diversity of the Earth's flora. All of these approaches have deepened our awareness and understanding of the environment we inhabit.

The second reason that psychoanalysis has been wary of proclaiming countertransference as a form of evidence is that suggestibility, the use of self as an instrument and the influence of one person upon another in the analysis seems to discount countertransference as a 'clean' form of evidence. It is as though we discount what we know and make believe that there is a form of analysis that can be free of contamination of the subjectivity of the analyst. Although this position had some merit in the times when the analyst's countertransference was considered an impediment to the analysis, since the importance of countertransference as an inevitable and potentially useful part of an analysis has been recognised, the validity of this argument has collapsed[8] Suggestibility, the influence of one person upon another, the analyst and analysand, is the sine qua non of analysis and is part of what forms the dynamic interaction within the analysis[9]. It is not be excluded from it but part of it and part of

[8] For a useful historical account of the development of countertransference see: Gorkin, M. (1987) The Uses of Countertransference , Jason Aronson, NJ

[9] Sandler, J., & Sandler, A-M., Comments on the Conceptualisation of Clinical Facts in Psychoanalysis Int. J. Psycho-Analysis in press

See also Flax, J. (1981) Psychoanalysis and the Philosophy of Science: Critique or Resistance? J. Philos., 78: 561-569

what is investigated when trying to understand the psyche of the patient. For psychoanalysis suggestibility forms part of the field of study. It cannot be eliminated. Rather it needs to be anticipated and interrogated.

Psychoanalysis in its study of the human need for relationship and the consequent psychical operations that this engenders, makes use of the evidence of the consulting room, a complex of signals which we attempt to decode and understand. The analyst's experience is a form of evidence which is then made sense of.

Our current use of the countertransference extends the usefulness of the talking cure from the neurotic to those with more psychotic, schizoid and borderline personality organisation. Key workers in the field, Racker (1968), Tansey & Burke (1989), Searles (1979), Sandler & Sandler (1976), Ogden (1982), Gill (1982) Casement (1985), Bollas (1987) have identified and systematised many of the components making up the countertransference.

Through an analysis of the enactments within the relational matrix of the therapeutic encounter guiding much contemporary psychoanalytic theory and technique, many therapeutic problems once considered to be outside of the scope of psychoanalysis can now be addressed. Valerie Sinason's (1992) work with the mentally handicapped and the learning disabled, Searles, Winnicott and Ogden's work with the severely emotionally distressed, Davies & Frawley's (1994) work with those sexually abused in childhood, has yielded valuable results. Their work has suggested that the kinds of bizarre, troubling and disturbing feelings and actions that occur within the transference-countertransference matrix can be understood and worked through. The transference-countertransference is used as a diagnostic tool. In using the concept of the countertransference, I'm presenting here what has come to be known as the totalist position. Countertransference in this schema includes the affects, thoughts, mental meanderings and physical reactions that the psychotherapist has to the total therapeutic situation with the patient

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Although I find this usage unsatisfactory and sloppy, I recognise that this is rapidly becoming the usage. If we see transference as the patient's total response to the therapeutic encounter then we can quite rightly regard countertransference as the therapist's response to that encounter. However most therapists use transference in a narrow sense and countertransference in a totalist sense which creates considerable confusion.

Countertransference is seen as a primary mode of communication both at the literal as well as unconscious and bodily level. It is a critical source for ideas about what the patient is straining to understand and symbolise for her or himself, for what the patient needs to be heard so that she or he can then assimilate what they are disclosing. Analysts now understand that by recognising the inevitability of involvement with the madness in the interpersonal field between analysand and analyst, a therapeutic space emerges in which new understandings of the dynamics of regression, repression, dissociation, the present unconscious and the past unconscious, the transmission of bodily countertransference and so on can be explored and new understandings of the mechanisms of defence that the psychic structure employs, in order to keep on going, emerge.

Part of the controversy around 'remembered events' is that within the trauma and sex abuse literature 'remembered events' have become privileged as though remembering or recovering memories with full affective discharge is a hallmark of competent and sufficient treatment. For the psychoanalytically trained therapist this is insufficient. Such events are given meaning and importance as they are elaborated into the psychic structure and life of the individual. The event or events are significant for the way it is 'embedded in the entire constellation of the patient's internal object world and concomitant aspects of self experience (Davies and Frawley, 1994).

Where the trauma literature focuses on the notion of repression, Davies and Frawley argue that the earlier and more persistent the abuse and terror, the more the ego is overwhelmed by unformulated experience. "The child exists in a timeless, objectless and selfless nightmare of unending pain, isolation and ultimately psychic dissolution"

p44 Davies and Frawley and "To the extent that the traumatic experiences remain unsymbolized, they lie encrusted in a primitive core of unspeakable terror and phenomenologically meaningless panic, intrusive ideation, and somatic sensation. As such they exist outside the domain of recalled experience, unavailable to self reflective processes and analytic examination"

Here they are not describing repressed experiences which can be remembered and worked through, they are describing traumatic experiences which lead to dissociated states. In Fairbairn's (1954) words dissociation is "a process of disintegration due to a failure on the part of the cohesive function normally exercised by the ego". In dissociated states, as opposed to repression - and this is an important distinction within our field - there is a foreclosure rather than an elaboration of psychic contents. The unassimalatable experiences are held frozen and cut off from the ego functioning of the individual. As Davies & Frawley write: "There is no verbal encoding via which meaning can be attributed to the mental representation of these experiences. Therefore they tend to re-emerge as fragments, meaningless, visual images; rapidly shifting physiological states; nightmares; intrusive thoughts and so on" . This is very different than the temporary loss of an experience that has been repressed, unconsciously fantasised on and so on.

Sinason (1995) elaborates the very finest attention to detail that psychoanalysis requires. In her discussion of 40 year old David who associates Daddy with anal violation and misnames his father's penis for the enema, she shows us how her scrutiny of the countertransference evidence revealed that the emotional charge in David's narrative was on the evacuation and not on Daddy. Her sensitivities were alert to the possibility that his speech was as foreclosing as it was disclosing. It did not ring authentic to her. The emotional timbre of his communication which is the subjective instrument the analytic therapist uses in order to form a preliminary picture of what is wanting to be said, what has happened and so on, was indicating to her that Daddy, penis and evacuation were not equally weighted. What was hurting was the evacuation and it was David's association to that and Sinason's careful unravelling of associations that made for an understanding of the relationship between the real event of sexual abuse, the felt

violation of the enema transmitted from father to son which the son then internalised and the elaboration of a fantasy.

David's father felt consciously uneasy with administering the enema to his son. He felt it was wrong for both of them. This felt wrongness contrasts with what exists but may be unconscious in perpetrators of abuse. Perpetrators of abuse aren't simply engaged in acts of unconflicted violence towards their victims. They bring to the act of rape their own (often unconscious) shame, guilt, revenge, their own conflicted and crazed feelings which then imbue the ambience around the abuse so that what is lodged in the real event is not only the victims terror, fear, perhaps even secret desires for attention from the perpetrator. What is also lodged in the event is the split off affect of the perpetrator. This forms part of the traumatic event and in so far as the event is overwhelming it will become dissociated with all of its complexity.

Sexual abuse constitutes a particularly damaging attack on relational bonds affecting the attachment patterns and behaviours which are fundamental to survival. When these are disrupted, there are emotional, cognitive, neural and bio-chemical correlates. As much as we may learn from unravelling these correlates, it is in our work as psychotherapists that we have the opportunity and the responsibility to address the inter and intra-psychic consequences of traumatic events; to explore the real event, the way the real event is uniquely encoded in the individual's relational configuration so that its multiple meanings can be heard and faced.

3. FALSE SELF

The concept of the false self is due to Winnicott (1965). His writing expresses his attempt to enter into the lived experience of the analysand and the analyst; the baby and the mother; the parents. His is a relational theory: a theory that recognises that the uniqueness of the individual is inextricably and intimately linked with the relationships within which it is formed: there is no such thing as a baby......wherever one finds an infant one finds maternal care. His theories, his understanding of psychological development, his clinical innovations and his numerous concepts: the transitional

object, the false self, the use of the object, the good-enough mother, have entered the psychoanalytic canon.

An often observed and often felt (in the countertransference) phenomenon is when the analysand is unable to experience themselves as being viable, worthy, as existing for her or himself in a reliable way and 'being an ongoing proposition'. Winnicott discusses the way a troubled, fragmented person may constitute a sense of being for her or himself by generating emergencies, or moments of intensity, which by their very nature require attention and solutions. In the establishment of such crises, the person gathers up for her or himself, a sense that he or she engenders, manages and survives: therefore he or she exists as an active agent responding to impingements.

For Winnicott, this problem - the lack of continuity or belief in self - arises when the infant's uniqueness has not been able to be recognised. It has instead been negated. But instead of giving up, of turning away from the possibility of relationship, of collapsing into psychic annihilation, the infant, finds and develops aspects of self that can capture and hold the interest of the caregiver:

> "The mother who is not good enough, is not able to implement the infant's omnipotence, and so she repeatedly fails to meet the infants gesture; instead she substitutes her own gesture which is to be given sense by the compliance of the infant. This compliance on the part of the infant is the earliest stages of the False Self, and belongs to the mother's inability to sense her infant's needs" DWW 1960p145

This quote addressing the aetiology of the false self in earliest experience, shows Winnicott finding a language which describes pre-linguistic emotional transactions. The shape of the relationship in which these interactions occur, is shaped by the mother's psychology and the child's creative adaptation to what it is offered. In its adaptation to the maternal substitution of her gesture for the infant's gesture, the infant begins to develop a False Self as an expression of personal agency, as an active, adaptation to an otherwise unworkable situation.

Humans work with possibilities, possibilities that can be recognised within the relational field. That which is not recognised cannot quite exist. But the resilience and adaptability of the human infant is such that it will search for those aspects of self that can receive validation. It will live then with the tension of wanting to bring forth the unrecognised aspects of self (Winnicott's True Self) while not being able to trust that they are of value.

This complicated idea of Winnicott's can easily be misconstrued. A common reading renders the False Self as simply the protector of the True Self unable to activate itself. But I believe Winnicott was getting at more than this. I think he is telling us about the way in which subjectivity or subjectivities are formed in the relational field and the textural and feeling tones of the different self states humans can encompass. His idea that what the child offers back to the caregiver when its first gestures have been nullified, is - while adaptive and 'false' - nevertheless real, demonstrates the complexity of human subjectivity. The False Self is no less real than the True Self. Or to put it another way, the defense structure is an aspect of self. It contains inclinations, ways of being that need to linked with the less developed, less visible, less recognised aspects of the self (the True Self).

The False Self has been constructed within relationship. Winnicott tells us that its aetiology lies in the infant's acceptance of the mother's gestures. The infant confirms the mother through entering into her gesture and making it theirs, both the mothers' and the babys'. The False Self is a practised self, in that the person has used it for self expression. The True Self contains possibilities, hidden aspects of the personality that are feared and dreaded. The psychoanalytical therapeutic relationship is a place for the True Self possibilities (and fears) to emerge, for its gestures to be recognised and engaged with. The True Self, like the False Self grows in the context of a relationship.

The False Self and the Truth Self need to come to a different accommodation with one another. In that new accommodation there can be an integration of those aspects of the person that have been forged defensively, and those that are as yet undeveloped. If we see the False Self in this way, as the bearer of possibilities rather than the keeper of the

real person, we can understand that psychic structural change needs to incorporate these aspects of self rather than jettison them. That which has been developed 'falsely' is of value and cannot simply be given up or lost.

Many patients seek psychotherapy and psychoanalysis because of a felt disjuncture between their different 'selves'. The private self is often a self who feels shame. The public self or the one that keeps them going, is a self whose nourishment depends upon a short term fix. Deconstructing the content, the feelings, the purposes, derivations of these different aspects of self and enabling the patient to experience them as different aspects of self, minimises the space between the True Self and the False Self. Where a hole existed between these two self conceptions, which neither filled, their association makes it possible for the person to integrate and turn outside in, those attributes which once were felt simply to hang on the surface of the person, and to turn inside out, those which were once hidden and deeply private. The inter-penetration of these aspects of self, the defensive (False self) and the private (True Self) now permeate the psychic structure giving it strength, resilience, the capacity to grow, to be nourished and nourish.

Winnicott did not propose a new term for the accommodation of The False Self and the True Self. He tried to flesh out what were felt as distinctive self states that in the course of a therapy could come to a less troublesome state of being. His attention to these senses of self (senses of self that I imagine were articulated by his patients), shows us both his respect for the patient's experiences as well as his genius for understanding early psychic development. His therapeutic work is not about the substitution of one state for another but about the knitting together the adapted self (The False Self) with a True Self that now out of hiding has a chance to develop.

Winnicott's work on The True Self and The False Self has been particularly useful to me in trying to push current analytic practice with adults beyond what has increasingly to be its mentalist period. Freud's work laid the foundations for a science of body and mind. Indeed Freud and Breuer's work on hysteria was among the very first which established the connection between physical symptomatology with no discernible organic basis to emotional life. Although the early period of psychoanalysis is marked

by a high degree of interest in the inter-relatedness of psyche and soma, this aspect of psychoanalysis (with notable exceptions) has not been in ascendancy during the post World War 11 period. While work with children necessitates explicit attention to a child's physicality, it has been quite possible with adult psychoanalysis as an adult discipline to disregard the body unless it inserts itself in especially powerful ways in the consulting room (see for example Sinason 1992, Davies & Frawley 1994).

Discussion of psycho-somatic or hysterical symptomatology has tended to privilege discourse about the psychic, seeing physical symptoms as manifestations of psychic distress, rather than as indicators of disturbances in the psyche-somatic development of the individual. Furthermore, within a mentalist psychoanalysis, physical actions taken by the individual: the cutting of self, the wish of the transexual to remove external genitalia, the stuffing and purging of the body in bulimia and anorexia for instance, are explained in terms of their psychic functions. They are classed as derivatives of psychic disturbance without due reference to the psyche-somatic field in which the human being's body develops. This is often even the case in sexual abuse or physical abuse cases where the patient's body has been literally penetrated or violated but the therapist's preoccupation is with a mental penetration and violation. The vulnerability of the body is translated as an emotional vulnerability (which of course it is), but the physical basis of that vulnerability is rarely addressed.

Winnicott's work both on the aetiology of the false self and his work on the mind and its relation to the psyche-soma, provide, the basis for a paradigm shift, for reintegrating that which has become inaccurately and falsely separated into distinct but unviable discrete entities.

I have found it particularly useful to extend his work on the 'False Self' to the notion of the 'False Body' and suggest that the individual's corporeality reflects instability in physical, somatic development as well as emotional development. In other words, to go further than seeing the body as the recipient or container of psychic distress (Bick 1984, Pines 1993, McDougall 1989), and instead to problematise a false body which is allied to the false self (Orbach 1986) They are co-participants in the psyche-somatic drama.

The False body can be understood as a parallel development to the False self. The gestures of the parental body 'overwhelm' the gestures of the infant's body. Furthermore if the parental body is itself a False body, this will be internalised and 'complied' with so that mother and child are linked by False Bodies (Orbach 1986).

In extending Winnicott's ideas about the self to the body, it is then possible to link in with those observations of Margaret Mahler (1968) who in writing of children who have not been able to achieve physical or emotional separation from their mothers, have bodies that are analogous to Winnicott's 'False Selves', bodies that fail to be fully alive for the person. They are rather, inanimate or predifferentiated. Mahler's ideas on the psychological birth of the infant correlate with problems at the level of a physical existence: problems in the physical embeddness of the individual, or what Winnicott calls 'dwelling in'.

Such a shift into thinking of the body as a co-participant in the drama of the development of the self, rather than the bit player (dustbin?) who carries that which is inconvenient and psychically uncontainable, is of considerable value in clinical work. It helps us understand and approach phenomenon that are often elusive. It also suggests modifications in technique.

In wanting to suggest some technical innovations, I run into a paradox of highlighting that - the body - which at the same time I wish to be arguing, needs to be thought of as not separate from but a central part of the psyche-soma self. This is a conundrum because of our current mentalist preoccupations. But I am emphasising observing our relationship to the body in order to begin the process of (re-?)integrating the corporeal with the psychic.

A useful tool for doing this, is to regard the countertransference as a possible site of information about the construction of the patient's body, just as we do for information about the construction of the patient's psyche. This means observing and registering the physical, the palpably corporal responses that are aroused in the clinical situation. At the technical level it means extending our view of the countertransference beyond the registering of emotional affects and the enactment of role responsiveness (Sandler

1976) or reciprocal role (Ryle 1990) to observe the physical dimensions of our experience that occur during the course of our work.

I want to give a few brief examples of what I mean. In employing the notion of False Body over the last decade I have found three particular ways in which it might announce itself in the therapy relationship.

A. There can be a felt request or demand within the countertransference for physical provision. There are bodily states that have been evoked in the countertransference, notably the evocation of a contented, purring body in the psychotherapist as an external body for use by a patient who had a hated body This body was understood by the psychotherapist as a creation on the part of the patient who needed a stable body in the room from which to deconstruct her hated (True) body and begin the process of developing a body that contained rather than split her ambivalence about her physical existence.

The evocation of bodily arousal in another way has been reported to me by a psychotherapist who experienced stimulation of the 'letdown reflex', the reflex nursing mothers feel when their babies are ready to feed, during the treatment of a regressed patient. The therapist who had not breast fed for 15 years, felt the tingling of the letdown reflex over an extended period of three times a week psychotherapy. The therapist noted these physical feelings in herself as well as more specific feelings around feeding, being fed from. She had the sense of being sucked at in differing ways, sometimes contentedly, sometimes hurriedly, sometimes anxiously, sometimes angrily. These countertransference responses were discussed with the patient for their physical and psychological meanings.

B. Using the idea of the False Body, one has a way to engage with the bringing of physical distress into the therapy relationship where it can be admitted, explored and through the acceptance of it by the therapist integrated into the body of the person. What had previously remained hidden and unexplored, found shape in the psychotherapeutic relationship and could then saturate the physical and psychological experience of the person.

An easily understood example of this involves a woman of thirty five who moved her chair and body so closely into the space of the therapist that the therapist found herself moving her chair back. The patient then inched her chair closer and the therapist observed this time, her desire to move away again, to create a physical space between them that felt comfortable.

The chair moving ensued over several sessions. The therapist felt crowded out and gagged. She felt as though she was being physically overtaken. She felt nauseous. In trying to understand her response to the patient and the physical ambience between them, she reflected on what she knew of the physical handling of the patient in infancy. The patient had sicked up frequently in early childhood and then bed wetted. The patient remembers being scolded for bed wetting and graduating to migraine and vomiting.

The patient and therapist understood together many of the symbolic meanings of the bed wetting, migraine and vomiting but it was the therapist's attention to the use of the interpersonal physical space in the room that brought the patient's difficulties with 'dwelling in' and accepting her body directly into the treatment. The therapist suggested at one point that the patient's body was to some extent unplotted for the patient. She didn't know where it began and ended and that it was only in its encounter with an other, with its butting up against another, that her own physicality could be experienced. The body ego was invaded, not bounded and the patient searched for a physical boundary in relation to another so that she could make that boundary her own.

In this instance, we could begin to make sense of the difficulties this patient had with her body. The spontaneous gestures of the True body, the sicking up, were not received in a neutral sense or as a message about too much milk going in at one time. They were instead translated into rejection of the mother. The daughter took on this idea, she gave compliance to her mother's gesture, as her own. Her physical responses then embodied both her own gesture and that of her mother's reading of them. The True body fought for a presence through the migraine, the vomiting, the encroachment on the space of another. In the therapy the distress that attached to the rejected aspects of the body, were

received. The therapist saw her experience as an attempt on the part of the patient to be physically recognised. That the patient was pushy and evoked a desire on the therapist to move away was a hint about the body instability and the anxiety about physical connection. The therapists understanding of this led the way for the transformation of physical discomfort, disease and the emergence of a body within the therapy relationship that was both bounded and connected.

C. Another way in which I have observed the 'False Body' coming to therapy is where the therapist experiences in the countertransference a version of the physical distress the patient experiences. There are countertransference feelings of disintegration and disassembling conveyed from supervise to supervisor in a case of a patient whose physical sense of self was so precarious that she need to confirm her physicality to herself through cutting herself. The supervise and the supervisor in discussing the case both seemed to float off.

Since reporting this, many therapists have told me of the struggles they have experienced in trying to stay awake with a particular patient. The physical demand in the countertransference is for sleep. Of course there can be no single understanding of such a phenomena aroused in the therapist. The inducement to sleep can have as many meanings as patients and can vary its meaning in the course of a therapy. The sleep could be a request for The capacity to be alone in the presence of another. The sleep could be a request to integrate the physical and the psychological. The sleep could be a search for shared soothing and so on. The variety of therapists experiences and responses points to the value in extending Winnicott's idea of the False Self to the body. When we extend the concept, we can explore rather than reduce to the symbolic, the physical aspects of enactments in the therapy or the countertranference.

If the False Self is created in relation to the mother (or caregiver's) psychology, then the False Body is similarly a relational construct. The possibility of True Body cannot emerge until there is a relationship to receive it. We can receive the True Body, and deconstruct the False Body, if we tune ourselves to the more physical aspects of the interpersonal exchange. As Freud argues, the therapist needs to tune our unconscious

like a radio receiver to the unconscious of the other in order to receive their signals. The work can benefit by extending this metaphor in a physical sense, by tuning our bodies, we can receive signals at a physical level in response to a particular patient. We can observe what is aroused in us physically, how we place ourselves, whether we feel physically at ease or in discomfort and so on.

Attention to such details enables us to extend Winnicott's work into domains he was implicit rather than explicit about. In being explicit, we begin to dissolve not just the divide between the True and False Self but between the Body Self and the Mental Self.

CHAPTER 2 THE FALSE BODY IN WOMEN

1. COUNTERTRANSFERENCE AND THE FALSE BODY

Psychoanalysis was in its origins much about trying to understand the relationship between the female body particularly and the female mind or psyche. Freud and Breuer (1983) discuss the psyche-somatic relationship of the female body to the female mind via patients whose physical symptoms have no apparent physical basis. One of Freud's great contributions was to find the links between the material and the mental and to propose a treatment based on the symbolisation of speech.

But in post World War 2 developments psychoanalysis has now become primarily a theory of mind and mental contents. Winnicott's work stands out from this tendency in the deeply physical sense that he conveys to us about his work and his understanding of mental processes. I am referring here not so much about the use of the Spatula or Squiggle - the literal physical play between analyst and analysand, as much as the tactile nature Winnicott's writing evokes and the sense he conveys of the person's psycho-somatic integrity on the one hand or the patient's difficulties with the business of being a being. The living breathing physical dimension of the person leads to an extension of his concepts of The False Self, to the body proper by positing the notion of a False Body.

The extension of Winnicott's notion of the False Self to the False Body links in with recent developments in the understanding of countertransference, including an appreciation of the use of the body of the psychotherapists within the treatment context.

Over the last several decades, Psychoanalysis in addition to being preoccupied with the phenomena of countertransference, has also been concerned with the subjectivity of the analyst, particularly in the work of the interpersonalists and social constructivists in the United States (Arons 1992, Ehrenberg 1992, Gill 1982, Levenson 1972). Most accounts of transference-countertransference phenomena and the intersubjective field between analyst and analysand have concerned themselves with an exploration of the mental

contents of the countertransference, the affects evoked at an emotional level in the therapy situation. But there are also affects that are stimulated at a more physical level within the therapy situation. These I will refer to as body countertransference.

Part of this is a commonplace. There is body language. We are all susceptible to it and we all use it. We communicate how we feel about ourselves in how we move, how we are in our bodies, whether we dwell within them or whether we seem ill at ease. We not only communicate with our bodies we also induce bodily reactions in others.

The psychotherapist, often without even registering it, takes body clues into account as he or she assesses whether they can be helpful to a prospective patient. If the psychotherapist has been trained within a discipline that takes as its focus the body - dance therapy, Feldenkrans, Alexander, rolfing, then the presentation of self as expressed through the body is of paramount importance when trying to decode and then restructure what is amiss.

But if the psychotherapist works mainly through 'the talking cure', even though the body is noted, it will not necessarily be examined within the therapy relationship itself and the feelings that are aroused at a physical level within the therapy may be disregarded or the therapist may lack a way to think about them.

Thus, one is led to engage that void, to focus on the body, to record what happens when one thinks into that category of feeling, and the meaning of therapist's body in the therapeutic relationship.

Winnicott's idea of the False Self suggests a way to think about what's going on intrapsychically when women remold themselves physically. Women say that they do this to fit in with prevailing aesthetic standards. For many women a body that is theirs and stable, that they live in, is a fiction. They have rather a crisis relationship to their bodies and their selves as though this is a way in which a sense of self can be maintained (Orbach 1978, 1982, 1986). The somatic or body self, like Winnicott's false self, may be fashioned defensively on a crisis basis. The body self finds itself through

crises which have to be managed and survived. The body has no sense of itself as being an ongoing proposition.

Winnicott believed that when the conditions for emotional growth are distorted because of failures in good-enough mothering, the baby finds a part of itself that can engage the mother. The baby may hide its distress, hide who it is, try to work out what mother wants from it or can handle, and so on. This set of operations on the part of the psyche of the baby are the false self.

The false self as defensive structure, a way in which the developing baby tries to capture and hold the mother or caregiver that it desperately requires creates problems of an authentic sense of self, of subjectivity, that are reflected at the level of an authentic bodily self. The body self may be kept going by meeting or resisting the perceived demands of others. The false body is a way to interest the caregiver and comply with its demands at a physical level.

Many a woman's feeling that her body itself is a shaky proposition, that is to say that her body is not really for her or of her, that is unreliable, a malleable vehicle for survival, is part of this attempt at compliance. Like the unintended development of a false self to shield an embryonic true self, the woman may find herself with a body that feels wrong. It doesn't seem to be her.

This phenomenon may be called the false body. Just in the same way that we are able to problematise the construction of a feminine psychic structure (Chodorow 1978, Mitchell 1974, Eichenbaum & Orbach 1982) so we are able to problematise the construction of a feminine body or soma (Orbach 1986)

The baby whose physical needs are recognised has the chance to develop a psychosomatic integrity. The baby whose physical gestures are misread or ignored will feel physically insecure. Here I am wanting to emphasise the physical basis of early human experience as opposed to considering the physical as a mental container. The mother's experience of the child's body, her projections onto it, her wishes for it, what she sees, give the child a particular sense of its body.

In the first few months, the physical exchange that occurs between caregiver and baby predominate the relationship. The baby is caressed, fed, held, hugged, changed, wiped, dressed, undressed, bathed, dried, rocked, winded, and carried. These activities may well be accompanied by cooing, singing, talking or melodious soothing of one kind or another. Physical relating is a primary mode of contact and infancy is characterised by sensual exchange between mother and child.

The emotional ambience that the baby takes up is dependent on the conscious and unconscious actions and feelings of the baby's caretaker; so too the physical sensations which the baby experiences are interpreted for it by those who care for it. Depending upon how accurately its caregivers are able to perceive the baby's physical needs the baby will come to have more or less confidence that what emanates from it will be responded to.

Gender has determined much of how a child is physically related to. We hold our girl babies for shorter periods, the duration of each breast feed is shorter than that for boys, we wean girls earlier than we wean boys and we potty train them sooner (Belotti 1975). In general such practices are evaluated for their psychological meaning to girls and boys. But these cultural practices also devolve on females at a physical level. They impact on a girl's bodily, on her corporeal sense of self, with the corporeal affecting the psyche in an Escher like chain, which then is brought to the therapy relationship in the physical aspects of the transference-countertransference.

If we add our knowledge of these practices to the routine caution expressed to girls where matters physical are concerned - 'careful on the stairs', and contrast that with the routine encouragement to be physical that boys receive - 'come on just one more stair' - we can, of course, recognise that in the intersubjective context in which the girl's body self is formed restraint and anxiety are rife.

In understanding the development of corporeality we need to take note of the process by which the child, and here again I emphasize the daughter, takes in both the psychology of the mother and her body. She literally embodies the mother's physical presence and the mother's physicality. Her body as much as her psyche is composed of maternal

introjects and if the maternal introject includes a mother's fear, loathing, discomfort or distress around her own body, this experience will be taken in by the girl in the process of her psyche-somatic development. It will form a core of her sense of self as crucial as her introjection of mother's psyche.

As Winnicott writes: 'The False Self is built on identifications'. So too, is the female false body built on identifications. It is an identification that builds up a bodily sense that is both real and unreal. It is what the girl, later the woman has to rely on as her body and yet it lacks authenticity, wholeness or reliability. It is both of her and not of her. She can try to make it more of her by manipulating it in various ways but in an underlying sense it is a thing to be done to, to be borne, to be displayed or to be hidden rather than the integrated physical basis of self.

Another strand of psychoanalysis, evident in McDougall's (1989) work has looked at the body as an expressive mode. Her work on somatisation in which she links pre-symbolisable distress to physical symptomatology is extremely useful. Before the developing person can talk, symbolise and contextualise its distress, McDougall argues (1989) the body takes the load of unthinkable or uncontainable feelings and conflicts. Daniel Stern (1985) believes that bodily experiences of the infant have to be translated into language in order for feelings to occupy mental as well as physical worlds. A baby is soothed when words attempting to describe its' experiences of distress are recorded by the baby. The baby may not understand what exactly is said but it seems to respond to attention that is addressed to the distress it expresses physically. In other words, the interpersonal field between adult and child and the initiative of the adult provides the experience of symbolisation and hence digestion for the child, so that while it may not be able to hold in mind an idea, its caregiver can and in conveying this to the baby via the melodic scale it creates a safe psyche-somatic field for it to be cradled in.

Mahler's (968) work with psychotic children also bears on this area. She writes of children who have never attained the security of body boundaries. Just as there is no psychological birth there is also no birth at the somatic, at the corporeal level. For Mahler the process of becoming a subject, an I, involves the child having its own body

and separating from the maternal body. If this process does not occur then the body is rendered inanimate and undifferentiated or in her words "Devivified and dedifferentiated".

Let us consider three brief case accounts to illustrate these theoretical considerations.

Herta is a German women born in 1942. She grew up in Munich in the poverty which enveloped first pre-war, wartime and then post second World War Germany. In the 1950's the ideology of Kinde, Kirche and Kuche kicked in with money from the United States Marshall Plan to reindustrialise German, place a chicken in every pot and a mother in every kitchen.

Herta's mother, whose own parents had suffered the privations of the First World War and who herself had scrubbed about for food in her growing up, was very anxious about her daughter's food intake. Her daughter was colicky in early infancy and the Doctor advised mother to feed the child very frequently. Herta would in response often sick up. This was taken by the mother as a sign of her rejection by the daughter; or so the daughter reports mother's sighing frustrations with her.

In early childhood, she was very pernickety about her food which caused great annoyance but would also be a focal point for the family. She had a series of food allergies, and she had a form of Pica in which she would only eat foods in certain combinations. At school she developed an appetite and would run home eager to eat lunch but as she recalls it, there was an emotional ambience of fear around her eating and mother fretted about whether or not the daughter would like what had been prepared.

In the fifties there was food in abundance and her parents grew fat. Like many German families, fatness became a symbol of plenty and eating for them a way to put behind them the pain and wretchedness of the first thirty five years of the century. But for Herta eating and fatness contained other symbolic meanings connected to defiance against felt force feeding.

Herta developed late and was skinny. Her mother would compare her to the Juden and say that she wasn't one of us. Herta knew not what the Juden were. She knew only that Jude was bad, somewhere between human and not human and possibly had horns. When at 18, as part of Der Generation Danach, she encountered the post 1914 history of German, during the days of Student Rebellion in the 60's and she saw for the first time the pictures of the Concentration Camps and the survivors she was horrified both at her country's history and at her mother's categorisation of her as a Jude.

Herta became a musicologist and worked for a while in New York. She sought me out because of a talk she had heard me give. I don't think she knew at that time that I was a Jew because Germans frequently confuse German based Jewish surnames.

She had one child but felt herself to be a terrible mother. She had not breast fed him as a baby. She was plagued with guilt about it but had felt under pressure from the baby's father to have her body sexually available to him. This relationship had subsequently broken down. She had an early menopause in her late 30's which contributed to her feeling uncreative, a sexual and amaternal. She was deeply somatic and her career and her mothering was hampered by chronic pains caused by ulcerated colitis. She did have periods of well being in her body but these felt to her to have a quality of unreality about them.

The aspect of her therapy I want to highlight here centres around the work on her body and my body. During the therapy it became obvious that Herta desperately needed a stable body. A body that stays in its place, can do what it is meant to do - digest, feed, sleep, move, make love and so on - doesn't attack one with pain and is content with itself in a reliable way. She felt that she didn't have a body. She had pain, she had hunger, she had allergies, she had sexual feelings, but these were phenomenological to her rather than of her. They didn't express her physicality, they were what happened to her or what she could make happen rather than spontaneous gestures of a physical nature.

She would talk of the trouble that her body was to her and her inability now to follow a nutritional pattern that would minimise her discomfort. She would talk about her body

as somewhat separate from her, as enigmatic, changeable and capricious. She saw it as an acquisition that was at times under her control and at times out of her control (Orbach 1986). When she was able to recognise it as the place in which she dwelled she would be overwhelmed by feelings of hatred for it and of deep instability about its capacity to contain her.

When she first was able to show us her body hatred two things occurred to me, one at a thinking level and one at a somatic level. At the thinking level, I felt very much as though we were in the space that Winnicott talks of when he says that before the True Self can come to analysis, the therapist must talk with the False self about the True Self. I felt that her hatred for her body was a step in her recognition, our recognition, that she had no access to a body, only a defensively constructed difficult body which needed to be acknowledged as such in order for anything resembling the beginnings of a corporeal self to be activated. But while I was thinking this and feeling excited at her ability to recognise the liability of her False Body, I simultaneously had the experience of becoming deeply and comfortably into awareness of my own body and how very at ease I felt with it. I was quite struck by this. Firstly of course it amazed me that as a woman, subject to the induced body insecurity all Late Twentieth Century Western Women encounter, I could be feeling this way and in a therapy session. But beyond this unusual and rather pleasurable confrontation with my own bodily awareness in the session, it was as though Herta - in her desperate need to create a body ego for herself that could take on the functions she needed in order to deconstruct her False Body - had created for herself via me a stable, contented body that was in the room. And although she felt incapable of such a body herself, she could evoke in the body of the less than human Jude who sat with her, a body capable of holding her and containing her. She could, as it were, give up her False Body because she had made me (her rejected Jude) a True Body. She had made a body for herself within our relationship.

This deeply creative act on her part, her making of my body into a good wholesome, nourishing and stable body was the (external) body object she needed in order to struggle through to finding a body for herself. There were many twists and turns within

the Countertransference but as far as my body was concerned I never lost the underlying feeling of contentedness when with her.

By the end of the therapy, equality of our bodies was beginning to be a possibility. For most of the therapy she desperately needed me to be different from her, to be untouched by her felt destructiveness or rather to be able to withstand it intact. Here, of course, there was deep significance to my being a Jew who had not been destroyed by her parents generation, who wasn't skinny and who had a body. As she could feel some affinity with me while recognising my separateness, she could allow herself a psycho-somatic reverie within the therapy relationship.

We talked about all these phenomena together, about how she has made for me a perfect body in the therapy and how this demonstrates that she is capable of creation not simply destruction. We wondered together whether as she became more inside of her psyche and her body, whether the perfect body she had created in me would falter or come down a peg or two? But perhaps I lived in it for enough 50 minutes' to have accustomed myself to that kind of comfort and pleasure in my own body. Perhaps we can both have bodies, that she can go beyond her mother's fear of her body and be in a relationship with another woman whose body accepts her and she accepts Since Herta, I have been aware of the 'perfect body' enactment in the countertransference with patients who have eating problems and from colleagues working with those who are physically disabled.

Sara is the patient of a supervisee. I saw Sara, a fifty year English lecturer, mother of two grown children in consultation for vaginismus. Although she had managed to conceive through intercourse, for most of her marriage she suffered with vaginismus. She had divorced this husband, her only sexual partner up to this point and was starting a new life and wanting help with this problem. She had a boyfriend with whom she was sexually active but they had not had intercourse.

She sat in the chair, as nervously as anyone else who has sat in that room for the first time over the years, but I was struck by a lack of physical exchange between us and the

contrast between her self presentation of primness, an old fashioned fifties virginal school marm and her talking to me about sex and sexuality and about her previous experiences of psychotherapy and sex therapy. I thought about my own prejudice and yet still something remained: 'women like this just don't do it' I felt. She was oddly asexual to me. The colleague I referred her to, a man, saw her for three years. She overcome her vaginismus to have full heterosexual relations with her boyfriend.

About six months into the therapy, my colleague would report in supervision that for several sessions on end, just prior to her abandonment of the vaginismus, he experienced a slight feeling of gagging, a fetid feeling as though he were with an overripe mango. He found it quite distasteful. It accompanied a wish on her part to be embraced by him at the end of the session which he found himself unreceptive to although he recognised that his dis-ease was probably countertransferential, that it marked a communication from her to him that expressed her discomfort with her physicality, her rejection of her body.

But it is the fetid feeling that I think is most remarkable and interesting. It wasn't foul and malodorous so much as overgrown but it had a definite physical taste to it and a sense of smell just on the edge of disagreeable. The distaste that it aroused in my colleague was offered back as an expression of her own readiness and this interpretation which allowed for her to be ripe, which validated her entitlement to her vagina pathed the way for her to change her body image, her clothes and for the vaginismus to dissolve. I believe it was the therapists courage in putting words to the physical exchange in the room which shifted the symptom.

The last case concerns the transmission of a countertransference bodily feeling from patient to therapist and then from therapist to supervisor. In this not uncommon phenomena, the confusion the therapist feels is often communicated to the supervisor. The supervisor having received a version of what the therapist experiences tries to contain her confusion, sort through it and hand it back to the supervisee in a usable form just as the therapist does for the patient. The patient Hilary who evoked the chain of feeling is a 25 year old woman who systematically cuts herself. She is also episodically

bulimic. She is Catholic from a poor large family in Southern Ireland. Left at an early age in a hospital for many months, raised by a mother who herself grew up in an orphanage in the days when orphanages were synonymous with the brutality of the workhouse, she was untended to emotionally and physically and now has an extremely unstable psychological and physical sense of self. She has tried to create and simultaneously defy the physicality of her self. Through two mechanisms that demonstrate to her that she is animate and alive and yet transcends the normal exigencies of corporeality, the cuts to see the blood, and the stuffing and expulsion that force her to recognise that she is indeed physically encased and embodied despite her sense that she isn't (Nakhla and Jackson 1993).

She has connected with her physical experience through the bulima, through feeling the distended uncomfortable stomach, through feeling the vomit course through her body, through ejecting something that has been physically encountered. These activities provide her with a sense of existence. They make material what is often felt to be only mental. And through her cutting she is forced to feel pain, the sensate manifestation that she hurts, therefore she is.

She would rather be only mental. She has considered becoming a novice to regularise and contain her impulses, to live by a set of rules that have spiritual meaning, to make something of herself by 'giving up the pleasures of the flesh'. But she is not only mental. She is a physical being and moreover one preoccupied with her physicality to the extent that she can't leave the house for days on end because of how she looks.

Hilary is prone to confusion. It would seem as if she moves into a space where it is as though she has vaporised or fragmented into elusive bits. This is not her self description - hers would be confusion - but it is the feeling engendered in the supervisee and then in me.

During a supervisory session, the therapist was giving me a verbatim. She had lost track of a part of the session and in trying to reconstruct it she disassembled. That's the only way I can put it. I didn't know where locate her, or indeed myself, either physically or mentally. As I caught this feeling and mentioned it to the therapist, I asked her whether

this sounded similar to what she experienced in the session. She said yes. She too had felt she didn't know who what or where she was, that she was floating, uncomfortably, physically not in one place and certainly not psychically or physically encased in the membrane of her skin.

This experience pointed not to de-embodiment but a kind of unembodiment or perhaps it would be more accurate to say pre-embodiment. An experience akin to what Mahler is getting at when she talks of devivification. The person has not yet been psychically or corporeally born. She is in bits, in fragments that seem unrelated.

So how might we understand what is going on here? When the interpersonal field between the therapist and the patient impinges sufficiently to induce feeling in the patient, a patient, whom the therapist treats as subject even if the notion of an 'I' eludes the patient, the bits that consist of the unintegrated self implode and disappear. The distress I felt in the supervision, the distress my supervisee felt in the sessions was a communication about the level of physical, somatic development of the patient. The physical development was as undeveloped as her psychological or perhaps one could say that her physical and emotional states mirrored one another. When her defenses were pierced as a result of the contact in the therapy, the upheaval it caused to her physical and psychological defenses was considerable. It terrified her, it terrified the therapist and it terrified me.

These cases, although sketchily drawn illustrate the range of bodily countertransferential responses that occur in the consulting room. They open up an extremely productive terrain to increase our understanding of the gendered mind and the gendered body.

2. THE FALSE BODY IN WOMEN

The body for the woman with a distorted body image is not only the site of an expressive symptom but it is also the principle medium through which she negotiates her psycho-social existence. In the course of therapy the anorectic, the bulimic, the

(obese) compulsive eater and the woman with an unstable body size, describes her body in distinctive ways which we need to understand. We are forced to take heed of the issues of corporealisation, a person's sense of their physicality and the ways in which somatic development dovetails with psychological development.

The treatment of women with eating problems brings to our attention two interrelated theoretical questions: the first centres on the conundrum of how to understand psyche-somatic development and the taking up of a corporeal sense of self. The second centres around the notion of what I shall be calling the false body. In stating the project in this way I realise that I am perhaps raising many questions. The very words - self and corporeal - hide a multiplicity of concepts that are in themselves problematic. I am inclined to think that they are problematic precisely because the notion of the body as distinct from the psyche is in itself an unworkable proposition. And yet we are here in a dilemma for this is indeed how the patient with an eating problem experiences her body. Indeed her vision of this may be so compelling as to incline the psychotherapist to conceptualise her problems in a bifurcated manner.

The relationship between physical and psychological development poses a conundrum because this is a somewhat unworked out and undertheorized area of developmental psychology. The issue of how the self becomes a subject and how the self recognises the physical boundaries of subjectivity is to an extent a tautological exercise, for implicit within it is the notion that it is possible to conceive of a psyche-self and a soma-self.

In his metapsychology Freud has drawn us a visual/hydraulic image of development by using metaphors from Newtonian mechanics to describe libidinal growth. But at an intrapsychic level, while the body and the unfolding of instinctual aims are clearly essential to his schema, we are left with the rather undeveloped notion of the body ego.

Spitz (1965) working within an object-relations framework proposes the existence of two systems: the co-anaesthetic which is the bodily, and the diacritic which is the emotional. For him, the co-anaesthetic is eventually fused with the diacritic as the latter becomes more highly developed within the context of the infant's relationship with its

mother. As Spitz has shown, babies who are only the recipients of adequate physical care can fail to thrive. They suffer anaclitic depression and even die. For the meeting of physical needs to be of any use to the neonate they need to be imbued with an emotional resonance. In other words, the details of being attended to physically take on meaning and aliveness within the context of an emotional relationship.

Mahler, Pines and Bergman (1975) link the development of body awareness with the psychological birth of the human infant during the process of separation-individuation. As the baby develops increased motor activity and interest in its physicality, mother names the body parts and mirrors the baby's interest in its body. The baby becomes a toddler and uses its body to differentiate. Mother's responses legitimate the body and its capabilities, helping the child to build a sense of body awareness. Rycroft (1985) speaks to the psyche's capacity to 'convert meaningless physiological sensations into significant psychological experiences . . . the psyche transforms sensations, which are discrete and passively received, into experiences, which form part of a continuum and are actively created'.

Winnicott (1964) sees subjectivity and the sense of selfhood firmly linked with the physical. 'The live body, with its limits, and with an inside and outside, is felt by the individual to form the core for the imaginative self'. McDougall (1989) sees the body as the mode of expression before symbolization is developed. Before language can contain the intolerable or uncontainable feelings that infants experience, the body becomes the theatre in which distress is played out. For these theorists then, the acquisition or attainment of a corporeal sense of self is entwined with psychological notions of the self.

These ideas suggest that from a clinical point of view, difficulties in early object relations may be manifest not only in the individual's psychical sense of self but in her physical sense of self as well. The capacity to somatize - to put onto the body - symptoms of psychic distress is clearly part of this. The phenomena of a patient's feeling that she does not live in her body, that she is only her body, has 'out of body experiences', or is alienated from it in some fundamental way is not a bizarre symptom

or developmental lesion of a different order; rather it may be an expression of physical and psychic mismatching in the earliest of relationships.

When working with women who appear to have gross misperceptions of their bodies, in that they perceive them to be either significantly larger or smaller than is demonstrably the case, one is led to look at the meaning and symbolization of the body. More accurately, one is led to look at the way in which the individual creates a split between what she describes as 'herself' and what she describes as 'her body'. Such a patient experiences a distinct cleavage between a mental, thinking, sometimes feeling self and a physical self that is an unwanted or deviant part. The body is felt to be an acquisition rather than an attribution, of the self. In Palazzoli's (1974) view, this disjuncture in the anorectic can be understood as her attempt to control the still-much-needed but felt-to-be-rejecting object.

The attempt to control the body and its appetites corresponds to the desire to control the object. Similarly one might argue that the bulimic or the compulsive eater's disavowal of regulatory mechanisms in the body signalling satiety and hunger is an attempt to blot out or disempower the still-much-needed but felt-to-be rejecting object.

Using Palazzoli's framework one can see how the body becomes a powerful arena for the attempted externalisation of internal conflict. The disclaimed, disassociated body becomes both the site and the source for the enactment and re-enactment of painful affect towards the object representation. In the case of anorexia, the anorectic's wish to be free of encasement in or encumbered by the body can be interpreted as a desire to do away with the internal objects and to create a distance between the negative or destructive feelings towards the object. In this way, the (still much-needed) object is protected from what the anorectic experiences as her dangerous or poisonous self.

In the large compulsive eater, the felt greed or insatiability of the woman overwhelms the need for the object thus rendering (in fantasy) the person as autistic, need - free or unattached. The physical manifestation of apparently feeding oneself gives the appearance of desire satisfied. But just as desire must be overridden by the anorectic in order for her to assuage her profound neediness, so too, the large compulsive eater in

overriding her appetite in the opposite manner also denies her need for the other or others. Fat (like emaciation) provides, in fantasy, a symbolic bulwark against desire and against the dangers of sexuality (Orbach 1978). Both extreme body distortions provide evidence that Object Relations has a physical component as significant as the psychical component.

I shall now turn to the second proposition, that the woman with a distorted body image has a 'false body' experience. During the last several years working with or supervising the work of psychotherapists treating anorectics, bulimics, and compulsive eaters, as well as women who are not symptomatic in this way but express great distress about their inability to 'live in their bodies'. The resonance of Winnicott's words with my experience of the anorectic within the therapy relationship has led me to extend his false self to the difficulties that anorectics have in attaining a corporeal sense of self.

I situate Winnicott's notion of The False Self within the developmental model that informs the thinking of writers on whose work I have drawn. In broad strokes, they would all argue that psychological development of the infant is dependent upon the relationship between it and its mother. Psychological growth proceeds on the basis of the 'good-enough' mother or mother substitute responding to the baby's initiations, providing a containing experience in which the undifferentiated neonate develops out of absolute dependence into subjectivity. In so far as the mother is emotionally unavailable, thwarts the baby's initiatives or disregards its dependency needs, the developing psyche will incorporate a range of defense structures. The potential self develops a split, with good experiences forming the basis of satisfactory ego development while bad experiences become elaborated into highly complex internal good and bad object relations representations (Fairbairn 1953).

What is interesting to think about in the context of the bodily difficulties that anorectics express is just how much - as far as we can surmise - of the baby's earliest experiences are primarily those of sensation. In these first few months, the physical exchange that occurs between caregiver and baby predominate the relationship. The baby is caressed, fed, held, hugged, changed, wiped, dressed, undressed, bathed, dried, rocked, winded,

and carried. These activities may well be accompanied by cooing, singing, talking or melodious soothing of one kind or another. Physical relating is a primary mode of contact and infancy is characterised by sensual exchange between mother and child. The emotional ambience that the baby takes up is dependent on the conscious and unconscious actions and feelings of the baby's caretaker; so too the physical sensations which the baby experiences are interpreted for it by those who care for it. Depending upon how accurately its caregivers are able to perceive the baby's physical needs, the baby will come to have more or less confidence that what emanates from it will be responded to.

"The False Self defends the True Self; the True Self is, however, acknowledged as a potential and is allowed a secret life...The False Self has as its main concern a search for conditions which will make it possible for the True Self to come into its own...The False Self is built on identifications..." (Winnicott, D.W. 1960 p143)

Thus Winnicott lists some of the critically important defensive functions of the False Self. The aetiology of The False Self are the failures in good-enough mothering discussed earlier.

If we extend the notion of the False and True self to include the body we have a handle on understanding the following important phenomena in women with severe body image distortions. Winnicott's concept of compliance helps us make sense of the woman's capacity to change her body, her weight, her size or shape to comply with what she imagines is acceptable.

A woman may come to feel that her body is not really for her or of her; rather it is a malleable vehicle for survival through attempted compliance. Like the unintended development of a false self to shield an embryonic true self, the woman with a distorted body image finds herself with a body that feels wrong. It doesn't seem to be her.

If the false body can be understood as having similar defensive functions to the Winnicottian false self, we can then see statements she makes about her hating her body as authentic statements which relate to what she feels lurks behind the false body,

i.e. an embryonic-hated-body. Just as the True Self fears that it will be found to be unattractive and that disclosure will bring rejection and just as the True Self has little facility for being, so the True Body is an unknown entity. The True Body does not exist within her imaginative possibilities except as a ghastly expression of unmet need. The creation of a false body developed to comply with the felt demands of an inner object.

She doesn't know her True Body, it has never been welcomed into a relationship and been authenticated. Just as the True Self needs to be received within the therapy relationship in order that truncated development processes can be put in train again, so the True Body - with all the attending hesitation that accompanies revealing it - needs to enter into the therapeutic dialogue in order for it to come to life.

Of all the body image distortions, the anorectic's distorted sense of her body is most palpable. She powerfully feels that her body is not right. Let us see here if we can understand what occurs in the mother-daughter relationship that ends up in what would seem to be a mother's misinterpretation of a daughter's cues and the substitution of mother's gestures which can then lead to the creation of a false body sense in an anorectic.

The gender prescriptions that have such a profound effect on all aspects of mothering (Eichenbaum and Orbach, 1982, 1986) are no less important in the development of a girl's corporeal sense of self. In trying to separate out the various influences that come to be expressed in the relationship to the body, four areas need to be considered.

Firstly we need to consider the fact that in raising a daughter a mother will be inclined to shape her physical development in line with accepted social practices. While girls of today's generation may well not experience a message of physical restraint and caution, girls growing up ten, twenty, thirty and forty years ago were certainly the recipients of a pattern in which they were counselled to show restraint in physical and sexual matters. From the playground to the dating arrangements of teenage years, girls' and boys' behaviour continues to be rigidly divided along sex lines. Beginning with the daily life of an infant and toddler, this division involves more than the obvious observable differences such as encouraging a boy to climb a ladder while sending warnings of

caution to a girl attempting the same task. The need to teach a girl to be physically a little girl involves three processes; one of negation, one of omission (teaching a twenty month old girl to kick or throw a football is not common practice) and one of positive encouragement.

Girls learn from am early age to take an interest in particular aspects of their physicality. Little girls learn about looking pretty and wearing appealing clothes. They hear so frequently about their prettiness that they take in the idea that being pretty and having pretty clothes are crucial and important attributes. Looking attractive is essential to their well being, to attracting a partner and so on. As they get older they learn the physical gestures that ensure that they are feminine. They learn how to hold a cup gracefully, to wipe their noses daintily, to run and walk in a 'ladylike manner'. As a result girls walk around with a sense of being watchful about their bodies. They know not to sit with their legs apart, they become fearful of vaginal odours, they know to harness their breasts in bras, they know to be careful lest they show evidence of an unexpected or particularly heavy menstrual flow and so on.

In contrast with girls, boys grow up learning that their bodies are powerful for them. They learn to push their bodies and to take pride in stretching their physical capabilities. It is as though we are looking at a mirror image: girls learn to restrain or contort or give up a potential, boys to extend a potential.

The same teaching extends to sexual matters. Girls are still learning that they shouldn't be giving their bodies away too hastily. This sentiment exposes the idea that a girl's body is essentially for another, her enjoyment of her sexuality will come through entrusting her body to another. In contrast a boy learns that his sexual appetites are legitimate and for him, something he is entitled to act upon. Ideas about gender and sexuality are not simply acquired in adolescence, they are part of parcel of what is conveyed to little girls and little boys in the process of growing up. Girls learn that a kind of physical demureness is appropriate and that a sexual relationship is part of the obligation of being a wife and mother rather than a proper female desire in itself.

In the last twenty to thirty years, this injunction of physical and sexual restraint has also extended to girls' management of their appetites. Current child rearing concerns express fears that children and especially daughters will grow up fat or with food problems. Much of a mother's concern for her family and an approved aspect of her social role is shown through food and so she is invested in her children enjoying it. She may, however, give confusing messages about food, especially to a daughter to whom she imparts the crucial lesson of being watchful of her desires in that area lest she be seen to be greedy and unattractive. And on the one hand she wishes her daughter to show pleasure and enjoyment in the food that she has prepared for her while on the other hand she directs her to be heedful of the food needs of others. There are significant differences in how girls and boys are breastfed related to time and amount and even weaning practices. In cultures which value breastfeeding boys tend to get more of it for longer and are weaned more gradually (Belotti, 1975). As children develop, the message of restraint is one a girl hears frequently. She sees and hears about other females being involved in food in a particularly intense way. She learns about good foods and bad foods, foods that make you fat and foods that make you thin. She learns there is something naughty about bad foods and they become particularly attractive to her. Food and eating takes on all manner of symbolic meanings so that it frequently loses its fundamental relationship to appetite (Orbach, 1978, 1982,1986).

Mediating the learning process by which a girl acquires her sense of physical restraint is the dynamics of the mother-daughter relationship. Mothers may well wish to give their daughters a far less conflicted notion of sexuality. They may well wish their daughters to be free of the food and weight problems that they may have experienced in their adult lives. And they may be able to convey to their daughters that their bodily desires and appetites are wonderful and wholesome. But such a message is unlikely to be unambivalent, for each women internalises the dictates of the culture in which she lives and her personal desires interact with wider cultural practices. More importantly, and this is the third point I wish to raise, most mothers themselves experience a measure of discomfort with their bodies. The same practices they are passing on to their daughters are practices that they themselves have learnt and internalised. This means that it is unlikely that mothers themselves will be relaxed in their physicality. The mother's body

is more likely to be the site of a kind of discomfort itself, to express the injunctions that have been absorbed in relation to sexual and physical appetites of all kinds.

Thus many a daughter has heard her mother sigh about the shortcomings of her body, many a daughter has witnessed a mother dieting and sneaking food, many a daughter has watched a mother put on her 'face'- the mask of make up that women learn to don in order to feel alright in themselves. This physical ingestion into the heart of the corporeal sense of self means that a girl will introject her mother's feelings about her body. If mother experiences the discomfort so endemic in Western female experience of the body, then a version of this will be introjected by the daughter. If the mother feels confident and at ease with her physicality, this will likewise be imbibed by the daughter. Hence, the daughter's corporeality embodies the mother's feelings about her body, her experiences of the physical interactions between them, as well as the instructions and modelling about appropriate physical femininity.

Beyond instruction, beyond the observances of the mother's physicality, the daughter also has another even more direct experience of mother's body which plays a significant role in the daughter's perception of self.

The process of psychological development discussed before involves the 'taking in` of the mother's emotional presence in the formation of the girl's identity. The essence of emotional growth depends upon the relating that occurs between mother and child. Part of what the baby is taking in the forming of its own personality is the physical sense of mother's body. It is actually mother's body that seems to provide or withhold succour, she gives the breast as it is wanted or she seems to press it on the baby or withhold it without the baby being able to comprehend or control its actions. The baby is scooped up and held in mother's arms in a comforting manner, but again not at its whim, at mother's. The physical presence of mother is potentially containing but also potentially disappointing. In crude terms, the mother's body is loved for meeting the baby's needs appropriately and hated for mismatching.

Just as the baby introjects mother's personality so too, the baby takes into itself the physical presence and ambience of mother and develops its own physical sense of self with this physical imago of mother.

All these experiences are folded into the complex of interactions that occur between mothers and daughters in relation to the critical areas of body/ physical awareness. The misdirecting of internal physical cues, the introjection of the mother's body, the experience of the maternal body and the gender specific focus on a girl's body undermines the possibility that the daughter will develop a secure body image. A daughters initiations are not authenticated, her gestures misconstrued and her mother's gestures offered in place of her own. This mismatching provides the preconditions for symptomatology that includes body image distortion.

A common occurrence during therapy with an anorectic is that a woman may at first say her body is alright, that there is nothing wrong with it and she doesn't know what all the fuss and focus is about. She may shun discussion of her body size, she may hide herself in oversized clothing, if pressed she will most frequently utter the sentence "it's too fat, it's horrible". During the course of therapy she is able to acknowledge that there is something wrong and that she does hate her body. Without wishing to press my idea into Winnicott it does seem to me that when this happens in therapy the potential true body has come to treatment. I recognise this point as having a parallel with Winnicott's observation that before the True Self has come to treatment, the therapist can only talk with the False self about the True Self. In other words, until the hatred and fear and the shakiness of the body are experienced and acknowledged one has to respect the protective functions the False Body embodies.

Perhaps a way to look at this is by seeing that the anorectic despises her body and that hatred of her body is a reflection of a more general kind of self hate, despair and hopelessness not able to be experienced directly. The hatred then is an authentic experience which has arisen out of failures in the early environment. It is a parallel development to feelings of self loathing or hate commonly seen in women which when reached in therapy are often a sign that potent defenses have been lowered thereby

opening up the possibility of direct engagement with the embryonic self. Such ideas are often expressed in a different form in the anorectic. With her they make their appearance firstly and most forcefully around how she feels about her body.

What this means clinically is that it is fruitless to dissuade the anorectic - except in the reality aspect of the therapeutic relationship - that her body is hateful. It denies her getting to a true experience. That hate needs to be acknowledged and received within the therapy relationship. And the hate that she carries needs to be expressed not just once but many times. When it is felt to have been heard, the way is open for the feelings projected onto the body to be integrated into the psychosomatic gestalt of the person. A productive way to discuss it might be as follows:

Pt: I really hate it. It is so fat and ugly.

Therapist: I think we have come to understand that despite the fact that your body is not in any objective sense hateful, you experience it as hateful and the horrible part of you.

Pt: I wish I could just do away with it, I hate it so much. Every hour of every day I am accosted with horrible feelings about my body.

Therapist: These powerful feelings of hate and horror for your body are feelings we need to face and understand together......

At another time one might have taken up the meaning that the hated 'fat` body is invested with, but in this instance I am wishing to point out the importance of the therapist's accepting the feelings of hatred, not by accepting the patient's definition of the body, but by receiving the patient's experience of it. In doing this one is interposing a bridge against the division between a felt 'ok self' and a hated 'body'. The anorectic has designated her body as the source of her problems and the changing of her body as the solution to her problems. While the therapist needs to generalise the distress, she cannot do this by disregarding the actual phenomena of body hatred that the anorexia expresses. And just as the patient comes to use the constancy and rightness of the therapists interventions in the building of an authentic self, so the patient will come to

use the body and the physical presence of the therapist in the making of an integrated psyche-somatic sense of self.

Pamela sought treatment for her eating problems in her late thirties. She presented as a large compulsive eater and during the course of twice weekly psychoanalytic psychotherapy lasting six years she had two brief periods of anorectic symptomatology. P is a professional woman in a stable marriage. She has three children. When she originally came to therapy she presented as an enthusiastic earth mother who took care of everyone, her children, husband and relatives. Her work in medicine mitigates a self experience of being unworthy.

In the beginning phase of therapy she described herself as a compulsive carer. She needed to do this in order to feel of some value. She identified with the recipients of her own care and experienced short term (narcissistic) gratification that her needs were being attended to in the process.

Alongside a need to administer to others was the world's experience of her as capable and competent. This was confirmed by her professional status and people's regard for her. However her interior experience was one of fraudulence. She was unable to hold together a sense of her accomplishments as being other than tricks she could pull off or 'naturally endowed skills' which she could claim no credit for. Her considerable abilities were disavowed or rather hung outside of her finding no internal reflection and thus could only be used in the service of survival rather than as nourishment.

This was mirrored in relation to her body. She felt only critical and that her body was counterfeit. Here where she felt she did have some responsibility and expert knowledge she experienced herself as refusing it. Often it felt to her as though her body 'was in control' not her - she could exercise no authority over it. She described it as a self willed child. Her body was a lump she was forced to accommodate to but one she refused to inhabit.

Her physical shape when she entered therapy resembled her paternal grandmother's body. Grandmother had been a figure of warmth and steadiness. Grandmother had lived

in the family home when P was a child and P experienced some tension between mother and grandmother over how much P should be 'spoiled and fussed over'. Grandmother's body was not experienced consciously in any negative way. Rather P took comfort on grandmother's lap as a child and in grandmother's physicality around the house.

P's mother's body was sturdy and trim but quite unwelcoming. P remembers running to hug her mother after an absence of several weeks when she was 15 and mother physically recoiling. P was of 'normal' size at the time but this experience translated inside of herself into the notion that there was something physically repulsive about her; that in her very being, in her spontaneous physical gesture she was unacceptable and too much.

P went on a diet, became briefly anorectic (about 6 months), then bulimic (for a period of eighteen months). For the last twenty years she had been a compulsive eater - sometimes briefly within normal range, more frequently 20kg larger than she wished.

During therapy, P's experience of mother's recoil was repeated at both the physical and emotional level several times. P found these experiences deeply shocking for in part of her unconscious she had split off the rejecting aspects of from that of the good aspects of mother who could be embracing. Up to that point she was only aware of the physically welcoming mother. The pain of her actual physical encounters with her mother were too distressing to bear and she had recreated mother as a physically alive and engaged person inside of herself. P responded to the shock by eating more to obliterate and cushion the pain but as the therapy progressed she dares to encounter the feelings more directly and to absorb and express the pain these encounters held for her. During this process her awareness of my lack of recoil, my physical and emotional acceptance of her assured her that she was not only capable of evoking rejection.

P realised that she had two distinct experiences of her own body; one which identified with that of her paternal grandmother which was warm, fleshy, and abundant and another which was 'absent in its presence'; that is to say, not stable, not knowable, unreliable.

It was this unreliable experience of her body, an elusive body that matched her early and continuing experience of mother and it was this aspect of her own corporeality, the unstable, almost non-material aspect of her body that provoked her to try to transform that body - to make it comply with what was wanted. She experienced her mother's recoil as a recoil of her physical and mental existence. But at the same time, she had physically internalised her mother's 'absent presence'.

Her physical sense of herself contained both an absent body (the maternal introject) and a present more welcoming body. This split experience entwined as it was with her early development meant that she had alternating views and experiences of her body. Her grandmother's physical and emotional presence probably protected her from more extreme symptomatology as it offered her some form of identification with a reasonable physical and emotional subject. However, the mother's disdain for grandmother and the conflicts between them meant that she could not unambiguously identify with her for this would have represented abandoning her internal relationship with mother.

Her body instability was linked with mother and this instability strove to find some security and recognition through the remaking of itself when she became anorectic. But the anorexia while bringing her close to her internal world of denial failed to offer her the imagined acceptance and recognition she would receive when she allied herself with the still-much-needed but rejecting object. Her continuing need for the rejecting object provoked her into a Winnicottian 'compliance'. She created the imagined 'false' body.

Her alliance with the grandmother's body was also a 'false body' experience. Through identification she attempted to have a body like the body of her grandmother, but this was no more authentically her own body. Often the most accurate reflection of her corporeality was paradoxical. She either experienced her body in bits held together by broad piece of elastic or as its opposite; a undifferentiated lump that could absorb anything, mold itself to anything, become almost inanimate one moment and highly adaptable the next.

In the therapy, my body came to represent both mother's body, grandmother's body and an ideal body. It so happened that during the course of her therapy, I became pregnant.

This event interposed my body into the therapy in an extremely vivid way and became the basis for much discussion, a certain amount of projection and a perhaps unique opportunity to work on her difficulties with having a body that was hers.

My body was experienced in a range of different ways from embracing, to withholding, to contained. I explored P's perceptions of my body as one might any other aspect of the transference and to the best of my ability I endeavoured to sort through the projections while allowing for identification and disidentification with my body. The pregnancy with its dramatic physical changes highlighted the impossibility of her having a stable sense of her body. At times she felt herself to be very fragile and frail. She was fat but this fatness covered up a physical delicateness. She had in fact been a rather sickly baby (or so she was told) and this sense of physical fragility alarmed her. It seemed at odds with her physical presence and yet there was something authentic about it. She imagined that I felt similarly delicate during my pregnancy (although she had remembered feeling robust during all her pregnancies except for the latter part of her third). It was as though she needed acknowledgement of delicateness; she needed recognition and legitimacy of it and when she could see me as delicate she could begin to allow her body to develop and strengthen from its rather weak roots rather than through 'over feeding'.

As the therapy proceeded we worked on the dilemma of her having a body that was neither Grandmother's, mine or her mothers, but her. In time, her body changed and became similar to mother's physical shape although the ambience that infused her body was far from one of an 'absent presence'. P felt at this time a certain fear that she would become her mother and that her attributes would be inverted and she would discover herself to be a cold uncaring, physically distancing person. The therapeutic dialogue was able to hear and work through her fears of her own psychic and physical coldness. My physical and emotional engagement acted as a counterpoint. She could risk restructuring her internal world in the presence of someone whose physical -psychic engagement she could begin to trust.

In working with P as is the case in work with other women with distorted body image, the therapists body can become prominent feature of the therapeutic milieu. It will at times be experienced in dramatically different ways, receiving the projections of the patient, being felt at one moment to be comforting and embracing at another to be large, invasive and too present. These feelings on the part of the patient will be an important thread running through the therapeutic dialogue. The patient has only a crisis relationship to her body and cannot imagine that in any sense the body in which she lives will be a source of strength for her. The anorectic's relationship to her body is such that almost every half an hour a ritualistic practice of some kind is undertaken so that a continuity of experience is kept up with the false body by it being remade again and again. By using the body of the therapist to work through her feelings about her own body and her mother's body she begins to introject a different physical presence and different physical possibilities for herself.

For the compulsive eater, a parallel process is in play. The act of eating without regard to hunger means that physiological processes that could provide for a sense of continuity are continually disrupted. There is an internal drama played out around hunger and satisfaction. Whether in dieting behaviour or in bingeing, the compulsive eater lunges from one crisis to another which she survives. The diet is the task she sets herself up to conquer, she manages and then fails, thus creating a series of exigencies that must always be overcome.

I have been suggesting then several things. Firstly I have proposed that we need to take account of the process of corporealisation and to see how its linked in with psychological development in general. We can see how problems in corporealisation express difficulties in object relations and how the body comes to take on aspects of those object relations. In the clinical situation I am suggesting that we need to look more closely at the actual particulars of the relationship a woman with a distorted body image has to her physicality in order to understand the developmental problems that have occurred and in order to help her restart developmental processes around the True Body, processes that I suggest are akin to the Winnicottian notion of the growth of the

True Self. And I have been proposing that looking at body image distortions in this way can be seen as the physical expression of the developmental level of Object Relations.

CHAPTER 3 GENDERED MIND GENDERED BODY: THE FAMILY

1.WOMEN'S DEVELOPMENT IN THE FAMILY

External cultural forces press in on psychological development creating particular structures in the individual family which then incline the psychological development of its daughters in specific ways. Culture defines the context in which the individual is producing intra-psychic processes through which the individual makes psychological sense of an experience, where gender and the primary role of mothers (or female maternal substitutes) is central in the development of a girl's psychological and physical sense of self

This perspective is drawn from clinical practice where for the past twenty seven years, I and colleagues have attempted to theorise the unconscious and conscious experiences and utterances of the adult women seen in therapy.

THE SOCIAL PICTURE

This last 27 years has been characterised by enormous turmoil and change for Western women. The Women's Liberation Movement has affected the lives of all women whether individual women have consciously identified with it, actively rejected it or felt that it had nothing to do with them. Women from all class backgrounds and cultural groups have observed that the public sphere has opened up ever so slightly for women: the mass media has begun to depict women in roles and situations unimaginable twenty five years ago; there is a new public rhetoric of equality for women while educational policy now purports to embody anti-sexist directives. Popular women's magazines aimed at women in different classes and age groups encourage women to get out there and go after what they want. Corporations run assertiveness training courses. Thus young women and older women are able to think about the world and their place in it in slightly less limited categories than their mothers.

But what is apparent to me, both as a woman and as a psychotherapist, is that the new expectations women may hold are not unproblematic. Women have been brought up to feel a certain way about who and what they are, what is and is not possible, and thus women find themselves unable to take up some of these new opportunities or ways of seeing themselves without conflict, guilt and stress.

At the same time as some of the new expectations cause certain kinds of difficulties, it is apparent that socialisation to the old ways of being didn't work either: 1 in 7 women are hospitalised as mental patients during their lives; women are the major users of psychotropic drugs; smoking is still on the increase in women; alcohol misuse is on the rise in women; eating problems are so widespread in women that they can be considered endemic. In other words, something is not right in women's psychological or mental well being. The political, economic and social reasons for this are no less complex than the psychological ones.

To better understand how women see themselves psychologically in these changes and how they may or may not cope with them, we need to understand the various psychological processes that prepare women to live in the world.

CULTURAL PRESSURES THAT AFFECT THE BABY

My starting assumption that the baby enters a world with the capacity to share in it and contribute to it, with a capacity to affect and be affected by those around it. The infant is perhaps best understood as a set of possibilities.

A girl baby raised in France to French parents will speak French, develop characteristics we associate with the French, will have body movements we recognise as French. The same baby girl raised by English parents will walk, talk and gesture like an English girl; she will have developed mechanisms like the rest of her contemporaries which will engage her energy towards common goals.

Despite the obvious nature of these facts, we are used to thinking of human nature as fixed. Even if we reject crude genetic arguments about personality and desire, or Freudian notions of libido driving us, we carry around a sense of ourselves as being

unique and, when pressed, we have few ways to articulate how we understand that uniqueness to have come about. We often discount culture, the culture of the individual family, of the extended family, of our class, of our racial or ethnic background, the educational culture we were part of as having had a part in making us the unique individuals that we are. But these enormously important contexts influence and shape us in profound and deeply idiosyncratic ways.

In saying this I am not wishing to give the impression that the baby enters the world as a blank page on which anything can be written. But I am wanting to stress that much of who we become, much of our emotional life, is shaped by the complex of influences that engage with us from very early on.

THE BABY AND HER CARER

the last several decades psychoanalysis has made us aware of the critical nature of early relationships in general, and of the mother-child relationship in particular. However it has abstracted those relationships, making the parental or care-giving figures objects - objects who fail or who meet children's needs. The subjectivity of the care-giver, her social circumstances, her psychology, is rarely in view.

For a gender conscious psychoanalytic perspective we have to read into these early experiences the experiences of those who parent us. This means that we will recognise that the way they parent, their capacities and their emotional availability will embody in some distinctive way their own social and psychological circumstances. A second generation black child whose grandparents grew up in the West Indies will be entering a culture that is both overtly and subtly racist. This racism will have deeply affected its parents lives and will find some expression in how the child is parented. The child will be affected by how the parents try to prepare and protect it from the effects of racism. Similarly, a parent who is disabled or has a disabled baby knows that her child will face actual discrimination because of our culture's disregard of disabled persons. The parental introject that the developing person takes inside of herself will include the parent's self experience.

This is important to have as a background when we are approaching the issue of psychological development, for it is all too easy in talking about the internalisation of bad object relations or the phenomena of projective identification or the concept of transference, to become enamoured by technical intricacies and lose sight of the social milieu and social constraints in which these psychic possibilities and outcomes in each of us, and in our clients, develops.

So the baby girl comes into the world. She leaves the physical womb and continues to be cacooned with her mother, sucking, sleeping, excreting, gurgling as and when she feels like it. She is apparently receptive to her local environment, but everything in it has to be organised in such a way that she can digest it. She can't yet distinguish colour, when she is eating, whether she has a mouth or a breast, whether or not she provides the food that nourishes her. These concepts are as yet foreign and incomprehensible to her. She is the recipient of care. She relies on others for that care. Indeed, it is so much the job of her caretakers to directly introduce her to the world that certain capacities, what I have earlier called possibilities, will only develop if they are attended to. Capacities we think of as being natural are possibilities that can take form only if they are organised and developed within the context of a relationship with another or others.

For example, a baby who grows up without language will not learn to speak. A sighted baby raised by blind parents has to be taught by people other than its parents to organise the shapes, gradations of colours and depths of field she perceives into comprehensible categories in order to see in a conventional way. A baby who is fed, bathed and changed but is not held or is not the recipient of human touch and holding may not thrive. Everything we think of as human has to be introduced to the baby in a way that she can use it, otherwise she does not develop in a way that we recognise as human. Wild children, those who have raised themselves as in the famous case the wild child of Sauvignon, fail to develop characteristics we associate with human beings. The way we become human is by apprehending human skills, characteristics and values in the context of human relationships. As Winnicott said, there is no such thing as a baby. Whenever you see a baby you see a relationship.

THE INTERNAL WORLD OF THE BABY

Psychoanalysts call the emotional world that the baby enters into, the world of object relations. This is to distinguish between the people who are in the baby's actual world and the psychic internal sense she can make of these relationships. The people in the baby's world relate to the baby in one way, as carers, as parents. For the baby they are sometimes experienced as whole people and sometimes as parts - a soothing hand, a warm breast, a pinch, a loud voice, a big smile, and so on. If we put ourselves in the baby's place we can see how small our field of vision becomes: we see a hand blurry in front of us, a coloured something or other making a noise; we receive stimuli we don't know necessarily know what to do with and we fade in and out of our world of sleep. Gradually we perceive a pattern to these sensations and objects. We begin to make a picture of ourselves in this field. We become accustomed to our mother's voice, to her hands, her smell, her feel and to the way we are handled. We feel discomfort and comfort and we associate it with what she is or isn't doing. She comes and she goes, she tends to us sometimes but not at other times. We get used to the feel and rhythm of her caring presence. Perhaps as a baby we begin to develop an awareness that we cannot control her or how we feel. She decides to change us, to feed us. She decides to listen to our cues or to disregard them.

As the baby internalises the good and responsive caring, it grows and flourishes. Care of a kind that can be metabolised becomes the food for psychological growth and development. Our development is both physical and psychological. The baby learns to recognise repeated physical sensations and stimuli that she initiates or receives. The baby develops psychologically with a knowledge of itself selves as existing in a mental sense and a physical sense. In other words, a psyche-somatic unity is being knitted together in which physical experiences have a psychological component and psychological experiences have a physical component.

As the baby develops and grows, it takes in aspects of maternal care (for it is maternal care which most of us experience) which can best be described as a psychological umbilical chord connecting the baby to its carer. It surrounds the baby in a womb-like

fashion until the baby develops sufficient motor and cognitive capacities to distinguish herself from her carer. It begins to know that a certain feeling is hunger and that it is satisfied by something outside of ourself, mummy's breast, a bottle or a banana. It distinguishes between being wet or dry, hot or cold. As Winnicott put it, the baby builds up a sense of itself as a person through repeated experiences which create continuity and give it a sense of being held emotionally and physically. This knowledge translates into the baby's experience that if it cannot be attended to the moment it is in need, it can carry a memory of the details of maternal care and soothe itself in that way.

As the baby develops language and motor skills, the capacity to show what it wants and resist what it doesn't, she proceeds towards a phase many psychotherapists have seen as crucial: the phase of separation-individuation which occurs between eighteen months and two years. This is a time when the toddler begins to have a sense of its physical powers, when the me/not me is becoming more distinct. It can survive when mother or any of its major caretakers leave the room. It is beginning to have a sense of selfhood, to know itself as a person with a physical beginning and end and a emotional life of its own. As she develops, she has to cope with the discomfort that she is bound to feel. How does the developing person manage disappointment while still very dependent on another?

PSYCHIC STRUCTURALISATION AND OBJECT RELATIONSHIPS: THE WORK OF FAIRBAIRN

As Fairbairn (1952), the Scottish analyst, understood it, one process is involved with trying to understand the whys of the felt neglect; i.e. why did mummy not make me comfortable then, why is everything so difficult now. Of course it isn't articulated in this way by the infant, but Fairbairn speculated that a version of this kind of attempt to question and reason is occurring inside the infant's embryonic mental apparatus. With this comes a great need to protect the still much needed caregiver. A kind of idealisation ensues in which the baby attempts to relieve the pain of helplessness by 'blaming' itself for instances of parental neglect or mismanagement. In other words, the primary caregiver is maintained as a potential giver and the disappointment is

explained, forgiven or excused by the baby itself taking on the responsibility for the failure to receive. The baby's internal response is "I'm not good enough, my needs are destructive, my love and dependency is too much".

A second process is caught up in repudiating the need for the care. The care that is desperately required is now negated. The baby's response is "I will care for myself, I do not need you". There follows a withdrawal of what Fairbairn calls libidinal energy from the primary caregiver, and the creation inside the infant of two images of the mother who now becomes an object which is more in the child's control. One image contains a bad, mean, withholding, disappointing and frustrating mother. The other is a soothing imago containing a nourishing, all present, ever understanding mother. The mother is loved and idealised on the one hand and hated on the other. The powerful emotions that the baby experiences are now held within its internal world, inside the world it has fashioned, a world of object relations. The world of object relationships is a retreat from the unsatisfactory aspects of actual relationships.

The satisfying experiences of maternal or parental care contribute then to the baby's growth. The unsatisfactory experiences of care create what Fairbairn calls a schizoid split in the personality. They propel the baby away from people into a world of objects that seem more controllable, and in that internal world the baby has some power and personal agency. She can explain her mother or caregiver's neglect by reference to her own actions - she is too much, too needy, too difficult. She moves out of the position of one who is a passive recipient of care and into the position of being active in relation to her care.

This embryonic psychic structuralisation becomes reinforced in the passage through to adulthood where we can see from the following example, it shapes one's internal experience in complex ways.

Jennifer is unhappily married to Bob. They have been together for 12 years and have three children who are ten, eight and four. Jennifer wants to leave Bob but she feels too insecure to do so, psychologically and financially. She is emotionally and economically dependent on Bob and hates herself for being so. She wishes she could stand on her

own two feet and has enormous contempt and self disgust for her continuing reliance on him. Although the ways in which Bob lets her down, thus fuelling her rage, follow a pattern and are therefore reasonably predictable, she hasn't come to terms with the fact of his being disappointing. She hasn't accepted who he is or the way he is. In between the instances of his disappointing her, she unconsciously resurrects him in her mind. He becomes the knight on the white horse who is not Bob but some idealised version of him, a white knight who can do no wrong, who will understand her, love her, please her and so on. Hence when he acts like himself, that is like old ordinary disappointing Bob, she is devastated. She hates him for falling off the pedestal that she has, without even realising it, set him up on. She alternates between dislike of him for not being the white knight, and dislike of herself because she thinks if only she were a good, less demanding wife he would give her what she wanted. In her internal world, the disappointing bits of Bob have been both idealised and degraded. The part of her that unconsciously idealises him blames herself for her failure. The part of her that hates him is humiliated by her attachment to him and tries to repudiate her need of him altogether.

Jennifer's mother who raised her single-handedly was a rather cold and unavailable woman. Although Jennifer dislikes aspects of her mother and feels deeply hurt by her, she would nevertheless describe her as a good person who looked after her thoughtfully and intelligently. From Jennifer's conscious point of view, the shortcomings of her childhood were circumstantial due to her mother raising her alone.

Inside Jennifer's internal and unconscious world, another reality, equally compelling, is at work. On the one hand she idealises her mother and desperately wants her to be warmer and closer. She craves from her what she was unable to give when Jennifer was little. When her mother comes to visit, Jennifer is full of anticipation that this time it will be different, this time they will understand each other, this time she will get what she needs. And yet, on each visit she is left feeling cold and empty. Her desires go unmet and her longing turns in on herself as depression and rage.

Bob's ways of disappointing her are not the same as the mother's ways but she experiences them similarly. The psychic energy first invested in her mother and then

withdrawn into the world of object relations has been reinvested in Bob. When he disappoints her, she has the psychic apparatus in place to cope with it. She can't leave Bob because she feels his lack of giving to her to be her fault, just as she couldn't really reject those aspects of her mother that caused her such grief as a baby when she was entirely dependent upon her mother for care.

I shall return to the adult consequences of object relations shortly. What I want to convey by this example is the intricacy of the internal world that is operating for Jennifer, and with it, the sense of how a psychotherapist understands how the baby internalises good and bad experiences with its primary carers. To recapitulate - satisfactory ones just get digested and are the building blocks of something we might call a core self. Bad ones being indigestible are split off. They are then transformed in the unconscious in two distinct ways either as an idealised relationship or as a hated relationship. In this constructed object relationship, the infant imagines itself as the primary motivater and cause of its own misfortune. At an emotional level this can mean that certain feelings become impermissible and as such are repressed.

WINNICOTT'S VIEW OF THE BABY AND MOTHER

The reason the internal world becomes so complex so early on is connected with the infant's continuing need of the caregiver. Winnicott (1965)has a slightly different formulation of the internal world. Like Fairbairn, whose schema of schizoid phenomena and repressed bad object relations I have just described, Winnicott too sees the infant as utterly helpless and dependent on its mother for care, nurturance, containment, and the emotional attention required for psychological growth. His understanding of what the baby does when it fails to get the adequate care he calls 'good enough mothering' is that it adapts itself to what it imagines its mother wants of the child. It develops a 'false self' that accommodates to others in the attempt to get what it needs. Meanwhile the baby's embryonic 'true self' goes underground, eventually becoming unreachable. The baby is a mixture of fragility and resilience. It protects itself by searching for some kind of contact even if it is only inauthentic relating that is available. So for example, if a baby senses that appearing contented pleases its caregiver and that this gets reflected back,

then it may be encouraged to bury its distress. It may try to soothe itself by giving to its caregiver, by showing signs of rapid recovery when upset, or detaching itself from distress by adopting a stance of contentment.

In addressing the uses this formulation has in trying to understand the specific process of internalisation that occur between mothers and daughters and how the legacy of the mother's own psychological development and current needs shape the mother/daughter relationship in particular ways, we need to insert the category of gender into our thinking. Earlier I suggested that the baby was not a blank page onto which we imprint or condition a set of responses. Rather as Fairbairn and Winnicott's formulations suggest, she has an agility to adapt. This is an expression of her personal agency. Each baby born has an enormous impact on her environment. She brings pleasure, pain or anguish to her parents. She may have been longed for or dreaded, she may upset her older sibling. In those who come to meet her she may engender love and the desire to care, she may engender anxiety and fear. How she responds to her feed, whether or not she settles easily, whether her birth has brought a feeling of calm or panic into the home - in all these ways her presence affects those who interact with her very directly.

GENDER AND SUBJECTIVITY

When a baby arrives the first question on everyone's lips is "is it a boy or a girl?" Depending on its sex a whole set of social interactions and constructions will follow. Gender is a key factor determining aspects of how, from birth onwards, a baby is handled, held, fed, bathed, clothed, cooed to, described and identified with.

We use different words to soothe a baby girl or baby boy, we may have a different tone of voice, we have different expectations of them and we describe their activities differently in relation to their gender. A boy is a robust eater, a girl greedy. A girl who is energetic may be called a terror, while a boy is described as active. There are differences in basic aspects of care too. Boys are generally breast fed for longer in time and for each feed than girls, held for longer, weaned more gradually and potty trained later.

A child begins to know itself as a subject, a distinct person who relates to other subjects, from about a year and a half. The toddler's apprehension of its gender coincides in time with its emergent identity during this phase of separation-individuation. In other words, at the same time as the toddler is realising its separateness from others and its own boundaries and capabilities, it is also knowing itself as a little girl or a little boy. Gender expresses the physical and psychological knowledge we have of ourselves as subjects in a world fundamentally divided by gender. Entry into the female or male gender determines how we think, feel, dress, move and act. Indeed recent feminist scholarship has shed light on recently is that the modes of thought, reasoning, and moral values that men and women hold are profoundly different (Gilligan 1982, Tannen 1990). All these characteristics are not stuck into people but are woven into the very fabric of the creation of the person. They are established very early on in the first arena of the child's experience, in the mother-child relationship, and reinforced in the wider worlds the child enters.

Mothers mother. Despite the changes that have occurred, where joint parenting, lesbian parenting, single parenting, shared custody between separated parents and so on have made the nuclear family in which mother rears the children at home and father goes out to work a minority position, for us and our clients, the norm was that mothers did the major parenting and that fathers were important but peripheral figures to the hourly responsibility of bringing up children.

Since a mother or a female substitute (grandmother, nanny, aunt, childminder) has generally been the main presence in a child's early life, it means that a father's active or direct relationship to a daughter may well be filtered through the mother daughter relationship. Father may not be an active person in the daughter's life until she has long passed out of babyhood and early childhood and is able to engage with him when he comes home at night. Up until that point, his relative absence from the ambience of early childhood may mean that who he is, is as much conveyed to the child by her main adult companion as it is gleaned through direct experience. This isn't to say that a father isn't important in the formation of a daughter's psychology but his significance is complicated by many factors: his absence or presence in the family environment, the

mother's attitude towards his fathering and what she conveys to her daughter, his active pursuit of his daughter and of course his conception of what constitutes fathering.

Psychoanalytic theory is usually told from the child's point of view. But this abstracted perspective excludes the view of the mother who mothers and of the other significant figures in the child's life. While Winnicott's work attempts to bring in the mother via his notion of the 'good enough mother', this notion is nevertheless problematic. The notion of 'the good enough mother' takes as it starting point a social milieu and psychological criteria for mothers that fails to reflect women's actual position and experience of mothering. Winnicott's view was that a woman comes to mothering with a distinct and secure subjectivity. While the mother nurtures the baby and attends to its physical and psychological needs, stepping into the baby's skin to know what it is experiencing and requiring, stepping out again to provide it, the mother is simultaneously supported by a husband who, particularly in the first few months of the baby's life takes care of the mother by tending her and taking care of the outside environment.

This description dominates psychoanalytic thinking, yet it is a misrepresentation of the mothering position, of the mother's actual experience and it misperceives many a mother's psychology. Few mothers are actively emotionally supported in their mothering. The labour that is part of the process of the creation of a social and psychological being is unacknowledged or hidden. The assumed subjectivity of the woman is often shaky. The confluence between the baby's needs and the mothers needs is an idealisation. To be able to give oneself over to the baby, as Winnicott suggests women do, presupposes an unproblematic, intact, highly developed and secure self to be able to return to. Adult femininity hardly looks like that. Most commonly women feel insecure in themselves and without a secure sense of self, the wish for merger with the baby and the wish for a discrete subjectivity compete inside the woman. Women come to mothering with their own personal needs. They are not simply the baby's object, they are women struggling for human contact and subjectivity themselves. Becoming a mother doesn't stop the process towards subjectivity or the desire for it, although the requirements of it may impede the mother's struggle to individuate.

As to Winnicott's picture of the mother supported in turn by the father, he is addressing social arrangements in which women have traditionally provided nurturing skills while men have provided economic protection. He has taken economic protection as synonymous with emotional attention but it is a rare adult woman who is the recipient of the kind of emotional nurture that she provides for others. Indeed, for many women, the need to be available to their children and the need to care for their husbands leaves them emotionally unsupported and drained. The satisfying aspects of mothering may nourish them, but this has to be set side by side with the tasks and burdens of unsupported mothering.

By and large, women have been brought up to see the emotional and physical tasks of mothering as a part of their role. Other aspects of their own self development have been held at bay. Little girls learn to care for others through direct instruction but also through the identification with the mothering person, through gaining approval for certain kinds of initiatives. In turn, women come to derive a certain amount of self esteem from their capacity to handle their children's needs and those of others close to them. For many, there may be a conflation of personal needs and external needs. The social requirement, that a woman should see herself as a midwife to the activities of others, is in conflict with the development of her own subjectivity. Inevitably, then, women try to find a subjectivity, a sense of self, through their mothering. Not having had a secure subjectivity, they may not be able to see their children as potentially separate subjects in the world, but rather as reflections, extensions and attachments of themselves. They are in a cleft stick because mothering is the place in which women have been allowed to be subjects; but being a social subject in a circumscribed field is not the same as being a psychological subject. A woman's struggle to achieve subjectivity may get stopped in its tracks or constrained by the overwhelming demands of giving to others what she still so badly needs for herself.

THE MOTHER DAUGHTER RELATIONSHIP

It is in this context then that a woman mothers. The mother- daughter relationship is shaped by the world that mothers live in and that daughters must enter. And the

mother's psychology was shaped in the same way by her mother. In this social world, the two key features of women's psychology are that women should not be emotionally dependent, but should instead provide a dependent relationship that others may rely on; and they should not initiate as people with their own autonomous needs but act instead as midwives to the aspirations of others (Orbach 1978, Eichenbaum & Orbach 1983).

At the same time, she directs her daughter towards a heterosexual orientation. By direct instruction, analogy or games, mothers and daughters engage in play which mimics the sexual arrangements of the adult world. Sometimes the mother is required to be the daughter, the father, the brother or the big sister. This kind of play is an attempt on the part of the child to fit herself into as well as simultaneously expand the definitions of gender and position in the family that she feels herself to be a fixed part of. The play turns frequently to marriage and through this the mother is introducing her daughter to the gender and sexual arrangements that are expected.

Within the mother-daughter relationship, the mother unknowingly exercises restraint about meeting the emotional needs of her daughter. At the same time she may thwart her daughter's initiatives, supporting instead aspects of her behaviour that conform to appropriate notions of 'feminine` activity. This is not to suggest that mothers are consciously withholding, nor that mothers are aware of being part of a dynamic of depriving. Mothers' motivation may include the wish to give their daughters the nurturance and recognition that they did not and do not receive themselves. And of course they do. But this desire, and the actions that flow from it, are in themselves mangled by the unconscious identification of the mother towards a baby girl. The baby girl stirs in the mother a multitude of identifications. She may represent to the mother her needy and unmet parts as well as her own experience with curbing her needs and desires. When her daughter expresses wanting she may find herself wishing to silence her without understanding where this impulse has come from. She can be alarmed if her daughter's needs seem copious. Unconsciously she expects her to contain them as she has stilled her own. This aspect of the mother daughter relationship is especially painful. It creates an inconsistency within the relationship and as a result there is what can be characterised as a push-pull dynamic in the mother-daughter relationship (Orbach 1978,

Eichenbaum & Orbach 1982). Sometimes the daughter's needs are responded to and sometimes not.

Because the daughter's initiatives are inconsistently responded to, the sense of self she internalises is imbued with a hesitation and wariness against the acknowledgement of needs and desires that arise within her or are stimulated within a relationship. She feels unsure of herself.

THE MOTHER DAUGHTER PHYSICAL RELATIONSHIP

The emotional exchanges between mothers and daughters are reflected in aspects of the physical relationship. We have noted earlier how in some of the most basic details of early life, baby girls and baby boys receive different treatment and handling around feeding and other matters of physical management. The girl acquires her sense of physicality in the mother-daughter relationship. This happens in three distinct ways: via the mother's feelings towards her own body; via the mother's experience of the daughters body and via the actually physical exchanges between the two. If the mother experiences the discomfort so endemic in Western female experience of the body, then a version of this will be introjected by the daughter. If the mother feels confident and at ease with her physicality, this will likewise be imbibed by the daughter. The entwining of a mother's body perceptions of her own body with her daughter's body may preclude her from seeing the daughter's body as different and distinctive. She may, without awareness, convey her own distaste and discomfort about her body to her daughter. The daughter will absorb these feelings and they will be part of what she takes inside of her as part of her somatic formation. Just as a baby introjects the emotional ambience of its mother and caregiver, so she introjects the physical ambience of her mother - both mother's feelings about her body, her own body and her actual physical experience of mother's body.

If we reflect once again on the importance of physical relating in the earliest months of a girl's life, we will be able to see how the literal body of the mother is at times available and giving and at times uncontrollable. The elusivity and unpredictability of the mother's body is part of what is absorbed into the daughter's body in her making of

her psyche-somatic self (Orbach 1978, 1986) Sometimes the maternal body is perceived of in positive ways, at other times it is experienced as a disappointment and is internalised in similar ways to the emotionally unsatisfactory aspects of the relationship. Then, the daughter's body can feel like it is partly a bad object.

It is in regards to a daughter's body that a father's active and direct presence can often been felt. For the father's relationship to his body is not usually as problematic as a mother's to her own or her daughters. In early childhood, father's physical relating to a child, with the throwing of his child up in the air, carrying it on his shoulders or providing a still lap to sit on when he comes home from work gives the girl a very different experience of her body. While in early babyhood, we are inclined to think of the mother's lap as a base of security. In childhood the stillness may be sought and found in father's lap for mother may be so busy doing household tasks that the kind of calmness which creates a sense of surety and solidity may be less available to the daughter from the mother at this point.

This physical relationship, both the active and still aspects of it, contributes to a different sense of physicality for the daughter. It can be very enjoyable and a key to understanding some of what women later crave when they look to men for acceptance of their physical attractiveness,

The separate but related issue of how physiological and sexual appetites are addressed and therefore internalised by girls brings us back to other important cultural forces that are entwined in a mother's attitudes towards a daughter's body. No mother today, no parent, is unaware of the violence, and particularly a sexualised violence, that is directed at girls and women. The incidence of sexual abuse of children disproportionately affects girls. The main form of sexual abuse is perpetrated by men on girls and the occurrence of rape and domestic violence are factors affecting female experience and women's experience of their bodies and their daughter's bodies in ways that are often overlooked. Our awareness of these phenomena is now growing. While women may still often repress their knowledge of the specific violence directed at females, they nevertheless carry a sense of possible danger for their daughters.

At the same moment as a mother transmits a joy about her daughter's body and persona she is also aware that she is vulnerable, that her loveliness may be exploited rather than enjoyed, if not now, then at some point later on in her life. This message, the protectiveness, the fear and the joy are conveyed to her daughter at some level. And her daughter absorbs a version of this message. She has to make sense of these colliding ideas in the formation of her physical persona.

Of course a father's relationship to his daughter's body is no less complex. While he may be available in early childhood he may feel confused and perplexed by an adolescent daughter's developing body and may, without wishing to or realising it, withdraw or curtail his physical relationship with her. These combined experiences reinforce and reflect the insecurity in relation to the critical area of body/physical awareness, undermining the possibility that a daughter can develop a secure body image.

CONCLUSION

As a result of the emotional and physical relationships that baby girls enter into, they can develop into women who come to feel hesitant about their needs, and indeed their very selves. In the search for validation a woman knows to look outwards, turning much of her attention outside of herself both to attend to the needs of others and to achieve the approval of others by mirroring their projections. Women grow up with a sense of never having received quite enough and often feel insatiable and unfulfilled. In not being encouraged to develop her initiating part, and draw a sense of authenticity and strength from that, the girl, later the woman, is victimised by a constant need for affirmation from external sources. Sadly, such legitimation is only temporarily soothing. For if one has been discouraged from pursuing one's authentic wishes, one has little experience of feelings of genuine satisfaction and contentment.

The inconsistency in the mother-daughter relationship does not stop a daughter's desire for this relationship to be one in which she can articulate her needs. Indeed, the longing for mother stays with us. Mother becomes embedded in our psychologies as potentially 'all providing' or 'all withholding'. This split experience of the mother may become

repressed but it is one carried by all Western women who are mother reared (Dinnerstein 1976). The wish to merge with the 'all providing` mother juggles with the experience of betrayal at the hands of the 'all withholding' one. This imago of mother in turn becomes projected onto women in general, and in becoming women we experience that split in ourselves.

The masculine presence, representing as it does a clear gender difference (as well as frequently a different way of life), provides the simplest form of disidentification from and access away from a girl's internal difficulties. Many daughter's relationships with their fathers contain the attempt to distance themselves from the internal image created in the female ambience by recreating themselves anew or finding aspects of themselves that a regarded differently. This is a feature of heterosexual development, where the attachment to a masculine figure contains within it not only the woman's early internalised attachment to her mother but her attempts at separation from her and towards attachment to another whose gender difference represents his alterity to this relational configuration.

A daughter's psychology then is born within a mother daughter relationship situated in a particular family, in a distinct culture and in historical time. The features that mark femininity are imbibed both directly and indirectly from the culture via all the relationships that impinge, affect or embrace the developing person. At present in the West, it continues to be mothers who mother. This imperative shapes a daughter's psychology in distinctive ways providing her with one the one hand highly developed relational skills and on the other with difficulties in self actualisation. It is a picture that is manifest in many of the clients we see in therapy.

2. A WOMAN'S PLACE

In Ken Loach's acclaimed film *Raining Stones* an unemployed Midlands working class man is determined that his daughter shall have a new, not borrowed, outfit for her coming confirmation. He senses the importance of this to his wife as well, even though

she is only exploring the possibility and is far from insisting on it. Wounded by the poverty that constrains and impinges on the expression of his masculinity through an inability to provide economically, our hero secures a loan with a marginal lending firm in order to deliver the goods.

There is a moment of deep pleasure between husband and wife. He has been a man - he has delivered. His daughter is given the confirmation outfit. But the heroism of the act unravels. The debt is sold to the loan sharks who then act as loans sharks do. They rampage and destroy our hero's home and threaten the safety of his wife and daughter. The attempt to redeem self esteem and worth by engaging in heroic behaviour based on old fashioned macho values backfires. The price of pride is too high. But his wife, understanding what it means to him and why he felt he had to provide by whatever means, forgives him. The destruction he has unintentionally wrought is understood and excused.

Ken Loach's movie is told from the man's point of view. It romanticizes, extols and valourizes the struggle of a middle-aged unemployed man to keep his dignity and come through for his wife and daughter by engaging, single-handedly, in risky acts that cause great destruction. Nowhere in the movie do we see the husband and wife talk with one another about the dilemma they face over their daughter. Does she or doesn't she need a new dress? If yes, how should they go about it? What does it mean to him that he and his mates are excluded from participating in the consumerist society that surrounds them? How does he feel about scrabbling around for work that pays tuppence ha'penny? How do they survive as a family and couple when their dreams of life are shattered by the economic reality of the mass unemployment they have little say about?

Ken Loach creates emotional pressure for us to empathise with a man's choice to fight back alone, to refuse to be a victim. The movie is billed as a comedy about survival, but in disregarding the woman and child's point of view the comedy relies on our applauding macho values rather than interrogating them to provide a different version of how a man can act.

I start with this anecdote because it is an everyday example of the gendered ways in which we approach the difficulties that can occur in marriage. Ken Loach, one of our most progressive film makers, whose finger has been on the social pulse since Cathy Come Home (1996), Wednesday's Child (1971), Kes (1969) and Riff Raff (1991), loses his critical eye when he turns to gender, marriage and relationships. He ends up commending rather than reflecting on the way in which this man - whose masculinity and sense of self is jeopardised by the economic mess of our time - refuses, in the most macho and self-defeating of ways, to accept victimhood. The film was enjoyed by many critics, and won awards at Cannes and Berlin. Their applause and honour suggest some of the reasons why there is such a very deep rift between women and men at this moment in history. When in a corner men are inclined to act, specifically, and often in a circumspect manner. The dramatic appeal of this is at odds with the attainment of intimacy - one of the crucial factors people seek in marriage-type relationships.

The eminent psychoanalyst Harold Searles's profound description of marriage (1955) as "the smallest mental hospital" is an observation I could readily apply to the confusions, hurt, misery and disappointment that marks so much of contemporary marriage as seen by a psychotherapist.

The madnesses played out in marriage have much to do with the unconscious contracts between women and men when they come together in an intimate relationship. These contracts are concerned with unconscious expectations, with what has been observed of the parental marriage and the marriages of significant others, with the kind of intimacy experienced in the first love relationship with mother, and with what is projected unknowingly onto a partner (Eichenbaum & Orbach 1982, 1983, Clulow & Mattison 1989, Ruszczynski 1993, Young-Eisandrath 1993).

We bring to marriage a desire to express and receive love, to exchange companionship, erotic intimacy, and our needs for attachment, and to fulfil a wish to have our individuality supported and extended from the base of a stable and secure relationship. Almost everything we desire from marriage, including the hearts and flowers imagery

which pervades our notions of romance, express, in their deepest conceptions, differences between men and women in their understanding of these desires.

In love, and in marriage, we start from the premise that men and women are speaking the same emotional language. We assume that closeness and intimacy, sharing and caring, selfhood, individuality and coupledom, relate to the same ideas. We assume that our imaginative worlds include reference points that cross gender. To a considerable extent this is true. But it is not always so. While we recognise that profoundly different skills and roles are employed by a father or a mother in parenting (as well as, of course, overlapping ones), while we even value and valourize those differences, we are hazy about the very profound significance of gender-honed differences and dissimilarities when we come to the nitty gritty of intimacy.

This haziness, the denial of our conscious and unconscious gendered desires, our confusion about the sexual politics of the contract between women and men, lead, in part, to the distress that Searles refers to when he speaks of marriage as the smallest mental hospital. We go mad in marriage because our expectations and hopes conflict deeply with our experience. We imagine, dream of and anticipate a relationship with one set of parameters. We discover that we are enmeshed in one whose parameters are foreign. We become dislocated, anguished, confused and often shamed. In that frame of mind we act from fear and from the most defensive and reactive aspects of our selves. We are then at our least creative. When we are disillusioned in love we are hurt. And when we are hurt, we want to inflict hurt.

I want to look at woman's place in marriage, and her perception of her place, (and even to touch briefly on a woman's perception of a man's view of his place), from a perspective that recognises the difference between women and men and sees gender, the psychic and social construction of femininity and masculinity, as both descriptive and critical categories. In describing what occurs from a woman's perspective in many intimate relationships I will also want to suggest that there is a need for serious revisions in the contract of intimacy. Indeed, I might go so far as to say that the search for intimacy as it is presently conducted by women within heterosexual relations often

flounders not because, in the inimitable words of comedienne Jo Brand, 'men are bastards', but because the skills and expectations women bring to marriage clash with those brought by men.

Central to the painful, divisive differences that contribute to the breakdown of the contemporary couple is a destructive set of culturally defined meanings that surround the concept of dependency. In Loach's film, the man's need to meet the economic needs of his family, and to perceive them as economically dependent upon him, leads to a situation in which he endangers himself, his wife, his child and all that is most dear to him. The compulsion to act on the economic front, ennobled in the film, is a contract we all understand: In the old script, the man "brought home the bacon" while in exchange the woman supplied caregiving, housekeeping and emotional services. She depended on him for money, he depended on her to iron his shirts, cook the dinner and take care of his auntie's' birthdays. Behind this contract, a contract that has been in disarray for the last two decades but, as Loach's film shows, can still unquestioningly entice and ensnare us, is concealed a more problematic contract: the disposition of emotional dependency needs between women and men (Eichenbaum & Orbach 1983).

Dependency is a dirty word and a disparaged idea in our culture. Right wing ideologues, anxious to dismantle the welfare state, have scorned our State services as the illness of a dependency culture that weakens and enervates its members. The attack has been persuasive, not because of its inherent correctness but because dependency touches a sensitive nerve in all of us. We may not be sure why, but we wish to disassociate ourselves or flee from it. Dependency is somehow weak, connected with notions of subservience, linked in the thesaurus with possession and loss of agency and therefore something to be abhorred.

The emotional appeal that the politicians can rely upon in condemning dependency resonates psychologically with the idea that dependency is to be avoided. But why do we consider dependency so awful? Why must we avoid, despise and condemn it?

Psychoanalytic therapists are impelled in their work, which is always a work both of research and care, to explore the unconscious meanings of problematic issues rather

than simply to accept and collude with conscious and manifest meanings. The psychoanalytic researcher wonders why dependency is so feared and dreaded, and why a call to deny or defeat dependency can be so invigorating. What is it in the developmental schema that makes dependency so troublesome?

The mother-infant relationship is marked by the dependency of the infant on the mother. This dependency is so profound that Winnicott (1965), a distinguished paediatrician and psychoanalyst, pointed out that in order for a mother to properly understand and interpret the needs of her utterly dependent baby, she must fall psychologically "ill" herself, into a state that will allow her to identify with and feel attuned to the baby's experience of need. Out of her understanding of and identification with that experience she will understand what she needs to give. And out of her own experience of being responded to in that emotional state she will find the wherewithal to provide.

If all goes well, the baby will take in the emotional nurture provided. It will feel comfortable relying on mother's external presence, her breast, her smell, her holding, her voice and contact, as it once did in the womb. The food for the baby's emotional and physical growth will come from the mother. Her ability to interpret its needs will be ingested by the baby and form the core of its sense of self and separate subjectivity. As mother moves from being an umbilical chord or breast to a real person in the baby's world, the baby will, from a safe and secure base, explore other relationships. It will develop its own motor, cognitive and language skills and move on from the state of utter helplessness to one in which it can make relationships with others. It will move from dependence to interdependence, recognising its need for others as well as its separateness from them. It will come out of babyhood into childhood and adolescence, and eventually into adulthood. It will develop a sense that intimacy and love are to be welcomed and savoured.

Dependency in this schema is linked with infancy. It is, in theory, an unproblematic aspect of a phase of development that results in adults who are able, ready and willing to make relationships with others similarly disposed towards interdependence. But infant dependency is rarely so straightforward.

Dependency is entwined for nearly all of us with notions of helplessness. The infant unable to ensure that his or her initiatives are recognised, needs are met, finds the state of dependency less the warm containing emotional cradle of Winnicott's idealised mother-baby pair, gliding towards mutual recognition and interdependence, and more a state of potential disappointment, fear and treachery. Frustrated by and unable to comprehend the actions of a caretaker on whom he or she has depended, the idea is planted that to depend is to place oneself in jeopardy. Herein lies the dilemma. Although there is a wish to depend no longer on a felt-to-be unreliable caregiver, the dependency needs remain. Neither having embodied sufficient emotional sustenance to bid farewell to the intensity of need, nor trusting another to take such needs to, a person is caught.

This dependency dilemma and the associated dilemma of helplessness, has the potential to affect us all as adult human beings. Good enough parenting prevents more extreme instances of helplessness: it can provide the child with an emotional ambience that enables experiences of ordinary helplessness to be metabolised. That is to say the child, later the adult, can recognise its needs, can recognise when he or she is feeling helpless and can acknowledge the pain of those feelings. The person can, as it were, live through and beyond them. He or she can tolerate the distress which helplessness causes without having to conceal it and without being overwhelmed by its expression. Having experienced and survived the feelings with another they become transformed, and a sense of equilibrium is restored. But for many, the prophylactic is insufficient. In place of a capacity to process dependency needs and feelings of helplessness, there is a dysfunctional response - away from engaging with the difficult feelings and instead expending energy to defend against such feelings.

In the human struggle to come to terms with unmet dependency needs, men and women are offered and find gendered solutions. They find themselves as individuals in the dilemma of wanting to be attached and connected - both because adults need to be connected to others generally, and because they need the love and attention of a specific intimate relationship to bring their dependency needs to. Then the problems that stalled aspects of personal development may find new pathways to resolution. But they

simultaneously fear a close relationship that will re-activate buried hurts from the past, expose them to what is now a dreaded state of dependency and evoke unsatisfactory patterns of relating in the present.

The gendered solutions set in train in early childhood and fashioned through adulthood evolve into entrenched patterns that are so much part of who one is, and so central to self experience, that they cannot be shifted without unhinging identity. The individual does not feel them as constraints of gender. He or she does not feel they are acting 'feminine' or 'masculine'; they feel themselves to be acting in ways that are personal and idiosyncratic, which of course they are. But as I think will become clear, these personal ways are guided by subtle and not so subtle gender influences.

Girls are encouraged to deal with unmet dependency needs by providing for others. Starting at an early age they are guided to be solicitous, thoughtful and caring of others, just like their mothers. They practice the skills of emotional relatedness, of sorting out one another's problems, and they develop a facility for interpreting the emotional temperature of others. When hurt they are briefly consoled but then taught to turn their attention to the needs of others, to bigger hurts that needs addressing, or to be self sacrificing in order not to inflict pain or distress on others. In their passage through adulthood, they come to be sensitive to the effects of their actions on others and to pay considerable attention to the needs of others by being helpful. They are practising what will later become a crucial aspect of identity: how to be alert, to tune their radar in to pick up on the emotional needs and desires of others.

Thus the girls, and later the women, are transposing their own needs for emotional attention into the capacity to meet those needs in others (Orbach 1978, Eichenbaum & Orbach 1982). They are giving to others what they long for for themselves. They know about deprivation, they know about longing for recognition and for their needs to be taken into account. Out of that knowledge, which Winnicott declared women needed in order to mother, they will identify with the needs of the person whose shoes they step into when they give to them. When they give, they are attempting to assuage their own needs. When they give, they are seeking a kind of gratification. When they give, they

are soothing themselves with their apparent needlessness. They can give. They know what's needed. They will provide emotional services without the other even being aware of being given to, or even being aware of being in need in the first place.

The boy, for his part, is learning and practising a different set of emotional responses to his neediness. As he learns to be separate from his mother he distances himself from the early intimacy by taking on a stance of being not like mother. While he may not have the model of a father to identify with on a consistently available basis - fathers spend considerably less time with their children than mothers - he will learn a different code and set of solutions to the problems of his unmet dependency needs. He will be offered the solution of appearing not to need, of denying his own needs - not through taking care of others and melding in with their needs as a girl might do - but by de-taching himself from others and appearing need free. He will bolster this self image through competing and defining his separateness. His self-identity involves making a space between himself and others. By the time he reaches adulthood, a range of heroic Man-On-His-Own imagery will be available for him to identify with. If it is no longer the Marlboro man, or the Cowboy, or James Bond, then it is the axiomatic hero of the modern movie - Ken Loach's protagonist, Coppola's tragic heroes, Kevin Kostner's politically correct saviour, or Mel Gibson's Mad Max. Their most passionate feelings are for conquering, defeating, performing heroics, or leading, not for sharing or exposing vulnerability. The point of these men is that they don't need, and rarely depend on, anyone. In fact, by a curious sleight of hand, their wives and girlfriends are deemed to need them. Not only can they deny their dependency needs, but also, like the women, they too can feel they are there to serve the needs of others.

In the last one hundred years, men have demonstrated this giving role through being the strong one and the financially providing one. Their silence is interpreted as knowing and wise, rather than an unknowing paralysis that for many men it really is. With the collapse of the economic arrangement between women and men, the veil of dependency has been lifted, exposing the emotional nurturance transactions concealed behind it. Men and women are in crisis because the old bargain, in which she provided emotional and household services and he provided economic stability, has broken down. Ken

Loach's 1990s man tries to resurrect that arrangement. He wants the money and the dress both to express and symbolise his love and attention.

A wife in a couples therapy complained about being neglected by her husband and he complained about her constant misery and her constant inability to find something interesting to do. She was a transported wife, having given up her career in the United States to follow him to England in order that they could continue to live together as a family when his work brought him over. He worked at least twelve to fourteen hours a day, five or six days a week, and she was lonely. She felt abandoned, and although she could easily pin her distressed feelings on his actual absence from home, she knew that to be a too convenient peg. There was something deeper going on that all her histrionic complaining could not move him to consider.

Her husband was a senior banker. Two hundred people reported to him. He couldn't go to the toilet without being followed by colleagues, so much was his attention valued. He felt beleaguered by his wife who seemed to want so much from him. He gave her money, a nice home, good holidays, what more could she want?

He felt a deep sense of inadequacy when it came to relating to the emotional needs of his wife. They were experienced as demands, and he dealt with this by designating her as over-needy and hysterical. Nothing was ever enough for her. True, she did a lot for him and she had smoothed his domestic and social path in England by settling the children, sorting out a butcher and doctor, assembling a group of friends, and so on. But, he remonstrated, he was there when he could be, and he had just bought her a new diamond.

In therapy the wife took on board the idea that she was expecting her husband to meet emotional needs she could not articulate for herself, needs which had arisen since they had been together and which were to be given attention and to be made to feel 'all better'. These needs engendered shame in her. She recognised that she brought some of them to the relationship from her childhood; that her disappointment with her mother had made her look to men to fill the hole inside her. Through playing house, looking after her children and husband and, more lately, through working, she had covered

much of the void. As she began to address this void, she reduced the attention claimed from her husband. She was no longer clingy and demanding.

On a business trip which took her husband away from home for seven days, she got on with her own thing and was even, unusually, away from the telephone during a couple of the times he tried to reach her. When he returned to London he was in a bad state and unconsciously provoked her insecurity by insinuating that one of his female colleagues had flirted with him on the trip and that he had been tempted. He was upset by the instability he felt in being out of touch with his wife, and unsettled by what he saw as her withdrawal. Although he disliked the way she would invade his space, or velcro herself to him, even less did he like the boomeranging of his own needs back on himself. The void caused by her withdrawal unconsciously led him to try to pull her back into a pattern which, while it annoyed him, also reassured him that he was not the needy one. She needed him and he could be irritated by that. That was a much less terrifying option than recognising his dependency on or need of her. It emerged that he was also deeply dependent on other people needing him at work. Although he resented her demanding behaviour, it soon became apparent that when it was no longer displayed, he was emotionally adrift and at sea.

Their marriage was, as Searles said, a mental hospital. The see-saw in which her needs concealed his needs was finely balanced. One kind of madness was when the balance was upset; another kind of madness followed the attempt to restore it. If the mental hospital was to offer a cure, it would have to provide the conditions in which they could each recognise and reclaim their own needs and insecurities, show them to one another, have them recognised, and then strive to address them through the acknowledgement of their mutual interdependence.

In the 1994 Reith Lectures Marina Warner spoke of the contemporary myths of rapacious women and marauding men that reflect our understanding of what it means to be men and women today. The evidence she drew on owed much to history retold from a feminist perspective. Drawing on many disciplines she showed how gender constructs our desires and sense of ourselves, and how we position ourselves in relation to the

other sex. Boys, obsessed with computer games which search, kill and destroy, contrast heavily with girls who acquire relational skills and then seek to express them in an intimate relationship. But in our collective psyche, the mythological character of the warrior, which is assigned to men and which young boys emulate, is now embattled with the powerful female who must be controlled. As womens' demand for the authorship of their actions has grown, so the demonization of women has increased. As Marina Warner argues, it is no accident that the Jurrasic Park's Raptor Dinosaurs are female - the feminization of the ultimate marauders.

The demonization of women at a cultural level is not strictly a conscious act. Indeed we might argue that far from demonizing women we idealize them. We protect this idealization by splitting them into categories of good and bad - Madonna/whore; good mother/single Mother - we separate out their troublesomeness and relate to their goodness. But when couple therapists confront marriages in difficulty what becomes immediately obvious is that the saintly qualities projected onto women have become tainted. Men and women can no longer hold onto the culturally created fiction of women that have been created.

Gender constructs our relationship to intimacy, and to a crucial aspect of intimacy, namely dependency. What Loach's film demonstrates to me is the vast difference between men and women's conceptions of intimacy. Men, stripped of the capacity to provide in the ways masculinity demands they should, do what they can to extend state provisions and make their wives and daughters happy by supplying what they think is wanted of them. Women provide emotional labour for families and relationships, accepting the anguish of men, supporting and forgiving them, even when they are a danger. Nowhere in the film, and sometimes in real life, are other alternatives explored - ones which depend on communicating, talking, facing disappointment together, taking emotional responsibility and exploring feelings of distress as an adult.

Marriage and intimate relationships touch us deeply. Through the particular nature of the bond that is created, childhood yearnings, as well as adult longings for care, nurture, and attachment, are stimulated in particular ways. The adaptations that allow us to

survive in work relationships or in friendships unravel in the merged nature of intimacy. This unravelling makes us crazy, partly because of our early histories and partly because the nature of the gendered exchange is incomprehensible from our different perspectives. We find ourselves in a mental hospital which becomes a place of madness and a place of retreat. But if the gender dynamics and the dependency dynamics can be recognised and addressed, we have a way out. We have a way of using the mental hospital as a place of healing so that the magical and wonderful aspects of intimacy which rest on mutual dependency and respect can remedy the misunderstandings and disappointments that dog so many marriages today.

3. FEMININE SUBJECTIVITY AND THE MOTHER DAUGHTER RELATIONSHIP

Over the last thirty to forty years a significant literature around countertransference has built up and countertransference is now widely understood to include all the responses that are aroused within the therapist when working with a particular patient. In other words, the psychotherapist's disposition to feel certain kinds of ways; to incline towards particular behaviours; to experience certain kinds of wishes in relation to a particular patient are now seen as much the nitty gritty of the analysis as the content the patient brings.

"My thesis is that the analyst's emotional response to his (sic) patient within the analytic situation represents one of the most important tools for his work. The analyst's counter-transference is an instrument of research into the patient's unconscious. "Heimann, P.(1950p 81)

Transference interpretations once given on the basis of the manifest and latent content of the analysands material are now given extra credence because they reflect the analyst's examination of the countertransference as well. That is to say, the analyst confirms their hypothesis about the patient by reference to their scrutiny of their own feelings about the patient; what is aroused in them; what they feel vis a vis the patient; what relational melee they feel drawn into by the patient and so on.

Psychoanalysis once a practice of historical discovery is now more commonly understood as an endeavour in which the relational aspects - the intersubjective field between the analyst and the analysand are at the centre of 'talking cure'. What occurs within the therapy, between the therapist and patient, the feelings the patient has for the therapist - the feelings they in turn arouse in the analyst and the working through of those have now taken centre stage. Clinical practice sees the therapy relationship as a re-enactment of previous significant relationships; as a defense against the experience of early object relations; as containing in nuance the emotional shape of former relationships.

Many contemporary analysts and therapists, ourselves included, look to the therapeutic relationship rather than the interpretation, as the site of psychic structural change. What can occur in the interpersonal field between analyst and analysand during the course of therapy is seen as curative. The countertransference is used as a diagnostic tool by practitioners. It tells us about the internal world of the patient, provides clues to the level of her object relations and it alerts the clinician to the defense structure of the patient. The use of the countertransference provides a way to relate to those aspects of the person that are hidden behind their defense structure. To give a simple example: the patient is extremely negative both about what she is talking about and towards the therapist. She feels hopeless as though nothing can get better. She communicates this to the therapist in a way that arouses in the therapist very negative and hopeless feelings. The therapist recognises this communication from the patient, feels herself embroiled in the negativity, feels even turned off by it and feels an impulse to withdraw attention away from the patient and abandon her with her own distress. By recognising the countertransferential nature of the feelings, the therapist is able to intervene in her own responses. She uses them to understand how the patient might be feeling. She doesn't reject her, rather she wonders about why the patient feels the urge to set up an intersubjective field in which she encourages rejection from the other. As she reflects upon this she begins to talk with the patient about the despair she imagines may be behind the negativity. She attempts to encounter the patient behind her defense structure and to provide a mode of relating that allows the patient to meet that

unconscious despair - a despair that has remained buried and split off for many years - in a relational context that will allow that despair to be felt and to be integrated.

The analysts wish to withdraw is understood as what the patient is able to create: a situation in which she pushes people away. But beyond this defensive structure, the analyst is also able to conjecture and theory build about the patient and the operations of her internal world. She begins to draw a picture for herself about the shape of this person's psyche, how she experiences the environment, how she came to be this way, what her original relationships felt like to the patient and so on.

As we monitor our countertransference reactions we are continuously challenged by the fact that each therapy relationship is unique, just as each individual within any given therapy relationship is unique. Each therapeutic encounter creates its own particular pattern, a pattern marked by a variety of emotional exchanges within the interpersonal field. No two patients reproduce the same relationship with an analyst, nor do any two patients engender identical feelings and responses in the analyst. Each therapy relationship is always being created between the two participants. And within the analytic relationship there is a tension between a re-enactment of the familiar patterns of relating- that is the way the person knows how to be in relationship - and a transcendence of that way of being in the new relationship.

And at the same time, when one works within a social and gender conscious framework, one is well aware of the fact that there is a commonality of emotional responses and internal object manifestations shared by patients which derive simply from their living in a common culture. There is, in many ways, more uniformity to the cultural influences which contribute to the shape of a person's psychology than interactions with the varied and numerous permutations of individual family constellations. So within the therapy setting one is not only engaging with the array of family interpersonal connections, but with the internalizations of the culture as well. Cultural prescriptions for gender, along with race and class, powerfully insert themselves into the very essence of who we feel ourselves to be.

We need to insert the fact of gender into the heart of relational theory and clinical practice. Just as there is no such thing as a non-relational subject, there is no such thing as a de-gendered subject. Subjectivity, a sense of selfhood, occurs in developmental time coincident with the recognition of personal gender and the gender of other/s. Personal pronouns may be neuter in the English language, but 'I' always refers to a masculine or feminine subject. 'You' always refers to a masculine or feminine object (Stoller 1978).

Recognising the notion of the gendered subject, clinicians and feminist theorists need to understand the particular issues achieving differentiated selfhood involves and means for women - both for women patients/clients and women psychotherapists. Psychoanalysis has only recently turned its attention to the implications of the notion of the gendered subject and yet this is a crucial area for both clinical practice and feminist research

Many women will say that they don't know who they are when they are in a relationship, that they lose themselves. That the person they are, the person who is revealed when they are in an intimate relationship is a different 'self' than the self they know outside of relationship. They have an unstable, and perhaps we might add a defensive concept of self. It is as though they feel themselves to be taken over in a relationship.

This phenomena, an instability in the sense of selfhood occurs within the transference-countertransference aspects of the therapy relationship. The psychotherapists reaction within the countertransference alerts us to the particular problems that the intersubjective field holds for women. Subjectivity, intersubjectivity, the achievement of what we have called an autonomous self or a separated attachment is shaped in a particular way.

Women patients/clients, we have observed (both in our clinical practices, in our colleagues practices and in the work of those psychotherapists whose work we supervise) crave a certain kind of relating that is it the same time quite hard for them to tolerate. The closeness and intimacy they desire is hedged in with defensive rejection,

with shame, with conflict about the desire for relating. They project onto the psychotherapist prohibition, disapprobation and censure for that wanting. And then when they allow that wanting to materialise there is a worry that they will merge with the other/the psychotherapist never to emerge as their own person again.

A crucial aspect of the development of a feminine psychic structure has depended upon the denial of a girls, later a woman's needs, desires and wants. She has had to shape her needs, in line with those needs that will find approval or recognition in those around her. This creates a situation in which the most personal aspects of self demand denial or recasting leaving the individual with a wary relationship to desire that arises from her.

This denial of needs can take all sorts of forms. The person can present themselves as need free, as confused about personal needs, as lacking in the words to know those needs, or by worry that she is overwhelmed or will overwhelm others with her needs.

This latter response can produce a particular interaction if the therapist only cursorily reviews what is going on in the countertransference. For example if the woman presents in such a way that is extremely needy, it may produce a frisson or rather more, an impulse to reject. The therapist may feel, even if she doesn't want to, a wish that the patient contain herself better and manage her neediness in a less voluminous way. She, who has also been raised as a woman, may be aware of the way she herself contains her own neediness and she may find the expression of it in the client disagreeable and even threatening. The clients neediness hides the real need by saying in effect 'I'm too much, I can't be helped, I'm hopeless, my needs are ugly, see you can't stand them/me either'.

Because this defense of super neediness is effective at an emotional level it can work. The therapist can collude with the patient by refusing to recognise that what is being presented is actually a defence - a defense of excessive neediness against the woman's internal conflict over her need. In other words by producing this form of defense she elicits discomfort in the therapist and the exasperated therapist can feel yes, you are too needy rather than doing what is required which is to talk with the woman about how this defense is designed to reiterate this state of affairs rather than allow them both to work on the woman's projected out internal conflict.

So within the countertransference, the inclination of the psychotherapist may well be to take up the countertranferentially induced demand to collude with a prohibition, disapprobation or censure at that wanting. But these inclinations are what lie at the heart of the problem of the woman's subjectivity in the first place. To do so, to act on the countertransference rather than receive it, process it and respond to those aspects of self hidden behind the projective identification would be to reinforce the very problems that the woman who has come to therapy sought relief from. In other words, the problem with achieving a feminine subjectivity - a self who is related to other distinct but interrelated selves; a self that has boundaries that are flexible rather than transgressable - arises because aspects of self have not been received and accepted by others. Those unwelcomed aspects of self have had to be split off and repressed. This is Winnicott's "true self", Fairbairn's "schizoid split", Eichenbaum & Orbach's "little girl". In order to achieve feminine subjectivity those split off parts of self need to be received within the therapeutic relationship, in the intersubjective field between analyst and analysand and through this process re-integrated into the person of the analysand.

"When a child's affective experiences are consistently not responded to or actively rejected, the child perceives that aspects of his own experience are unwelcome or damaging to the caregiver. Whole sectors of the child's experential world must then be sacrificed (repressed) in order to safeguard the needed tie. This defensive walling off is the origin of the dynamic unconscious." (Stolorow & Atwood 1991)

Luise Eichenbaum and I have written extensively about the social requirements of femininity and their impact for the psychological development of girls. We have examined the ways in which a gendered psychology is reproduced from generation to generation with a particular emphasis on the mother-daughter relationship as the pivotal transmitter of the culture. In our work we have proposed that women, as the people responsible for the emotional and physical welfare of others, come to feel troubled about their own needs for nurturing, dependence, initiative, agency and subjectivity. Although we did not describe it as such in our first writings it was first within the transference-countertransference configuration that we became aware of the

predicament posed for our women clients around the issue of emotional dependency (Orbach 1978, Eichenbaum & Orbach 1982).

Our clinical finding that patients' refusal of offering of a relationship in which their needs for care, love, attention could be accepted and welcomed led to a questioning what this meant and why this was so. Repeatedly we witnessed our women patients' minimising their needs after the initial crisis which brought them into therapy had passed. Repeatedly we experienced their surprise that we actually found their needs reasonable and understandable. Repeatedly we witnessed their disbelief that we found them to be worthy people. And repeatedly we came up against a defense which essentially kept us at a distance. We began to understand a defense structure in which the woman kept aspects of herself hidden and off limits to the relationship for fear of being rejected by or overwhelming to the therapist. And we understood that our task was to gain access to what we called (taking it from our clients language) the little-girl inside by repeatedly making interpretations which spoke to the conflicts about recognition and acceptance of that fuller self. We understood our goal, in some sense, to be the integration of that split-off part of the ego thereby enabling the woman to be more fully and authentically her own person.

In those early years we were well aware of our part in the provision of a new experience for our women patients. Influenced by Winnicott, Fairbairn and Guntrip's work on the developmental struggle from infantile dependency to the development of an individuated self, we surmised that the early dependency needs of female infants had been thwarted contributing to a feeling of illegitimacy in relation to needs that arose from within her thus producing enormous difficulties with experiencing a subjectivity.

We laid great stress on the provision of a relationship that could accept and work through an early problematic merger, a merger that we read off from the transference-countertransference matrix "marked, not only by the daughter's need of mother, but with the mother's need for psychological merger with her daughter. (Orbach & Eichenbaum 1988)

The therapy relationship could be used not only to explore the conflict around dependency for women but also to provide a relationship where a woman was not constantly shoring up her false boundaries by fleeing into pseudo-separation. Within this context we acted as the container (Bion) of our patients' anguish, desire, omnipotence, rage and so on. We often had to work hard to get these emotions into the intersubjective field, but once there, we knew we could tolerate and survive them. We knew too, that we were being made use of through our interpretations which spoke to the conflicts about needs and desire, which spoke to the feelings of hopelessness at ever being met or understood emotionally and by offering the possibility of a relationship with another woman which, we thought, could challenge the inevitability of complicated and restrictive mother-daughter transference dynamics.

In recent years a more detailed reading of the countertransference has confirmed many aspects of our early theory building. It has also allowed us, however, to question more closely our participation in the transference- countertransference configuration. From this current vantage point we see that in order to transcend the interactional pattern of the patriarchally shaped mother-daughter relationship, a relationship in which each woman's subjectivity is restrained and denied, more is required of us than merely the ability to contain and survive.

What do we mean by this? In order to answer that we must first address the most critical of problems feminist theorists have been grappling with - that of the subjectivity of women. For we cannot speak of woman, mother, daughter, analyst or patient as subject without first addressing the reality of woman as object -non-subject - both within patriarchal culture and within psychoanalytic theory.

In those early years, unbeknownst to us, in offering ourselves as the container, the one who could tolerate and survive, we were perpetuating the ideal of woman (mother) as object. Rather than be an object who disappointed, failed or could not tolerate the daughter's needs for dependency or initiative, we could now be the object who could be there to provide and bear witness to the difficulty that providing caused, to the defenses it threw up, to the anguish it provoked.

It wasn't so much that we saw ourselves as the replacement mothers or perfect objects that we perceived our patients required in order for their own subjectivity to emerge. That's to say we didn't see that we were being the perfect mothers they wanted/needed (which was incidentally a criticism flowing from a misreading of our work), it was more that for many of our patients their very fragile sense of existing meant that to impose ourselves as separate subjects within the therapy was technically unfeasible. In other words, their developmental level meant that we were only experienced as their objects we couldn't be experienced as separate subjects without a concomitant experience of their obliteration.

Clearly this was not the only way we experienced ourselves within the therapy, because even if we were being used by the patient as their object we nevertheless still had agency and our own subjectivity and our engagement in the therapeutic endeavour was active. We were not simply the sum of our patients projections, we were an important part of the therapy relationship. They could only make use of us as an object if we could simultaneously retain our sense of ourselves as subjects too - subjects who could experience a version of the feeling states our patients were in and give it back to them in digestible form.

But a further technical problem ensued directly related to our gender. For us to absorb the countertransference without becoming ourselves submerged within it required a subjectivity of our own in which our boundaries were flexible without being violated. That assumed a far greater sense of internal solidity than we might often have felt. In essence in trying find a way to be both the patient's object and a subject we were grappling with the issue of the therapist's subjectivity.

Recognition and presentation of oneself as a full subject within the therapy relationship and within the mother-daughter transference-countertransference configuration, may be problematic for the woman analyst. Women therapists talk about feeling too pushy or too self-important if they articulate their presence within the inter-subjective field. They feel far more comfortable being the object who is there to listen, to nurture, to contain, to accommodate, tolerate and survive.

A woman therapist can feel enormously pleased with herself for being exquisitely aware of her patient's needs and desires and yet uneasy with the expression of a different viewpoint or the assertion of an interpretation that includes self reference. To differentiate in this way and to insert oneself into the therapy is to assert one's subjectivity. Mindful of the power of the analysts position and perhaps reticent about her own legitimacy and subjectivity, this can feel extremely complicated for the woman therapist.

So then we must ask how does the transference- countertransference configuration change when the woman analyst/mother emerges as a whole subject? This emergence powerfully affects the experience that both female and male patients have in the treatment and shakes up, at a very deep level, the internalised object representation of woman/caregiver.

Therapist and patient both exist within internal and external worlds structured by a feminine gender identity. The creation of the relational matrix in which the analysand lives and the involvement, both conscious and unconscious, of the therapist within that relational matrix is saturated with the meaning of gender. A woman analyst will have a somewhat predictable range of responses to her women patients stemming from her own gendered subjectivity. In some sense we might say they have lived in a shared experience, an experience of being a girl and a woman in a patriarchal culture. The consequences of that experience are something they each, in their own way, have adapted to. Each will inevitably have points of vulnerability around a set of culturally prescribed social and psychological edicts for women.

For example, both client and therapist will experience her own internal negotiations with the expressions of desire, entitlement, agency, emotional needs, recognition, envy, differentiation, attachment, intimacy, boundaries, anger. Obviously their personal relationship to each of these states will vary, but the common denominator they inevitably share is that each of these emotional states poses some sort of psychological dilemma for a woman and achieving a position of safe, authentic, and entitled subjectivity is a veritable feat for women. For subjectivity is more than a developmental

or interpersonal achievement for women. It is a cultural and political taboo. This is no less true for the woman analyst than for her patient and so what this means is that both the transference and the countertransference will contain the dilemmas, conflicts, prohibitions and struggles of achieving or maintaining a secure subjectivity. The analyst's subjectivity (as opposed to her use value as the patient's object) now presents itself as a critical component of a successful analytic experience. For what is required in the analytic relationship is not only the holding by an object (mother) of the patient's developing subjectivity; what is required is an encounter with another subject.

Subjectivity itself is only achieved in the context of relationship. Stolorow and Atwood argue that subjectivity is always an aspect of intersubjectivity. That is to say, we are who we are because of relationship:

"the concept of an isolated, individual mind is a theoretical fiction or myth that reifies the subjective experience of psychological distinctness... the experience of distinctness requires a nexus of intersubjective relatedness that encourages and supports the process of self- delineation throughout the life cycle....the experience of differentiated selfhood is always embedded in a sustaining intersubjective context (Stolorow,. & Atwood,1991)

Stolorow and Atwood's work based on both clinical practice and the important observational work of Stern, coincides with concerns of feminist psychoanalysis. Distinctness, a differentiated selfhood, a knowing of oneself in relation to self and others poses a difficulty for women. For gender conscious female psychotherapists, a number of questions present themselves: in what ways are earlier mother-daughter dynamics re-enacted by denying (consciously or unconsciously) female subjectivity within the analytic relationship? In what way does introducing analyst/mother as subject into the relationship affect the woman patient's struggle with her own subjectivity? How does a gendered perspective alter our theory and technique in relation to what so commonly is referred to as a mother transference? How does this analysis help both to analyse and to use countertransference differently?

A gendered reading of these transference- countertransference configurations reminds us of the commonality of women's experience in patriarchy. We are not surprised by

these psychological internalizations and adaptations because they are part of a paradigm - a paradigm which denies women's subjectivity.

CHAPTER 4 GENDERED MIND, GENDERED BODY:

INNOVATIONS IN PSYCHOTHERAPY WITH WOMEN

1. FROM OBJECTS TO SUBJECTS

A psychoanalytically informed feminism has been able to situate itself as social criticism. In the last few years, gender conscious workers in the field have shed light on the crisis in masculinity; they have deconstructed our fallacious notions of homosexuality, of heterosexuality and made the links between practices of exclusion and inclusion that marginalise not just women but vast sections of population.

Within psychoanalysis, a gender conscious perspective has suggested important new ways of conceiving and working with women and men. To the development of women, of mothers from being primarily regarded as the objects of analysts and analysands to being rather subjects both in the consulting room and within psychoanalytic theory itself.

The most striking feature of work with women from different class and occupational backgrounds, of varying age ranges, cultural and ethnic backgrounds, sexual orientations and political persuasions, was the deep shame, resistance and confusion coalesced around the issues of dependency, neediness, wanting and the desire for attachment. Women in therapy came with a variety of concerns or presenting symptoms ranging from phobic and obsessional symptomatology to feelings of depersonalisation, of a sense of fragmentation, of an inability to express themselves, to know about their own desire, to know themselves except in response to the activities of others; with seemingly inexplicable feelings of loss, emptiness depression or wariness; women busy with doing and caring for others but bereft of self, full of disturbing anger and so on, in other words, the emotional range seen by any psychotherapist in the course of their work.

Tucked in with these presenting complaints emerged an almost uniform mantra of negative self assessment fixed upon by the individual woman about her inability to stem the flow of her neediness. Women were in thrall to the idea that neediness for

relationship and a wish to be related to consistently, translated into evidence of dependency which they judged to be an appalling weakness.

It became palpable that women felt desperately uneasy with the exposure or expression of their needs for attachment, for nurture and attention and that this uneasiness was linked in with guilt, confusion and sometimes an inability to understand needs and desires that arose within them. When the possibility of a relationship for them was presented, as in the therapy relationship, hesitation and fear and a retreat from the exposure of dependency became the markers of that relationship. Resistance too, denial of, withdrawal from the relationship became within and without the transference a striking theme. Embedded in the woman's sense of self were deep and profound taboos against the recognition of need and desire and dependency.

First thinking about this led to looking at the constraints that surrounded mothering as both a social and an intersubjective process. Like the shift in psychoanalysis characterised by object relations theory from the oedipal period to the earlier stages of life, the mother was repositioned as the prime figure in all women's psychologies. Mother and the mother-daughter relationship, Dinnerstein (1976) and later Chodorow (1978) and Orbach (1978) wrote was the site of women's first love, first disappointment, first longings, first desires. She was the world and the shape of relationship she could offer became the shape of relationship that was internalised by the developing person. But her capacities within the mothering relationship and particularly within the mother daughter relationship were constrained by the psychological and social mandates of patriarchy.

The mother was not free simply to nurture, to contain, to stimulate her baby daughter. Her mothering was shaped by her sense of her own unmet dependency needs, her own thwarted desires, her own conscious and unconscious responses to the denial of her subjectivity and agency. That is to say that social mandates girdled her own capacity to mother and shaped it in particular ways. Her mothering was marked by her personal struggles, her own needs of her daughter, her own confusion about attachment,

dependency and relationship and by her continuing struggle to find a subjectivity that may have been curtailed in her own development.

Setting a context for the mother moved away from the limited idea of the mother as the baby's (failing) object to the complex relational interplay between two developing subjects interacting in a relationship of ambivalence and longing. The failures of good enough mothering could be situated both intra-psychically and socially. The structure of parenting in which women alone mother makes good enough mothering both an unlikely and unusual outcome of present parenting arrangements. The internal bad mother, the internal bad object relations that Fairbairn (1953) elaborated so beautifully in his endopsychic structure clarified what occurred at the clinical level.

Fairbairn graced the baby, the developing person with agency. He understood that when the baby is unable to digest experience, when its distress goes unrecognised and unheeded and therefore is unavailable for metabolising as such, the baby develops intricate psychological operations for managing the relationship in which it has experienced the distress.

This emergent agency, the mental activity of a potential subject who creates structures in which to survive showed a dynamic interior world in which the potential subject is caught in a psychic dilemma. She needs to interact in order to engage, to exchange and ingest relational nutrients. But her disappointment impels her to withdraw, to fashion relationships in her head with objects rather than real others. This retreat from people to the inner world, the world of object relations starves while it appears to protect. While it gives the illusion of power and agency to the person as they are not only victim of its relationships but its author too, it nevertheless deprives them of the engagement that would allow subjectivity to develop. What is needed is defended against. Contact is sought but feared. The individual is cut off, an object, a Winnicottian true self' in a world of objects not able to discern her or others subjectivity. Our formulation of this, derived from our clinical practice, led us to the term "the little girl inside"; the gendered construction of internal object relations.

In the therapeutic relationship the analyst feels her or himself not simply as witness to the externalisations of the inner world of object relations of the adult patient, but as the recipient of these relational constructions. At the same time, the therapist endeavours to be an enabler of a new experience, to not conform but to challenge the transference projection. By this is meant, that the therapist in being able to tolerate the pain, the hurt, the anger, the disappointment and confusion that the mother had been unable to allow the child, the patient would now have a chance to assimilate their emotional experiences rather than constantly regurgitate them. In the transference both aspects of the internalised bad object relation were represented one moment being perceived as the disappointing object, the other as the tantalising one. Etched into the transference and into current intimate relationships was the shape of the patients defense structure. If disappointment was in evidence then a retreat from the real relationship into the world of object relations occurred. This was equally true where love or understanding were offered. The idealisation was more powerful than the experience of the actual relationship for the actual living breathing relationship could barely get through.

Observing the simultaneous desire for, fear of and retreat from the real relationship and recognising that the therapeutic work lay to large measure in deconstructing the so well built defences against attachment and looking through the transference-countertransference dynamics, led to an understanding of the resistance to a relationship and to the way in which our work was interpreted inside the profession, the origins of different narratives within psychotherapy.

The resistance within the therapy relationship forces a reconceptualision of the requirements of the therapy. A rigorous analysis of the defences and the provision of a holding containing and potentially enabling relationship was held to be all that was required but the analysand remained someone with an object she could not touch, could not employ in her service. In Winnicottian terms the psychotherapist could survive her attempts to destroy her but that survival did not get materialised into a new intra-psychic formation as long as the therapist remained only her object rather than a separate person, a subject with whom she was engaging. As long as the therapist was simply an object the patient remained one too.

This observation that the therapist needed to be more than just a better object for the patient than the mother had managed to be, coincided with concerns about the difficulties that merger and individuation posed for our women patients. The original mother daughter merger might well be suffused with the longings of the mother to find her own self and continue her struggle towards subjectivity. Little girls might engage in attempts at separation in an attempt to repudiate the needs that could not be met within the merged attachment. But whether expressed as a false separation or a disassociating from needs, the weight of the mother's longings and her provision of a relationship which was heavy with her own need to merge, meant that almost inevitably intimate relationships would reproduce this dynamic. While many therapies disparaged or were contemptuous of the desire and fear of merger, it was inevitable. Before individuation could be experienced, the patient might need to merge and to psychically meld into the therapist. The therapist needed to not resist this but to recognise it as a possible phase within the relationship. The therapist could provide for that merger without losing herself and without bringing her own unmet needs into the relationship. The therapeutic stance was a derivative of Winnicott's observation of aspects of primary maternal preoccupation. The therapist needed to provide a psychological umbilical chord for the patient, a cradle of psychic holding which was unencumbered by personal needs.

If this kind of closeness could be allowed to the patient, if she could use the therapist in this way, then through working through her defences against accepting her needs, she could work towards a different kind of attachment, one in which a genuine separateness and selfhood could be supported. Mature dependency could not proceed unless dependency needs were recognised. If the therapist did not repudiate our patients attempts to depend upon her, , they could find a secure base to explore their desires and needs in the present. Their sense of selfhood, their subjectivity could be allowed to develop.

It was here too that gender was crucial, gender not as biology, but the gendered nature of selfhood and subjectivity. For many women, their sense of self as both separate and connected could not be affirmed by their mothers. The mother's need to have the daughter as her object prevented the mother being the subject for the daughter. The

therapy needed to sort through this quagmire: to redefine and psychically reshape separateness, similarity and attachment.

In the therapy, it was the recognition by an other of the legitimacy of those needs that was crucial. The therapist couldn't meet the original needs. But the therapist must be able to recognise them and to unravel the intrapsychic processes at work when the analysands desire for attachment or dependency was wanted, ridiculed, ignored or thwarted. There was no need to be frightened or relieved by the defensive expression of such needs - that is to say when they were presented as insatiable or in their obverse as non-existent. Rather they needed to be named and not denied even while they might not have the possibility of being recognised outside of the therapy relationship. But in this endeavour the therapist needed not to be the perfect or the good enough alternative mother, but an other who could tolerate and engage such needs rather than deny or distort them. By engaging with the person and their hesitant desires then she, in time, could internalise the encounter in time. This new relational experience would provide for a sense of authorship and acceptance of conflicted and uneasily felt desires.

In the field such work was portrayed as those 'giving, nurturing therapists'. Yet this crucially missed the point: technical aspects of the therapeutic work had always focused on the impossibility patients had with receiving. It was quite impossible to be 'another' providing the dreaded 'corrective emotional experience' that Franz Alexander (1953) had been attacked for earlier.

The elision drawn between the attempt to reach someone behind their defense structure and a therapist who gratifies were intriguing. A therapy that addressed how hard women found it to receive - because they couldn't be sure of the giving, that they had no emotional place in which to put what they so desperately wanted, was being characterised as being overly giving.

This mischaracterization spoke to the taboo against women's desire and women's dependency needs being allowed.

The 1980's was a decade of significant change reflecting a paradigm shift within the practice of psychoanalysis. Countertransference and the analyst's use of her or his own experience within the analytic relationship have been at centre stage. The subjectivity of the therapist and its place within the analytic relationship is the focus of contemporary discourse. It is worth noting that British Object Relations theory has influenced American Schools of Psychoanalysis - particularly the interpersonal school (Sullivan) and self-psychology (Kohut) - more so during this past decade than at any time previously. As countertransference theory found a prominent position in the American schools, it was apparent that the British School, particularly the Independents, had a tremendous amount to offer.

More recently, the social-constructivist paradigm has elucidated the participation of both parties within the analytic setting. Both parties are weaving the complex transference-countertransference web. Within this framework far more attention is paid to the subjective, that is the personal, full emotional reactions of the analyst within the therapy. The transference pulls the therapist into the only kind of relationship that the patient knows how to create and together patient and therapist in some sense disprove the patient's prediction that this relationship will follow in the path of the others that have come before. The therapist's ability to understand the ways in which the analytic relationship re-enacts previous patterns and the interpretations of the dynamics in the here and now between patient and therapist is the work of analysis. The ways in which the analyst is pulled in, however, depends on the idiosyncratic, unique, internal object world that is the personality, the subjectivity, of any particular analyst. The countertransference, then, will complement the transference differently in any given analytic dyad. A feminist view is useful here because we have discussed the ways in which women can often times too easily be drawn into the Other's experience and feelings. The permeable boundaries that have been a part of women's psychological development necessitates a very particular awareness to relational engagements. It is the ability to be aware of and to maintain one's own subjectivity as one engages within the analytic relationship that is of critical importance.

The American schools to some extent share a relational approach. They differ in their adherence to a classical drive model, but across the board we have seen a progression from the classical analytic stance of analyst as neutral interpreter to an emphasis on the two person process that is the analytic relationship. Attention is placed on the here and now inter-subjective experience between therapist and patient within the transference-countertranference configuration and the multiple levels of interaction in the analytic relationship. The search for metaphor and allusion in the patient's narrative, and its application to the therapist patient relationship has become a guiding principle of the work. This revised analytic participation looks at the plausible account of the patient's transference, the mutual but asymmetrical nature of the analytic relationship, the use of oneself and questions of technique regarding the subjective experience of the analyst. The internal object relations of both participants come into play as complicated re-enactments of the patient's intrapsychic and interpersonal drama unfold. This is obviously a different view than the contemporary Kleinian one of transference and projective identification[10].

In the new perspectivist approach, one could no longer see oneself as interpreter of meaning to the patient's narrative, but rather one saw oneself as co-participant in creating meaning through the analytic exchange (Gill 1982, Mitchell 1988, Aron 1992). The various elements which make up the current discourse reflect the more pluralistic theorising which one finds today within the American psychoanalytic community. The therapist is seen to inevitably fall into patterns of re-enactment with her patient and must find her way through a process which is both receptive on the one hand while simultaneously demanding an active subject on the other. Edgar Levenson (1983) describes the process of falling into the patient's patterns of relationship and then

[10] (The work of Christopher Bollas and the Sandlers contain aspects of this new paradigm and is are examples of the cross fertilisation of the American and British Schools.)

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resisting transformation, that is, stepping outside of the transference pull, analysing the re-enactment within the therapy relationship thereby providing, in action, not merely through interpretation, a new experience.

Extending the perspectivist approach, current views tend to stress the therapist's idiosyncratic contribution to creating the inter-subjective field, both consciously and unconsciously not merely interpreting it.

Throughout the 80's, coinciding with these developments, feminists began the critique of the mother, and therapist, as object. Therapists experienced themselves as the much needed object - both for transference purposes - as well as for use in the new relationship, they began to question their position of container, nurturer, the one who survives the attacks, the one who tolerates the distress. This new, but better version of the mother who had disappointed and failed to appropriately meet the needs of the patient did not accurately represent who the therapists were within these relationships. Just as mother was the object for the developing infant, the therapists were to be the object for the patient's transference use. And yet, there was a feminist critique of mothering in which the consequences of mother as object both for women and for the developing psyches of their offspring was well understood.

The misogyny of the culture found expression in the objectification of women in general and in a different way this was no less trivial a matter within psychoanalysis. The therapist was not only object, but a subject as well. In hindsight, it seems obvious that that perception was most likely to come from feminists who had understood the struggle from object for others to subject with agency in daily life. As Jessica Benjamin (1988) wrote: "the idea of intersubjectivity reorients the conception of the psychic world from a subject's relations to its object toward a subject meeting another subject." The position of the therapist being a selfless, idealised other was now under scrutiny.

The current generation of mostly male theoreticians developing and extending current views on countertransference and the analyst's subjectivity had perhaps been influenced not only by British object relations theory with its emphasis on the pre-oedipal period, but by feminism as well (Eichenbaum & Phillips 1992). For as they experienced

themselves as the early mother in the transference (more so than they had done previously), they did so with the insight brought about during the previous decade by feminists that, indeed, the mother was also a person in her own right. In addition, and equally as significant, is the fact that they brought to that new relationship a subjectivity born out of male experience. If men were going to be maternal objects they would do so with visibility. As they tolerated, contained and survived their patients emotional charge, they would do so with a voice. They would search for a way to appropriately make use of the countertransference in such a way as to see their own contribution to it as well as finding a voice from which to express their own subjective reaction to the intersubjective dynamic. This is a new kind of maternal object, one which may represent a more fluid and complex experience of gender in the analytic relationship. Men's differently constructed sense of self impelled them to bring themselves in. Their fears of merger, particularly with the feminine, however, influenced their capacity for attachment.

Not surprisingly on the other hand, as this new paradigm evolves women have more difficulty with being subjects in the analytic relationship. In many ways it is far more ego syntonic for women therapists to be objects. To receive, to listen, to contain, to give back, to tolerate, to accommodate are modes of relating with which we are all too familiar. The new paradigm in which we are more fully present, more fully aware of our own reactions and responses, more fully aware of what we ourselves bring into the analytic relationship and the ways in which this is responded to by the patient demand a clearer and fuller sense of ourselves as subjects. How we have come to know ourselves through and within relationships has historically not demanded full subjectivity, in fact, we might dare say that it has demanded something far less from us - an inhibition of our full and complex selves.

Clearly these notable changes in femininity are seen through a particular lens in the practice of psychoanalysis. For in this new paradigm one must have a voice and a sense of being entitled to or justified in one's perspective. One must feel and believe that her perspective, her reactions, her internal reading of the inter-subjective field must be present in order for there to be two subjects in relationship. Paradoxically the necessity

for the bounded presence of the therapist has contributed to an increasing ability to be more of a subject within the analytic relationship. The requirement to see and experience the patient as other, to be aware of our transference and projections, to analyse and monitor the countertransference, has benefited the woman psychotherapist's own process of developing subjectivity. Supervisees often find it difficult to make interpretations which are inclusive of themselves as important players in their patient's emotional worlds because it makes them feel too self important. If one works within the classical or Kleinian definition of transference, this difficulty is, on the face of it, less apparent. But the therapist as interpreter of experience demands a different presence than the therapist who acknowledges that they are a co-participant in the therapeutic encounter. It also requires that as the patient struggles to find her own voice, her own subjectivity, so to does the therapist struggle to find and articulating her voice.

Another aspect of this parallel process is the patient's attempt to find and express agency and to have her actions reflect an internal, authentic experience as opposed to having her actions determined by her reading of the Other's desires. The woman patient feels conflict about acting on her own desires and often sabotages her own efforts. Similarly the woman therapist may feel guilty for setting a boundary - which is an example of her subjective presence - and changing her stance in relationship from one of accommodater (object) to a subject with agency. We can see the parallel process for both women as they shift their stance from object to that of subject.

Similarly the woman therapist may be the target of more anger than her male counterpart for maintaining her boundaries and holding the frame of the analytic relationship. We are all far more used to men being able to maintain their space and the importance of having that space whether it be for work purposes or merely to sit and read a newspaper. This is no less true within the analytic relationship with a male or female analyst. The woman therapist may experience more difficulty in maintaining her boundaries rather than giving in and deferring in some way to the interpersonal pressures within the relationship. This is perhaps most noticeable with female students and candidates around the most practical issues of fees, appointment times and so on,

but it continues to be an issue for the more seasoned female practitioner in the more complex dynamics of analytic engagement.

Another example of this becomes apparent when we look at the requirement of the analyst to tolerate not knowing the ways in which one is playing a part in the externalization of the patient's internal object world. In the not knowing or what Donnel Stern (1983) calls the unformulated experience, one must simultaneously lose oneself or turn oneself over to the patient's process at the same time as one maintains a differentiated state of subjectivity. One is not operating out of a false confidence, but rather a confidence born out of a trust and awareness of one's own subjectivity. This stance requires of the woman therapist an act which conflicts with traditional feminine gender development. As object, women were not required to develop or maintain a visible subjectivity. A feminine self is traditionally more permeable and adaptive. To that end a woman's integrated subjectivity was either underdeveloped or to a greater or lesser extent invisible. The therapist's authentic, more personal participation within the analytic relationship inevitably results in a more visible presence. This visibility, not only represents a more progressive position within psychoanalysis in general, but moreover it represents the most dramatic change from object to subject for the woman practitioner.

2. GENDER DEPENDENCY DYNAMICS AND PSYCHOTHERAPY

GENDER AND THE CONSTRUCTION OF A PSYCHOLOGICAL SELF

Gender is not as Freud thought, something that happens to you when you are three or four and the child discovers the psychological and social meanings of genital difference. Gender is assigned at birth (Money & Erhardt 1973) and is key factor determining aspects of how a baby is handled, held, fed, bathed, clothed, cooed to, described and identified with.

We use different words to soothe a baby girl or baby boy, we may have a different tone of voice, we have different expectations of them and we describe their activities in relation to their gender. A boy is a robust eater, a girl greedy. A girl who is energetic may be called a terror, while a boy is called active. Boys are generally breast fed for longer than girls, held for longer, potty trained later. In subtle and crude ways, unconsciously and purposefully, sex role stereotyping shapes our responses to a child's gender. If we reflect on our routine responses we will observe how we differentially relate to boy babies and girl babies.

Differences in the treatment, attitude and expectations we hold for girls and boys help establish deep gender differences in the psychological self very early on. All of us inhabit and contribute to a situation in which women and men live in different emotional worlds, experience shared encounters differently, see things with different eyes and hear and speak with a different voice. Even the modes of thought, reasoning and moral values that men and women hold are profoundly different (Gilligan 1982).

Each generation raises its children in this profoundly gender differentiated world. And as the neonate develops into the infant and the infant into a toddler, its experiences of the world and of itself are continuously gender specific until it begins to apprehend its own gender coincident with its emergent identity during the developmental phase known as separation - individuation occurring roughly at age two (Money & Erhardt 1973, Mahler, Pine & Bergman 1975). In other words at the same time as the toddler is realising its own subjectivity, its distinctness from others, its connections to others, its own boundaries and capabilities, it is also knowing itself as a little girl or a little boy. Its identity is bound up with a knowledge of gender. The two are inextricable. Gender expresses the physical and psychological knowledge we have of ourselves as subjects in a world divided by gender.

GENDER AND TREATMENT

Through all social classes and ethnic groups, a disproportionate number of women men go to their GPs suffering from what they define as depression. Large numbers of tranquilizing drugs are prescribed daily to women patients. One in seven women in the

UK spend some as psychiatric in-patients. And the dominance of alcoholism and violence as problems for men versus the dominance of eating problems as problems for women, further attest to the gender specific nature of our psychologies and our psychological responses, and the problems that lead people to seek treatment.

The dimension of gender is a dimension of treatment. A failure to address the dimension of gender, to become gender conscious in our work is a failure to address fundamental aspects of the human self leaving the psychotherapy in significant aspects circulating around the margins of the clients experience without encountering the central human core.

Thus, I think it is imperative that physicians, counsellors, social workers, psychotherapists, have an understanding of the specific stresses and desires that inform femininity and the specific stresses and desires that inform masculinity as masculinity and femininity are presently constructed in our culture in order to work effectively. And I think it is imperative that we understand these gender specific desires and stresses not simply as they affect our clients, but as they affect ourselves.

GENDER, PSYCHOLOGICAL DEVELOPMENT AND THE MOTHERING RELATIONSHIP

Object relations theorists argue that we acquire our psychology, our sense of self and our sense of the possibilities that exist in life, through our very first relationships. Those who raise us have the job of providing us with the sex role and psychology that is appropriate to our gender. For a client group of adult women today these first relationships have generally been with their mothers (or female substitutes).

So far, nobody I think would dispute this argument - the importance of gender and the importance of the mother. Analysts from the most conservative traditions to the most enlightened are in accord about the importance of sex appropriate behaviours in child rearing. What is in dispute however, is how we understand the consequences of and the experience for the individual mother raising the individual child in our culture.

If we recognize that social inequality permeates the relations between the sexes, we will see child rearing practices and the mother-son, mother-daughter relationships reflecting some permeations of the patriarchal order. This way of seeing illuminates and critiques existing socially sanctioned practices. If on the other hand we either condone or fail to see the mechanisms of social inequality, then we will perceive child rearing practices as what "should be", without critically evaluating what these social practices mean for a child's development.

Thus if we extract the mother from her social relational nexus we simply see the ideal of the 'ordinary devoted mother' who gives herself over to the care of the baby. We then account for disturbances in the mother-child relationship as instances of maternal pathology (which they may well be of course) and we will locate that pathology strictly within the individual and perhaps the mothering she received.

On the other hand, we can, without denying these insights, situate the mother's psychological state within its broader social context. How did the mother come to have her psychology, her sense of herself, her sense of parenting. How has a mother's feelings about her own gender - both her conscious ones and those that remain buried - affected her parenting. How has her psychology been shaped to allow her to accept her social position?

From a gender conscious perspective, we see that an aspect of mothering involves preparing a daughter to accommodate to, to accept in some degree or another, the restraints on women's desire that she herself knows. While another aspects involves preparing a son for a life which in many respects differs from her own and is psychologically unknown. A mother may think that she is treating her children equally and she may quite purposefully reject enslaving her daughters, or valourizing her sons. A mother may they impress upon a daughter the importance of living for herself, of not being tied to husband and babies, of the importance of economic independence and so on. A mother may envision and wish to give her daughters access to a life different and less restricted than her own. But while a mother may encourage her daughters at a conscious level, at an unconscious level, quite different processes may be at work.

For at an unconscious level, as much clinical evidence demonstrates, a daughter represents for a mother herself or rather aspects of herself. In relating to her daughter, she inevitably finds, or perhaps we might say she creates in her daughter aspects of her own personality. She treats her daughter as she treats herself. She treats her daughter as she has been treated. She treats her daughter as she is presently treated. In so far as she has suffered and is suffering emotional deprivation, she will visit this on her daughter. In so far as her initiatives have been thwarted or redirected she will encounter conflict within herself about wholeheartedly supporting her daughter's desires. We see clinical evidence of these conflicts handed down in the felt experiences of mothers of daughters and daughters themselves who say and demonstrate that aspects of themselves - in particular their needs for dependency and their needs to initiate - are illegitimate (Eichenbaum & Orbach 1984).

What I am referring to here is something quite subtle for I am not wishing to imply that a girl's needs have simply been ignored. It is rather that they have been converted into relationally directed activity; to emotional ministering and the midwifery of other's activities. It is as though a girls own needs are channelled into looking after others, to finding satisfaction from that, and to providing relationships for others on which they can depend, in which their initiatives and desires can blossom and to which they can bring their emotional needs.

At the same time that a girl learns to encourage others to rely on her, to bring their troubles to her she also understands she has no one to bring such needs to herself. Indeed many girls grow up hearing the explicit message that they should not expect anyone to be there for them emotionally. Learning to curb neediness or to hide it is considered essential. The result is that she feels needy. Her psychology and sense of self is permeated by painful feelings of deprivation and longing, feelings that are often repressed and split off.

This repressed, split off part of the girl and later the adult woman motivates many of a mother's responses and initiatives toward a daughter. The mothers repressed feelings of neediness create a tension in the mother so that she is inconsistent in her relating.

Sometimes she is emotionally available, sometimes she is harsh and punishing when faced with her daughter's needs (Orbach 1978, Eichenbaum & Orbach 1982).

EMOTIONAL DEPENDENCY AND GENDER

At the same time, a mother's feelings about a son's gender, about masculinity set the mother-son relationship on a different course. A boy's initiative is more generally encouraged, his curiosity supported. Where a mother may fret inside when a toddler mounts a slide for the first time, she is likely to convert that anxiety with a boy into words of encouragement whereas with a girl she may bid her take care. She accepts that he must 'master' the world and that 'boys will be boys' so that in place of the effort towards containing and constraining so obvious with girls we find encouragement towards initiatives. At the level of emotional need - for nurture and succour, it is not that boys get more than girls but that their own needs for emotional relating are not converted into responding to those needs in others. This means that they do not equate the having of such needs with feelings of unworthiness or unentitlement. In addition boys and men are raised to expect to enter marriages in which they will receive emotional attention without acknowledging that it is being given and without being shown how to provide it themselves for others. Men's apparent independence then rests not on their lack of need for others, but on the fact that their dependency needs are in some way legitimized and at least partially addressed by their wives without their existence being acknowledged.

Certainly boys needs get misinterpreted or ignored as much as girls needs, but a crucial gender difference would seem to be around the area of giving and the area of entitlement. If we see a male client who is preoccupied with giving to his mother and others instead of responding to his own needs and desires we diagnose this as a problem expressing much greater distress than the same phenomena routinely seen in a woman. We expect and condone men's self interest whereas we would describe the same behaviour in women as selfish.

DEPENDENCY DYNAMICS AND PSYCHOTHERAPY

I think we can see then how a woman's dependency needs can be a source of discomfort to both the client herself as well as the male and female psychotherapist. We have been brought up to be suspicious of such needs in women. If we are women, we reject or suppress them in ourselves and both women and men are uncomfortable with their exposure. We view such needs with contempt and as any clinician can verify, we will often hear a client who dares display her needs for emotional support described as insatiable, greedy, bottomless.

Our unexamined contempt of an aspect of a woman's emotional life carries over and is brought to the therapy relationship. Unwittingly the therapeutic relationship may become the site of the rejection of such needs once again. When a woman seeks therapy she may still be wanting to have her dependency needs met but everything in her experience tells her that they will be rejected or twisted into looking after others so that it has become dangerous for her to even acknowledge these kinds of needs, let alone hope that anyone can see them as important.

How does the dependency scenario play out in the psychotherapy? The most obvious thing to be said is that it can seem to be a non-issue.

Let us say for the moment, that what the client most needs and what she is seeking in the therapy relationship is the possibility of having her dependency needs addressed. That desire may be met internally with anxiety. She anticipates approbation and censure for her needs. She may project onto the therapist the same kind of taboos on desire, on initiation, on wanting, that she herself has internalised. She sees the therapist as forbidding her from having such needs. She may be wishing and hoping that her desires can be acknowledged and accepted but she has little experience with this being the case and unconsciously she cannot help anticipate that within the therapy her wishes will fare badly. She may avoid bringing up her desires to the therapist. It will be up to the therapist to interpret the transference-countertransference material in this light.

Let me pause here to address a question that is frequently asked about whether it is a therapist's job to meet the client's needs for dependency. Note that I have written that the problem is that 'the client is seeking the possibility of having her dependency needs

addressed'. I say addressed. I do not say met. These conflicts cannot be circumvented by gratifying/meeting such needs in therapy. Indeed, the client has developed enormous resistance to the acceptance of such needs in herself and couldn't possibly allow the gratification of such needs. To address dependency needs is not to meet them but to explore the conflict around those needs and to contain the conflict within the therapy relationship.

Let me further add that the very question of whether it is appropriate for a therapist to meet a client's dependency needs is itself a reflection of the acute discomfort we can feel when confronted by the fact of women's dependency. Gender conscious therapists are often criticised for 'gratifying the (libidinal) needs of their patients' and are often portrayed as allowing the client to become overly dependent. The misrepresentation of our position occurs I believe, because psychotherapists have unexamined conflicts about dependency and these unexplored conflicts lead to a reflex disdain towards their own and others dependency desires. By caricaturing a position on 'the addressing of dependency needs' to one of 'gratifying them', the issue of women's unmet longings is bypassed.

But this caricaturing leads to serious consequences when working with women. It can miss the critical conflicts and repressed desires which need to be analysed and worked through within the therapy. Because training infrequently addresses gender and psychic structuralisation, there is a possibility that the therapist will misunderstand the client. Worse still the therapist and client may collude and confirm the client's fears about her needs by the therapist's unenthusiastic response to such (often haltingly expressed) needs. In the early stages of therapy, for example, the client may endeavour to 'look after the therapist'. She relates to the therapist as she has been encouraged to relate to others, that is to say she has the needs of the therapist in mind, she wishes to not be too much trouble and so on. A therapist who is unaware of the impact of gender socialization on dependency needs can easily collude with these fears. If on the other hand, the therapist points out that the therapy could be a place for the client to express her needs - that it is a place in which she could get attended to, the client may become acutely anxious. This is such a novel state of affairs that she may not know what to do

with the attention and the space. She may be so habituated to caring for others, that it makes her uneasy to have attention riveted on her. And it is here that a great deal is asked of the therapist if she or he is not to collude with the client's defense structure. For it is in this space that she needs to hold the client and help her tolerate the feelings aroused by receiving attention.

SOME PRINCIPLES OF GENDER CONSCIOUS THERAPY

In order to more fully understand the complex of feelings of women clients the psychotherapist needs an understanding of three major points which need to be worked through during the course of the therapy:

1. How a woman is likely to internalize women.

2. What a woman client is likely to project onto a woman psychotherapist.

3. What lies behind the coping mechanism (the defense) of being so solicitous to others.

These three points might be said to form a foundation for an approach to psychotherapy that begins to address and purposefully incorporates the fact of gender experience into the psychotherapeutic relationship and the transference- countertransference aspects of it.

The first point is that the psychotherapist needs an understanding of how women are likely to internalise women.

All clients will have an extremely complex internalisation of women (the women she meets, and the woman she herself can be). The client will almost certainly have been mother raised or female mother substitute raised (nanny, aunt, granny etc) and in the very earliest stages of psychic development, she will have experienced her most intense difficulties and intense pleasures, as well as her moments of calm and contentment in the ambience of her mother. These early experiences are like a template, organising her relationship to self and future experiences. Mother then takes on tremendous power. She is loved and hated, wanted and feared. These contradictory imagoes of mother are internalised by the daughter. In her identification with her internal mother, she

experiences herself as both full of love and as hateful, as someone who can be permissive or controlling, as someone who can give and be wanted, and yet one who can arouse in others feelings of fear and powerlessness. (Dinnerstein 1976, Chodorow 1978, Eichenbaum & Orbach 1982)

The second point is that the psychotherapist needs an understanding of how these complex and contradictory internalised imagos of women derived from the legacy of the clients experiences with her mother find their way into the heart of the therapy relationship. The prohibitions that the client has absorbed early on in her relationship with her mother and significant others are then projected onto the therapist (male or female) when she seeks therapy. She then comes to experience the therapist as someone who is frustrating and disappointing her.

The third point is that the psychotherapist and the client need to be able to discover, without the therapist shoring up the clients defense structure, what lies behind the compulsive coping mechanism of being so very solicitous and caring. What will be revealed if that defense were to crumble or could be seen behind?

I think that what terrifies psychotherapists and clients alike when they confront what is behind the defense, is the excruciating psychic pain revealed as the cost of a psychology honed to the care of others. Behind the competent giver and nurturer, is often a person who experiences themselves as without a known and reliable self but a 'false' self (Winnicott 1960) that chameleon like responds to and initiates behaviours that are only acceptable within its relational nexus.

COUNTERTRANSFERENCE

The process of psychoanalytic psychotherapy depends upon psychotherapist being able to step into the shoes of their client, to experience what they are experiencing, to feel it, see it from the client's perspective, and then to step back again into their own shoes to help the client with their distress. The ability to step in and step out of another's experience is a skill learnt in training. We try to imagine what it is like to be in our client's position. We try to envision what his or hers external and internal life is like.

And through an examination of the countertransference - what we may be feeling at any given moment with a client and the feelings that are evoked in us by a particular client - we begin to construct a picture of the shape of his or her defense structure, the feelings behind the defense structure and the overall shape and stance of the client's presence in the world.

The diagnostic method of examining the countertransference, is one of the tools of the trade of psychotherapy. It is as essential to us as a plane is to a carpenter. Analyzing the countertransference permits us to consider how we feel what we feel with a particular person rather than to respond spontaneously to how that person makes us feel. Our ability to understand our own feelings in relation to the client is one of the key features of the psychoanalytic enquiry. The psychotherapist asks her or himself, what is the client experiencing that in this relationship she is acting in such a way that I feel engaged, I feel pushed away, I feel seduced, I feel rejected, I feel attacked, I feel admired, I feel envied, I feel pitied, I feel angry, I feel ungenerous, I feel bored, etc. What is the client trying to convey to me about her or his experience in relationships through creating similar feelings in our relationship? What kind of responses do the induced feelings call forth from me? What feeling state am I enveloped by? Is this feeling the split-off affect of my client? In other words, by examining the countertransference feelings, the psychotherapist microscopically examines particular aspects of the therapeutic relationship.

COUNTERTRANSFERENCE AND GENDER

In the countertransferential enquiry, psychotherapists both consciously and unconsciously refer to received notions they hold about appropriate behaviours and desires on the part of male or female clients. They hold a set of expectations that guide their understanding. Although psychotherapists endeavour to scrutinize their reflexive expectations about their clients, gender expectations are often ego syntonic and therefore do not come to conscious awareness.

When a psychotherapist - a man or a woman - examines their countertransference and the therapeutic milieu of a particular client and is engaged in the process of trying to understand that client, they inevitably do so from a particular perspective, a perspective that will have encoded within it deeply held notions about gender (and I should add, class and race and ethnicity).

What this means in practice is that the content of what a client says, as well as an understanding of the transference- countertransference dynamics is made to fit into categories of experience, developmental imperatives that tend to be gender biased as opposed to gender conscious.

In the attempt to alert the reader to what may be the difference between a gender biased approach and a gender conscious approach I offer the following example:

A woman is telling of her experience at a dinner party. She bemoans the fact that she is so greedy and has great difficulty in restraining herself. She is quite distressed by this and continues on to say that when she starts to eat some dessert she just can't stop. She feels ashamed of herself and thinks that she better take herself in hand.

These comments might be received in a gender biased psychoanalysis without being necessarily explored. The analyst may follow the narrative, notice that he or she is feeling somewhat depleted in the countertransference and note that the client feels overwhelmed when she has a need. The analyst wonders what the greed symbolises. He or she identifies the clients conflict around need and the feeling of insatiability and thinks about the clients need to empty the breast, to suck out the mother's goodness, to spoil what is being given and so on. He or she reflects upon the patients greed towards the analyst and how she does and doesn't manage what is given in the sessions (the feeds). The clinical issue will focus on helping the client recognise that her greed is preventing her from moving on to tasks of a reparative nature.

On the face of it there is nothing blatantly patriarchal about this way of thinking; the analyst hears the clients experience and understands it in developmental terms. But let us pause and examine this thinking. Doesn't this interpretation too uncomfortably

parallel the clients own beliefs? Therapy is not about simple concordance surely, but about exploration and understanding in a context. Instead of exploring the use of a highly emotive word 'greed' - a word with which the woman beats herself - it is taken as a given. Of course the woman has a propensity to feel greedy, don't we all thinks the analyst. Aren't desserts temptations anyway and isn't it right that we should regard our desire for them as something that must be restrained.

What happens if we now set the client's phrase in a gender conscious context. How does the analyst now see and interpret both the content and the countertransference material? The therapist notices the use of the word greed. In fact the gender conscious therapists also identifies with the clients derogatory remarks. But she takes pause. She questions her own responses as she questions the clients. Why should they concur so readily; what does greed mean to the client? What is it about desire that stirs up such reproach and guilt; what is the role of food in a woman's life (Orbach 1978). Is the clients perception of her greed around food a metaphor for greed/need in general; what is it about need that evokes such conflict that it is felt as greed ?

Within the countertransference, the psychotherapist reflects on how the client exhausts her in the session and s/he wonders why. Could it be to weary the therapist and deflect her/him from exploring the defensive aspects of the projective identification as though to convince the psychotherapists that her need cannot be addressed? Is the client communicating the level of exhaustion she herself feels from the effort of having bound up her needs so assiduously? The clinical issue will focus on helping the client accept her conflicts about desire. The ability to tolerate her conflict will allow her to become aware of her conflict instead of obliterating it through denial or insatiability.

The differences in the two approaches are plain. The Kleinian approach accepts as given the greediness of the client. In fact what gives the Kleinian interpretation its convincing character is that it is so terribly familiar. Of course women are greedy. Of course those greedy little needs cannot be met. Of course the woman must recognise her greed prevents the metabolisation of the good breast.

The gender conscious approach challenges the (unconscious) but culturally received notions of the inevitability of women's greediness. In its place it problematises desire.

Let's say a client Penny, tells us about how she has just split up from a relationship with her boyfriend. She feels bereft and lonely. When she was with Jack, she felt clingy and insecure. She was always searching for confirmation that she was loved and wanted, but Jack was unforthcoming and even when he was responsive, she felt she had manipulated him to say he loved her or would stay with her, so she really didn't much believe him. She now tells her psychotherapist how awful she is for being so clingy. She doesn't know what happens to her when she gets close to someone, but all of a sudden it is as though she feels lost and she can't do anything without the other person's attention, support, approval. She also tells the therapist that before she was with Jack, she felt quite good in herself, competent and secure. She would like to get back to that state of not needing. She would like to be like that now. She anticipates that the therapist will approve of such a desire, after all being a whole or healthy person means being independent doesn't it? And obviously she is sorry she is crying and drivelling all over the place, really she'll pull herself together in just a minute.....

A psychotherapist would be thinking on several levels as he or she was experiencing Penny. At one level the therapist would be sketching her or his preliminary view of Penny's relationship to intimacy. They might wonder about her ability to hold the boundaries between herself and others, about issues of merger and separation, about Penny's lack of trust and so on. At another level, a far less mediated level, the psychotherapist might find herself concurring with Penny's stated desire to do away with troublesome needs. It would help considerably if a close relationship didn't unstitch her so. And at yet another level, the psychotherapist might realise that she or he felt restless when Penny talked about how clingy she could be. If they scrutinized their countertransference, they might ask themselves what this restlessness might be about. They might conclude that there was something about Penny's need that made them uncomfortable, and something relieving about Penny's avowed wish to be able to get herself together.

Thus we can see that Penny's projection onto the therapist might be isomorphic with the therapists own thoughts and desires. Penny feels uncomfortable about her needs, Penny feels relieved at the thought that she could get herself together and handle them. Ah, good, you might think until we insert a critique informed by our knowledge of gender. For once we insert that critique, we have to ask ourselves, why are we all, psychotherapists and clients, so very afraid of the exposure of women's dependency needs?

Men and women will have different answers to this question based on their own gender linked experiences. Broadly speaking we might say that men are alarmed by the display of women's dependency needs as something they are meant to do something about/with but haven't learnt what it is exactly.... and women might be alarmed because of their own repressed identification with neediness; one woman's exposure of neediness threatens to stimulate the neediness of the other.

If we look at psychotherapists responses we might see that they have specifically gender linked responses too. We might observe that a male psychotherapist while imagining himself to be holding an enquiring attitude towards this exposure of neediness, might quite frequently collude with the defenses that the client will surely muster to push the neediness away. When the client reports feeling much better following a session in which she has exposed her neediness and says she doesn't feel so vulnerable any more for example, or she might say she feels angry about something completely unrelated to the content of the previous session, the therapist may fail to see either response as about the difficulty with sustaining work on the level of the dependency need. Both the therapist and the client may relax. They may take the manifest content as the real content and thus unwittingly reinforce a felt experience in which exposure of need must be followed by its resuppression.

A woman psychotherapist may well have the following version of her response to Penny. She may feel how very demanding Penny is and she may offer interpretations that instead of describing Penny's desire and her defense mechanism, have the effect of judging it. She may concur with Penny about how greedy Penny is, she may suggest

that Penny has not given up the desire to be at one with someone else, implying that this desire is in itself infantile. In other words she colludes with the projection that Penny has onto a woman psychotherapist, that the therapist will disapprove of her desires for a dependent relationship.

If the therapist is conscious of gender issues instead of collusion a great deal of the therapeutic endeavour will be expended upon examining what Penny wants in her relationship with the psychotherapist in the present and how she can accept that desire in herself, that is to say, observe her rejection of it while struggling to receive and digest the therapists attention.

We can see from what we know of Penny that she feels dreadfully insecure. In each of her adult relationships she has stuck herself velcro-like to her partner and felt herself to have lost who she was in the process. But in the course of the therapy she comes to understand that neither of these two selves - the velcro person nor the heroic coper and non needer - serve her well. While they are how she knows herself, they feel both real and unreal to her. She comes to see them both as defenses - as what Winnicott might have called False Selves - against a very unsure and underdeveloped self. What she fears is that in shedding these false selves she will find that she is nothing and has nothing.

In the course of the therapy it is likely that Penny will alternate between velcro-ing herself to the therapist and disentangling herself. She will experience much shame about her wish to be stuck to or inside the therapist's orbit and will anticipate the therapists disapproval. She may well attempt to 'provoke rejection'. She may attempt to ward off the pain of her unmet historical needs by aggressively denying such needs in the present. She may do so by disparaging the psychotherapist, ridiculing her or his interest in her. She may induce in the psychotherapist - via the countertransference - feelings of hate, rejection and despair. The power of these induced feelings is a testament to the strength of her defense structure which makes her feel as though she shouldn't want or need such intensity of connection. Secure selfhood cannot exist in an environment in which one is consistently compelled to pay attention to the needs of others. One first has

to receive in order to put in train developmental processes which lead to selfhood. Thus she still needs an attachment in which her needs are paramount. If the therapist, male or female, can tolerate the level of Penny's need for connection, if the therapist can read it through the highly unattractive defenses that are designed to evoke rejection, if the therapist can tolerate what might feel like Penny's overwhelming need for connection, and one which may be all hedged in with rejection of the therapist - then they can help Penny work through her conflicts about dependency within a relationship that continually and explicitly acknowledges the existence of such needs. The therapist will stand by and in so doing help Penny tolerate the feelings of nothingness and emptiness. In this way Penny will become less fearful of what she may initially perceive of as her vacuum or the badness that lives inside her.

In time the shame will dissipate and Penny will be able to experience connection without obliteration. She will be able to ingest the acceptance and respect from another in the present and begin to transform an internalised picture of herself as existing only through compulsive caring. As she and her needs are related, to in the present, she will know herself as someone with desires, with entitlements, with a beginning, with an end, with an autonomous-relational self (Eichenbaum & Orbach 1987) that can make attachments without being swamped by them. And this Penny, will now embody a psyche that is a challenge to our current construction of femininity.

CONCLUSION

What is revealed behind the insistent giving, behind the caring, of our women clients, is a confusing anger, a well of loneliness, of unknowing, of inchoate desire, of wanting. The psychotherapist might understand this as a desire for an attachment not contingent on denial of selfhood. She or he may see that what the therapy must provide is the conditions or rather the pre- conditions that will allow for the development of selfhood, of subjectivity of a self that has a beginning and an end, that has needs that occur and can be acknowledged and sometimes met and sometimes not. But to allow this discovery, to provide such an enabling relationship in which the experience and meaning of needs is being responded to in this way, means that a psychotherapist and

client have to enter into a relationship in which much neediness and vulnerability will be exposed and in which much uncertainty will be expressed and in which the client will wish ever so often to retreat behind known defenses because they dare not trust that the psychotherapist can be there for them, can tolerate them, can accept the attachment.

I hope that this brief account, conveys a flavour of the kind of therapeutic ambience that occurs when questions of gender are inserted into the therapists understanding of an individual psyche and defense structure. Our present social relations, interpersonal relations and relations to self are showing the strains of our current patterns of gender socialisation. Therapy and the symptomatology that drives people into therapy exposes how very costly this socialisation is. If we can dare to and bear to listen, as clients and therapists, we hear the pain that ensues from the current construction of femininity and masculinity. Perhaps now fifty years after Freud's death, we can begin to answer the question: What Do Women Want? For the psychotherapist concerned to understand our ideas about how gender constructs the psyche, the task is to challenge the boundaries in which femininity and masculinity have been allowed. Just as one hundred years ago, Freud discovered how sexual repression created widespread symptomatology in Victorian bourgeois women so today, we need to understand how the taboo on female desire - by which I include the taboo on dependency needs and the taboo on initiating create particular symptomatology in women.

3. SEPARATION AND INTIMACY: CRUCIAL PRACTICE ISSUES IN WORKING WITH WOMEN IN THERAPY.

A woman's psychology is defined to a very large extent by her designated social role as mother. This is true whether or not she takes up the (very recent) option to be a mother. The structure of parenting in which women mother is almost universal within the Western world, and thus appears natural, but in exploring developmental psychology we

can see the psychological imperatives that structure this role and the ways in which mothering occurs. We can see how a girl comes to be a mothering person and we can discern the shape that gives to her psyche. When we are looking at a woman, we are looking at the psychology of someone who has, to some measure or another, been brought up to take on the social role of caregiver and nurturer, to introduce infants and children to appropriate ways of feeling and behaving, to be the provider of the continuity between generations, the person responsible for the continuity in relating and so on.

Mothering then, not mothering in the biological sense of the capacity to give birth, but in the sense of the socially established notions of what goes along with being a mothering person is a key feature of femininity. When women break away from these aspects of their personality or when they feel inadequate with established practices as givers and nurturers they suffer dis-ease. Little girls are brought up to be women who will have an awareness of the needs of others, who will minister to those needs - even to anticipate them before their articulation and demonstration. Women come to provide comfort and emotional support services to those around them: family, co-workers, bosses. Operationally, this means that much of a woman's energy is directed to working out what others desires are so that she may respond appropriately to them. Frequently it will require that she defer to those desires.

A second determing feature of woman's social role - again the notional norm until very recently - is linked up with the idea that a woman has only reached adulthood and been "successful" as a woman when she has connected herself with a man. This connection is conceived of as important and yet highly difficult to achieve so that in order to secure a man she must make herself into someone that others will find appealing. When she finds her man, her social status, and how she is perceived in the world, still largely depends upon his location in society. Adult separate womanhood is not a category that has until this last decade received any open respect or legitimation.

These two determining features of a woman's social role have a profound effect on her psychology . They shape it in particular ways and are instrumental in creating certain

kinds of feelings she has about herself. They operate in the most obvious and in the most subtle and unconscious ways. Let's take the most obvious first and then we will try to sketch some of the developmental steps that ensue in the process towards femininity.

The conceiving of oneself as a nurturing, mothering type of person, who responds to the desires of others and defers to them, has what can be considered both negative and positive consequences for the woman's psychology. To start with what feminist psychologists, Jean Baker Miller (1976) and Carol Gilligan (1982) have seen as positive, the capacity to relate to others, to care for them and to think about them, creates a way of being that is people orientated rather than instrumental. It is a version of the 'being` state that Winnicott (1965) refers to. Feminine emotional values of care, concern and outer directedness are represented as important rather than the values of competition, success in the world, and so on. That these values are not socially validated should not lead us to reject them Jean Baker Miller suggests, for they are the skills that although acquired through women's location as subordinate, are nevertheless positive and represent a bulwark against the damaging values our public culture stands for.

This position seems valid up to a point. It is important to legitimate feminine values and feminine morality and to cast women's psychological development in its own terms rather than in inevitable contrast to male psychology. However the obvious negative consequences of this way of being revolve around the creation of a personality that needing to be on the alert all the time to respond to others, has little chance to develop its own needs. Moreover, it would seem to elevate a consequence of oppression into a virtue. While undoubtedly it is a good thing that women have developed these skills of caring, they have a complex underbelly that needs to be addressed. Far from achieving the 'being' state, the demands of giving, so frequently built on a base of deprivation, render women continually psychically busy so that they are chronically in the Winnicottian 'doing' rather than 'being' state. Further the conception that one's own needs are important and worthy of being addressed by oneself or by others, is missing. The self is validated in emotional service rather than through being directly related to. Many women express their response to this state of affairs in the everyday language of feeling something is missing, not quite knowing who they are or what they want,

commenting that when they are in a close relationship, they may say they 'lose' themselves, or they may say that when a relationship ends they no longer know who they are.

Let's turn briefly to what women in therapy present for there can be no more dramatic exposure of this tragic underbelly than the painful states women reveal in the consulting room. Listening to women who come to therapy, there is a remarkable similarity in the content of what they say and the way in which they perceive themselves. Of course in the therapy relationship, particularly in the beginning, the things women share about themselves tend to be in the areas of dissatisfaction. Nevertheless it is startling to realise quite how low women's self esteem is. Women remark frequently on how basically at fault they are or how inadequate they are in essential ways. They feel that there is a disjuncture between the way they show themselves and are seen to be adults in the world, and their internal experience of insecurity and uncertainty. They worry that if people could see through them they would discover the frequently frightened nervous and angry little-girl inside who is not at all sure where she does belong in relation to others.

Women talk of the consequences of seeking self definition through relating to others. The relating becomes so enmeshed that they have a difficult time experiencing their own identity as a separate free standing person who relates with other separate people. Women talk of how they stay in unsatisfactory relationships fearing a loss of self if they were to withdraw from the relationship. New relationships are frequently sought driven by the need not simply for connection but for identity. This need for connection is linked with the social requirements of feminine deference and submission. Women discuss how habitual deference to others militates against developing one's own opinions. Women encourage others to express their wants and ideas and then use those as reference points for their own thoughts and feelings. When a woman does express an opinion, she may be preoccupied with the reactions of others. Under such circumstances, dissent or conflict often induces a kind of panic. Controversy is experienced not simply as difference but as potentially dangerous, for some it is felt as a sort of annihilating differentiation. Of course, in therapy, as in consciousness raising

groups where women first gave vent to their feelings in a self conscious way, it becomes obvious that when given the opportunity of being listened to, women have many strong opinions and clear thoughts about most situations they find themselves in. Their deference and lack of confidence does not accurately reflect their lack of thought or opinion but rather their socially derived psychological position.

Women in therapy discuss how complicated the emotion of anger can be. It is a feeling that can cause great difficulty. It can feel uncomfortable and even dangerous for it goes against the grain. It is an assertion of one's self in relation to another, an act of differentiation. As such it is somewhat incompatible with notions of the primacy of others experience. Women's unease with acknowledging or expressing their anger creates a situation in which they fear that it is enormously powerful. They fear it could alienate at least, annihilate at most, the person towards whom it is directed. They fear they will lose what little they have.

In therapy, an internalised critical part of woman's psyche presents itself starkly. It is as though women carry around a third eye, a kind of punitive judge, who watches every action, thought and interaction closely. More often than not the judge finds fault. She has done something wrong or shown herself to be greedy in her needs and desires. The internal judge is keenly aware of the specific relational contexts in which women must live and constantly reminds her to be supremely aware of others feelings. The judge assesses the effect she is having on another person and depending upon whether she has been deferring and caretaking appropriately or inappropriately, engenders feelings of guilt, remorse or gratification.

Beyond such specifics, a common and critical feeling that so many women voice, is that of a despairing hopelessness of ever being truly understood. Women rarely have the expectation that another person will be interested enough to really listen. To listen not in order to interpret, diagnose or offer ideas for change, but rather to listen in an attempt to understand and make contact with all aspects of who she is. Her inner life is confusing, painful and at times overwhelming. The idea that another woman could attentively engage with her is both frightening and exhilarating. It feels as though for so long,

perhaps for as long as she can remember, she has always had to take care of herself and not to look to others for emotional understanding or nurturance. This has been so much of her way of being that finding herself on the receiving (rather than the active giving) end of a relationship in therapy can feel quite awkward, perplexing and poignant. It stirs up all kinds of needs, desires and longings which she has contained.

The question then arises, how do women so uniformly come to have this kind of psychology, a psychology that means we frequently do not feel whole, we can feel undeserving, we can feel fraudulent in significant ways, we can feel exhausted with all the giving that comes of being the emotional antennae, we can feel that our real selves have either not emerged or if they were to they would be unattractive, and so on.

One of the advances that feminism has made possible has been to see the importance of mothers in the lives of women and in the forming of a woman's identity[11]. Feminist scholarship in psychoanalysis and other therapeutic disciplines, has shed light on the structure of this relationship and it is detailing the ways in which the mother-daughter relationship impacts on feminine psychology. In doing so it has shifted the focus from the mother- son and father-daughter constellations, 'privileging' the mother-daughter relationship. In this relationship, the mother, who has been raised as a woman herself is the child's first most consistent and visible representative of the feminine. Who she is, how she is, how she feels about herself and what she projects about herself, powerfully inform the daughters emotional and physical experiences of femininity and of mothering. They will influence how she feels about her mother and how she feels and conceives of femininity and mothering for herself. Beyond this obvious but often neglected reality are the many dynamics in the mother-daughter relationship, dynamics

[11] See for example Nancy Friday My Mother Myself New York 1978,

Judith Arcana, Our Mother's Daughters, Berkeley, California 1979,

Adrienne Rich, Of Woman Born: Motherhood as Experience and Institution New York, 1976 Elena Giannini Belotti, Little Girls New York 1977.

that occur as a result of this relationship shouldering the burden of the social and psychological requirements necessary for the reproduction of femininity.

Before we go into some of the specifics it is important to remind ourselves of the social context in which this relating occurs and the imperatives that attach to it. The mother is placed in a problematic position. An important part of mothering involves providing an environment in which her children can come to take up their designated masculine and feminine roles. She is instrumentally engaged in the process by which the sexed neonate becomes a gendered person. In other words, it rests upon her (or the primary caretaker who tends to be a mother substitute and therefore for the purposes of this argument we shall refer to mother) to bring to life the psychological birth of her infant. A most important feature of that psychological birth - the experiencing of oneself as a subject in relation to other subjects - is the perception of oneself as a male or as a female subject.

Gender is inextricable from our notions of subjectivity. The ordering of the sexes is a fundamental characteristic of human development. In enabling her infants to assume a gendered sense of self, the mother relates to them in gender appropriate ways. This occurs on two different levels simultaneously. One is in regards to appropriate sex role stereotyping; the other in shaping their psychological sense of selves. In the first of these, she introduces a boy to the ways that her world deems are the ways of being a boy and she introduces a girl to the suitable ways of being a girl. This means that she relates differentially to them, encouraging different aspects of their personalities so that they will conform in broad strokes to the sex role stereotypes with which they need to fit in. While it might be protested that mothers do not do anything so crude as sex-typing their children, one would be hard put to find many mothers who are comfortable with their boys wearing pretty dresses (except in a dressing up game) or many who are at ease with their girls playing with toy automatic rifles. At a less obvious level we can notice how boys are routinely encouraged to confront and overcome the implicit dangers in an adventure playground. A mother may grit her teeth and bear it as she watches him careen through some treacherous pole vault. She may find it far more of a challenge to contain her anxiety when a daughter wishes to do the same thing. She may

indicate that the danger is one to be avoided, not one to be mastered (sic). What we all feel as opposed to think about what boys and girls can/should do are deeply influenced by the cultural prescriptions in the most explicit and the most subtle of ways[12].

The simultaneous but more subtle, and frequently unconscious, ways in which the mother-daughter relationship guides our taking up our gendered positions is of principal concern to us in coming to grips with understanding women's interior experience. The way in which the mothering person draws the psychological possibilities that exist are shaped by many factors. They include the mother's own experience of being mothered, they rest on her conscious and unconscious feelings of having a daughter, her identification with a same sexed child, they are influenced by the kind of support she receives in parenting, and how she feels inside herself. All of these factors are in themselves framed within the social matrix of the mother, who is a member of the subordinate sex being charged with bringing up her daughter to assume a similar social position. This is the problematic of the mother-daughter relationship. The relationship is set within excruciating parameters. The oppressed mother, must negotiate her relationship with her daughter around and within the fact of her own subordination. She may well wish to transform the possibilities that exist for her daughter and encourage her to break free of some of the confines of femininity. She may on the other hand, be uncritical of her own position, or upbringing seeking to provide mothering and guidelines for life on the lines that she herself experienced. Most commonly, mothering includes a melange of contradictory conscious and unconscious stances which express a playing out of the various possibilities in relation to women's social subordination. But however the subtle variations play out in each mother-daughter relationship, that relationship is nevertheless constrained by wider social practices. It is an ironic and

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[12] Money, J. & Erhardt, A. Man & Woman, Boy & Girl: The Differentiation and Dimophisus of Gender Identity from Conception to Maturity. Baltimore, MD 1973

Stoller, Robert J., Sex and Gender: On the development of masculinity and femininity, New York, 1968

Oakley, Ann, Sex, Gender & Society New York 1973

cruel phenomena of patriarchy, that the already oppressed shall prepare the succeeding generation for a similar fate.

Fundamental to the uptake of femininity is the taboo on dependency and the taboo on initiating. Girls are brought up to provide a dependent relationship for others, to be the emotional life line and emotional processor and support system to others. In this context they learn to service the needs of others and come to identify their needs with the satisfaction of meeting those needs in others. This overarching dictate is conveyed by the mother to the daughter in distinct ways. On the one hand, the daughter is encouraged to play co-operatively, to be a little mother, to pay attention to other children's wants, to be kind and solicitous. These personality characteristics are praised and encouraged. At the same time, it is indicated to the daughter that she should develop the facility to contain her own neediness. She grows up without the expectation that her emotional needs will be attended to. This dictate finds expression in the mother daughter relationship itself. The mother, unnurtured herself and weary from all the giving out that she is doing frequently looks to her daughter to be especially solicitous to her. In teaching her to be thoughtful and caring towards others she herself becomes a candidate for such attention from her daughter. A cycle in which 'giving` occurs out of unmet personal needs is thus set in train. The mother becomes the daughter's first child.

This stress on giving and attending to the needs of others inevitably thwarts the daughters development of 'independently' initiating parts of herself. She initiates within the context of behaviours that are sanctioned. She restricts her initiatives in other areas of interest or at best feels uneasy about them. Gradually she looses the facility to discriminate about needs and desires that arise internally. Such needs become a manifestation of what is possible. Needs that are impermissible either do not surface or do so with hesitancy and fear. Eventually, desire itself is felt as precarious. Thus a girl's psychology develops with a fear and repression of her own needs and wishes. These unmet needs are consciously and unconsciously rejected by the girl who then comes to understand them and consequently a part of herself, as bad. An illegitimacy, a sense of undeserving and unentitlement follow. As she grows up her psychology embodies feelings of unworthiness and self hate.

It is no exaggeration to claim that orthodox psychotherapies tend to view women's problem's as we have discussed them as the manifestation of a truncated pre-oedipal development. In other words, the insecurity a woman may feel, the way she may inhibit her desires, her conflicts around dependency, come to be seen as expressions of her stuckness to her mother. She is still wanting from her mother and has not been able to move through the pre-oedipal phase to the oedipal phase. What needs to happen is that she needs to separate. Although this position is represented in rather a crude way it is undoubtedly the prevailing view within psychoanalytic therapy. Many a therapist has been heard to remark, 'the process of separation is one that starts in the first session and continues through to the last.' In this approach, separation from the mother is the sine qua non of the therapeutic endeavour. The patient/client must come to accept that she cannot get what she needs from her mother. She should work through (i.e. give up) the longing and accept the loss of what she cannot have. Having done so, and 'separated' she will be in a position to take what a heterosexual relationship in the present can offer.

While on the face of it this is an eminently sensible proposition (of course she cannot get now what she did not get then from her mother), the pursuit of such a course too uncomfortably reflects the social implications of women's subordination which are that she should not expect continued nurturance, that she should accept her lot, that she should resolve not to want. It is isomorphic with women's daily experience. It implies that her wanting is over abundant and must be curtailed. If she can come to grips with wanting less then she will be able to partake of what is there for her.

With this diagnosis and the therapeutic effort being expended towards separation, the therapeutic work proceeds towards a restructuring of the defence structure. An attempt to relate to the unmet/unseparated self is abandoned in favour of a thrust to stabilise it more firmly behind a defense structure. The proposed forms of the separation contributes to a consolidation of a Winnicottian 'false self'. The woman learns to inhibit her needs more effectively. As a result she may well feel temporarily less out of control, or in danger of being overwhelmed by them but in essence, psychic change has been directed towards a change in the defense structure rather than resolving the discrepancy between the embryonic undeveloped self and the defenses. The therapist

and client come to collude in a process in which the woman client's needs are once again de-legitimized. A shared assumption is that the need is something one must negotiate rather than see if it can be met. A parallel that might make this clearer is the idea that a compulsive eater will solve her food problems through dieting. Such a response is not a solution per se. A diet is but a short term measure to hold back the desire towards food by channelling it in a particular direction. The 'compulsivity' manifest in the distressed eating behaviour is now harnessed to obsessive practices about what one should and shouldn't eat. The desire is held back rather than addressed, investigated and met.

Putting the stress on separation is rather like blaming the victim. The woman is condemned for what she has not had. (The poor person is blamed for their poverty). Women always strive to get what they need, often in circuitous or indirect ways. It is an expression of strength and the urgency of unmet needs that alerts women to being such good caregivers to others. It is the indirect expression and the systematic transposition into giving to others that causes women such tremendous stress. For the gender conscious psychotherapist then, we can see that the issue is not to encourage the client/patient to give up the wanting, nor for her to accept the expectation of not getting. What is required rather is that a woman receive encouragement to struggle through for what she needs, to have that wanting accepted as legitimate and understandable. In other words, the woman's desire needs to be recognised now and looked at straightforwardly rather than pushed underground once again.

In so far as it is manifest as a present wanting for authentic relating then this desire needs to be and can be met in the therapeutic relationship. The task of the therapy is to address the original not getting and to provide an experience of consistent caring that can be ingested in the present. Of course this does not imply that the therapist can 'make up` for the loss the woman carries with her. However the present contact can carry the sorrow, rage, upset and confusion surrounding past unmet need while meeting the need for relating that occurs in the present. As we shall see, it is the working through the defences against such kind of relating that form a central focus of the therapeutic work.

Separation is such a very difficult area for women because it rests on the dilemma of the person who has not yet had sufficient emotional supplies to consolidate a psychological sense of self which can allow for a genuine separation. In other words, it is not separation that is fundamentally at issue, it is intimacy. At first glance it might appear that women are fluent in the area of emotional intimacy - and indeed such a claim has great force when set against men's general ineptitude in this area. Women do know how to get close to one another, they do know that intimacy is something they seek and value, they do routinely engage in encounters that reflect some intimacy. However that much desired intimacy brings its own set of problems. In intimate relating there is a rapidity in the dissolution of boundaries between self and other. This dissolution and the resultant psychological merger with another may be greatly desired and/or it may be met with great trepidation. A temporary psychological merger with an other is especially precarious if one is unsure of the boundaries of the self in the first place. The merger is much wished for but may be felt to be dangerous for one may feel stuck in it. The falsely constructed boundaries between self and other so endemic in women's psychology hide an undeveloped and shaky sense of self identity. The merger may feel like a 'loss of whatever sense of self' one has garnered. (Thus women will often say "I know who I am when I am not in a relationship, but I lose myself when I am in love.") Beyond this loss, intimate relating in providing a feeling, however brief, of being understood and met, can be excruciating for it can stir up all the longing that has for so long gone unmet and hence has been repressed and denied.

In the therapy relationship the defence structure and the defenses that are manifest, are most profoundly defences against intimacy. Intimacy with the therapist is the most wanted and yet the most feared event. Intimacy experienced with the therapist is felt to be so painful that almost before it has been digested it gets undone, or there is a retreat from it. One can observe this within the flow of an individual session and over the course of several sessions. The desire for contact is so profound and so unknown that steps towards disengagement, and towards what might appear to be separation are rife. The client's assertion that she does not need anymore after but a few sessions or later on that she is doing better and could stop therapy now, have significance in this context. They are frequently the utterances of the defence against intimacy. They are not

signposts towards a genuine separation. For this reason, the work focuses much attention on the minutiae of movement and nuance within the therapy relationship. The impact of the contact between the client and therapist; its implications and how it can be used as the nourishment for the development of the client's embryonic self; the distrust that such contact can be relied upon; the playing over time and again of the same worry that the client feels herself to be too needy and too burdensome; the retreats from the contact (by client and by the therapist) and the ways in which these are understood and worked through in the therapeutic dyad.

Out of such an examination, comes a different kind of contact, one that is less staccato than the original push-pull of the mother-daughter relationship. A contact that allows for the genuine development of a sense of self that permeates all of the woman so that she can engage with others without the concomitant loss of self (which occurs when a shaky defence structure is pierced rendering an undeveloped self vulnerable) or the compromise of not getting. In this way both the taboos against the meeting of women's dependency needs and the taboo against initiating are challenged. The women's needs that arise in the therapy relationship are acknowledged, as well as her fears of the exposure of those needs. In providing a complete interpretation, (i.e. speaking to the need and to the defense) the therapist goes some way towards them being met. In the process of the needs being met, the client is transformed. She no longer views herself as a needy person who must curb whatever comes up in her. She no longer feels herself to be unentitled and unworthy. She no longer suffers a gargantuan split between the private and the public. This begins to shift the motivational basis from which women's care-taking comes. It allow the woman to give and receive out of a wholeness rather than from the compelling need to attach out of an incomplete sense of self. Her hesitancy now in regard to the expression of her own desire reflects an engagement with social reality rather than with personal feelings of illegitimacy.

All this is not to say that a therapy as described can in any sense alleviate the inequities of the world. The world at large will not suddenly appear benevolent and available because the individual woman has been able to take in nourishment in therapy and build up a psychological self. The world may still be experienced as hostile and this will not

be simply a projection. For the world is hostile to women. It discourages their initiatives, it denigrates their desires. It silences women in various explicit and subtle ways. An understanding in psychology does not change the outer world, but it may alter the woman's ability to cope with it. It will not provide for 'adjustment' to the social mores but it brings their relationship to the individual's psychology into sharp relief.

CHAPTER 5. GENDERED MIND, GENDERED BODY:

EATING PROBLEMS

The growth of anorexia, bulimia and compulsive eating in girls and women is a paradigmatic expression of gender based intra and intra-psychic conflicts in the latter part of the 20th century.

Although there have been enormous changes in women's roles, girls and women continue to absorb the notion that their desires and needs must be relationally directed. Despite the growth in opportunities outside the domestic sphere, girls and women continue to understood that their place in the world will come from their capacity to emotionally nurture others, anticipate their needs, and to seek satisfaction through meeting the needs of others. As a result personal needs that are not relationally constrained cause discomfort. Girls and women also understand the centrality of the female body to their place in the world, both as objects for others and for themselves. The current aesthetic means that few women can feel safe in their bodies.

Eating and body image problems expose the price paid to this socialisation. We encounter the problems of women depriving themselves emotionally and physically. Women become uneasy with distress, with emotional need and attempt to manage their needs through the process of denial. They inscribe upon the body the rules of culture.

The psychological consequences of these cultural mandates shape a feminine psychic structure in particular ways. This in turn suggests some important clinical implications.

We can see quite obviously that a consequence of privileging the needs of others is the confusion, guilt and conflict that arises in recognising or meeting personal needs. Indeed, personal needs separate from the needs of others may be so deeply buried that the individual conflates the recognition and meeting of other's needs as a need of her own (Eichenbaum and Orbach 1982). The recognition of personal needs which provide the essence of subjectivity cannot be recognised. Instead they are feared, dreaded and an internal battle exists to suppress them (Orbach 1986) The inability to recognise personal needs, the taboo on such recognition creates in the feminine psychic structure an

insecurity around need and desire and deep feelings of unentitlement. If we connect this with the aesthetic mandates for women we can see a parallel phenomenon. Women are accustomed to creating themselves physically for others. This means viewing themselves with the eyes of the other; as though from outside. They evaluate, know and relax by creating an internally structured external confirmation, by providing in their aesthetic, an approved of form.

If we reflect on early experiences of little girls we can observe a psychological and physical preparation for the uptake of a feminine psychic structure. Girl infants are held for shorter periods than boys, they are fed less at each feed, they are weaned earlier and more abruptly (Belotti 1975) they are potty trained earlier. Although one may not wish to argue that these are per se instances of deprivation their preponderance cross cultures suggests that consciously or unconsciously those who parent set up a situation in which girls are seen to have smaller or more containable needs.

This theme of needing less is translated into the conscious and unconscious ways girls are related to. Not only are they directed to serve the needs of others but they are encouraged to minimise their own. When they do experience a need, whether for food, love, comfort, relating, nurture, they may become afraid of it feeling that it is overwhelming, illegitimate, and bad. They may try to repress it, to curb it. They have difficulty recognising needs and when a need arises it may overcome them and feel huge. They feel uneasy, bad and greedy and engage in various psychological strategies to re-repress the need.

Schooled to serve others and to create the conditions in which others may look to them for emotional and physical care and support, women become extremely wary about their own need for a relationship or relationships that will provide them with emotional support and emotional reciprocity. They may crave such relationships but are fearful about bringing their needs to relationship. They may cover this up by appearing not to need or by presenting themselves as over needy and helpless. Both these defences serve to reinforce the idea that dependency needs are dangerous.......they must either be

squashed so that they aren't exposed or they must be hyperbolised scaring both the originator and the intended object of the need.

This phenomena occurs in the therapy relationship. The woman with an eating problem may present herself for treatment with a symptomatic relationship to food. But alongside this and underneath this is a shame about the needs she has for the therapist and within the transference countertransference nexus she may create feelings of apparent self sufficiency on the one hand or of apparent insatiability on the other. This may parallel her relations with the food. Unable to distinguish between internal desire and appetite and the restrictions and rebellions that arise from a relationship to food forged on the basis of trying to conform to an external aesthetic rather than an internal physiological need, she may either eat to obliterate the feelings of hunger (Orbach 1978) or deliberately not eat to feel some comfort from overcoming the feelings of hunger (Orbach 1986)

The thrust of the therapy needs to address itself then to problematising women's needs, whether these be in relation to food, to needs in general, or for the therapist. Part of the difficulty in addressing these issues is that the therapist, female or male, may not have interrogated their own attitudes towards women's needs, women's desires, women's appetites, women's dependency needs and of course, the sex role stereotyping - that is to say the limitations of the roles, social and psychological - that is constructed on top of gender assignment. If the therapist has not thought through the complex meanings of these areas for themselves and for their female patients then they are in danger within the therapeutic setting of reinforcing the defence structures that now ill serve the patient. Instead of understanding why the patient acts and feels the way she does, they may inadvertently bolster up the defence rather than deconstruct it. Deconstruction is problematic because there is considerable resistance which can be exasperatingly experienced in the countertransference. The patient unsure of this new territory, of the possibility of identifying personal desire may be so fearful that she acts out in the transference in ways that encourage the therapist to back off. Meanwhile, as the therapist who encourages the woman to explore her needs, one may feel hopeless as the patient retreats, tests the therapist or acts in ways that evoke rejecting feelings.

If the psychotherapist or physician can encounter the woman behind her defense structure then there is a possibility of a productive therapy. One way to try to do this is to get into our patients experience rather than collude with the wish on her part to disassociate from it. The transference countertransference gives us, through the mechanism of projective identification, a unique instrument for encountering both our own feelings when confronted with a woman with an eating problem and the feelings that she is experiencing.

If we take the example of anorexia with bulimia features and we follow through our feelings when confronted with a patient suffering in this way and scrutinise and decode the countertransference - transference, we may get a sense of the terror and the fear of dependency needs that are involved in women with eating problems.

The anorectic who appears for help - and despite lots of prejudice that states that anorectics do not seek treatment, my experience is that many do - is in a great state of confusion. She has been forced to confront something within herself from which she has both been hiding and benefiting. She feels caught out. She is weary with looking after herself in the way she has found but she is unconvinced that any other way of going about her life is possible. For her, anorexia is not a problem but it is a solution. She has overridden continuously erupting bad feelings, problematic feelings, conflictual feelings, feelings of need, of hunger, of wanting, by creating out of herself someone who can survive feelings through denial: someone who doesn't need to eat, to sleep, to digest, to reflect, to need, to want, to attach. She has created a new persona, an admirable person, a need free person, subject to no-one's control and untouchable by others.

By seeking treatment she fears she must submit and surrender. She wants someone who will understand her, who will respect her. But she is scared of being patronised, of having control wrested away from her, of being invaded and of being made to comply with a treatment protocol that compromises everything she understands as central to her.

True she is desperately weak from the effects of malnutrition. True she is mentally out of kilter because of the seams she has trained her thinking and perceptions to inhabit are

limited and limiting. True she has heard about the struggle for control that she will encounter with the practitioner when she presents herself for treatment. True she is desperate to give up this lonely struggle.

But all this she feels she must conceal from herself and the clinician. She doesn't know how to feel ambivalence let alone express it. She doesn't know how to stand up for herself. She doesn't know how to use language to express her conflicts and her wants and so she is caught in a terrible web hemmed in by concealment on one side, the desire to surrender on the other, fury on another, inchoate protest on another and the embattled sense of having to struggle non stop; never being able to be still, having to be busy internally all the time, scanning on the outside, trying to protect herself while revealing her need - a need she experiences as deeply humiliating - for help.

And what do we as the clinician experience: what is being communicated to us; what is the emotional ambience?

To encounter such a patient is to be put in touch with very difficult feelings. One may feel anger at the person who presents themselves. Their physically emaciated stance is deeply troubling. It evokes feelings of fear. We are frightened when we have to confront such extra-ordinary denial. We are not sure how or why but we are alarmed and out of that discomfort we wish to protect ourselves to either disarm the person who is making us feel so uneasy, or we may inadvertently disassociate from the feeling in order not to be overwhelmed by it.

We feel pity and yet we find this odd. Why pity? How does a virulent refusal of food engender pity? Why are we inclined to defuse what the anorectic is doing by pitying her?

And if we don't succumb to pity we are left uncomprehending. Thrown out of certainty and into confusion. We observe a refusal to eat. We observe a hunger strike. We observe a massive involvement with food and we observe a phenomenon in which when food is taken in, when emotional sustenance is on offer, it has to be immediately repudiated.

We find ourselves in wonderment. How does someone survive so long on so little. How is someone so diligent. How can she be so tenacious, so insistent. The wonderment begs a response of distance in order to separate oneself out from the intersubjective field one has been pulled into.

We observe ourselves asking questions to ourself. What does it mean that this person and that thousands and thousands of girls and women in this last part of the twentieth century, women in cultures where the economic level of development means that food production and delivery is in theory available to all - what does it mean that this woman we are sitting with or this girl in the room with us, has taken as paradigmatic with survival the injunction that she shouldn't eat or if she does succumb that she should then immediately disavow her action by using the physical equivalent of white out and evacuating herself through one or other method.

What is it, that is so bad about her, so undeserving that her appetite must be seen to be overridden. Why and how have young girls and women come to feel so bad about themselves. Why have girls and women understood that their place depends on diminishing themselves, on depriving themselves, on starving. For we would do well to recall that she does indeed feel hungry. She registers it and she then vanquishes it. She dominates and controls it by disregard. What is it that disenfranchises her from the world of food and yet keeps her beholden to it like an abstaining junkie caught in a crack palace.

Her behaviour reveals an enormous amount of energy, of creativity, of power, invested in food refusal. Confronted with that we are both in awe and alarmed.

In this space between her feelings and our feelings - or in her disavowed feelings that get conveyed to us through the projective identification we sense a power struggle. We encounter a girl or woman who has both understood and failed to understand her place in the world. Who is both acceding to and refusing that place. Who in her appearance demands that we look at her and re-evaluate what we understand by femininity - but who at the same moment wishes to emulate the stereotype of femininity. We encounter someone whose sense of her own agency is limited by psychic and social girdles. She

feels constrained to act in a very small space but she has a fury about the cell she has created.

This putting together of the psychotherapists feelings with the feelings of the patient allows us then access to the intra-psychic and intersubjective space between us. She is terrified of feelings, of her need for another, of disclosing to herself that she has needs that need to be tolerated rather than banished. If we refuse the countertransference demand to be as scared of her as she is of herself; if we fail to be awed by her apparent refusal to eat or her fear that if she allows a need to emerge whether an emotional need or her physical appetite that she will be overwhelmed and overwhelming; if we recognise the defensive nature of her fears and instead of succumbing to them respect that she experiences them and therefore work with them, we have the possibility of offering her a relationship in which needs that arise in the present can be addressed.

Paramount among these needs, is the allowing of her dependency in the therapy on the therapist. I know this is a controversial point, for the patient may articulate her wish to not need anyone and her fear of breakdown and collapse if she were to surrender to another. I know too that this is a controversial point from the perspective of how we as clinicians view dependency issues. But it seems to me that if we think about the psychic structure of femininity, the profound taboo on expressing needs means that girls and women have very often failed to have an experience in which their dependency needs were met. As a result they are frightened about relationship, about dependency and about need in general. They believe that dependency on anything other than starving or bingeing is harmful. It exposes them to the hurts and disappointments in their original, parental relationships. Having split off these hurts, and taken on the idea that their needs were bad, rather than being in a position to understand that their original caregivers were unable to adequately provide emotional care rather they have internalised relationships in which their dependency needs get activated as dangerous. They create defenses that aim to keep them apart from their dependency needs.

This then is why we must engage with this fear rather than bolster up and collude with a defense structure that is about ensuring a kind of autistic relation to others.

I don't want to pretend for a moment that this is easy. As I said earlier, her fears will induce in the therapist feelings of exasperation. In a million ways, the therapist will be discouraged from providing a relation which can address the patients needs for contact, recognition and so on in the present. The patients over neediness or continued flaunting of her pseudo independence will test the will of the most compassionate therapist. But if the therapist can see that what she or he is experiencing is a counterpoint to the patients fear, they will have an entry point into addressing the fear of dependency directly.

At times the therapist will wish to give up, to believe that the patient can't be helped. But if the therapist's countertransferential response can be verbalised in such a way as to talk into the patients fear that she can't be helped; if the patients despair can be allowed into the room, tolerated by the therapist rather than hidden between the two of them, then the embryonic self nestling behind the defense structure may have a chance to get going in more productive ways.

The patient has little experience of bearing feelings. For a host of historical factors, feelings states of all kinds will have come to be experienced as dangerous and unmanageable. As the therapist is able to at first articulate for the patient what she or he imagines to be the patient's feelings, as the patient is able to use language to symbolise feelings, they begin to be held in the mind and her experience of herself begins to be transformed. She has the beginnings of language as a means of expression and she has someone who is working to hear her language. Through the therapists receptivity to what is articulated both directly and indirectly in the countertransference, the patient can slowly begin the process of reconnecting with disassociated feelings. The therapist offers back to the patient, her feelings in a digestible form. She stays with her as at first perhaps the patient resists. The resistance is understood as fear rather than defiance and the ability of therapist to share this way of seeing the operations of the patients defense structure allows for the next stage to happen, for the patient to receive her own feelings and assimilate them. She takes them on bit by bit, metabolises them and lives through the experience of having feelings. In this way instead of the feelings haunting her and demanding either constant expression through bingeing and constant binding up through

repression through food refusal, the feeling is, as it were done with. It has been restored to her, felt and finished with. She can be in the present.

This kind of interchange is what is required for if we attempt to simply treat the patient we induce in the treatment a restatement of the problem that besets the patient. We need to find a way not to do to her but do be with her. Eating problems of all kinds express a kind of autistic withdrawal. The person cannot trust, cannot easily work hand in hand with another. She can submit, she can psychically vacate the self while she is being treated and being done to much as the sexually abused child disassociates from the act in order to survive. But in this operation of the defence structure, in the removal of the motivated self from treatment, we then all - the patient, the doctor, the OT, the nurse, the psychotherapist become dehumanised. We are acting on instead of acting with the patient.

If we now fold into our discussion the question of food, we can recognise and respect her need to be in charge of this area. She has defiantly done so and will defiantly do so even after she has been in a treatment programme (if not during it). So better surely that we recognise her need to be in charge rather than engage in a power struggle about whose food, whose body. What she requires is a chance to face up to her difficulties with eating, to let us know that she doesn't know how to eat and keep food inside her, to expose her difficulty around feeding herself, identifying hunger, tolerating and feeding that hunger, digesting, and recognising satiety. She needs to detoxify from her prejudices. She needs help to be able to experience food as nourishment and pleasure rather than failure and indulgence.

In these discussions about the minutiae of food, we introduce teaching as a parameter of the psychotherapy. This is not to say that what one does is to impose a set of ideas about food or nutrition on the patient - I am quite convinced that patients know more than enough nutritional theory - it is more to implement a process with them where they begin to evaluate their experience vis a vis food, rather than banish it and suppressing it through the act of vomiting or fasting. The woman with disturbed eating has the chance many times a day to dare to experience basic feelings, basic needs and basic appetites. If

she can risk allowing these to emerge and not sabotage them (either with foods that she has already decided aren't allowed or dietary schemes that must be followed) she has the opportunity to experience hunger and to respond to it directly. She has the opportunity to explore what she is wanting when she is not physically hungry but finds herself gravitating towards food. This chance to pause, to reflect, is not only often an unusual situation in itself in relation to food, where the patient is so often eating against the deprivation that she simultaneously enforces, but it is a model - literally and metaphorically in which to work out her conflicts about needs, about desire in general.

The therapy becomes the setting for the understanding of the difficulty with recognition of need and with the meeting of it. We act with the patient and not on her and the space is clear for us to listen to her, to ask what problems she is trying to solve through her eating/not eating.

When she answers in terms that speak to body transformations we can explore with her the unique meanings different body sizes have for her. We can explore with her the extremely rich unconscious meanings thin and fat might reveal to her - meanings at variance with her conscious experience. We can enable her to tell us what the attempted separation between body and mind between corporeal and mental reality achieves for her. As we investigate corporeal issues at a deeper level we become aware of the way in which eating disordered patients discuss their bodies. They tend to see their bodies as quasi-commodities; elusive but essential parts of their personas rather than the place in which they dwell. Indeed it is common for the woman to describe a split between herself and what she describes as her body.

Having heard the articulation of such a divide by women patients so often I am convinced that this is indeed the way it is experienced. The body is felt to be an acquisition rather than an attribution, of the self, and a frequently unwished for acquisition at that. (Palazzoli 1974) has spoken to this problem in discussing the disjuncture the anorectic experiences between her body and her self. Palazzoli suggests that it is possible to understand the anorectic's pursuit of control over the body and the

overriding of bodily functions, in terms of the attempt to control the still-much-needed but felt-to-be-rejecting maternal object.

For the anorectic, the body represents those aspects of the original mothering relationship that were especially disappointing to her. The body becomes the recipient of the splitting and repressing mechanisms that come into play when profoundly negative feelings are generated towards the object. (To put it simply the body is a nagging reminder of the bad mother. It is a stand in for her.) The desire to get smaller, to do away with the body altogether, the often felt sense of disengagement from the body, are responses forged out of wish to create a distance between those aspects of the object and an-as-yet undeveloped self. The separating out of the body serves to protect the object from the anorectic's felt to be destructive impulses. The push towards destruction arises out of the conviction that the undeveloped self is bad, dangerous or poisonous.

Reading and interpreting the material in the therapy relationship, it strikes me that the body is not only the physical and visible expression of the object itself but it is as well the concrete manifestation of the need for the object. The undeveloped self is enveloped by conflicting desires. The identification with the bad object relation and the introjection of the bad object means that the body is also a visible representation of the need that must be tamed and controlled.

So the anorectic in controlling her body through controlling her appetite is not simply wishing to separate from the bad object relation, in controlling her body she is attempting to control desire itself, to repudiate her needs. Her success at overriding the mechanism of hunger, of sleep or of pushing her body through strenuous exercise on highly inadequate nourishment, are ways of reassuring herself, of soothing herself with the idea that there are no needs she cannot tame. She can go without.

If her needs have not being accurately interpreted and recognised then they must be separated out from her. She represents herself to herself as someone without essential needs. She physically shores up this self image by being some one with apparently no need even to eat.

Sandra, a 24 year old nurse on an acute cancer ward, collapses from fatigue. She's been working almost ceaselessly and under great pressure for eighteen months. Everyone sees her as an enormously caring and capable young woman who goes out of her way to make her patients as comfortable as possible, to watch that the doctors get their decimal points in the right place when prescribing, who ministers to the grieving family and friends of her patients. She's a model nurse, a model woman, a model carer. Selfless, conscientious and kind, her collapse engenders surprise and concern.

Sandra's collapse was caused by starvation. Involuntary starvation. Sandra lived in a nightmarish contradiction of providing the essential care needed to others to regain their health while depriving herself of the most basic means of keeping going herself. Like many other young women in the West - so many that we would rather not know - Sandra has been denying herself food for years.

It started when she was 11 years old. She enacted a ritual she believed to do with her approaching adult femininity. She started dieting. Following her older sisters and mothers, her attitude towards food became mercurial. Food took on the status of magic and naughtiness on the one hand and tempter and punisher on the other. From being encouraged to eat along with her brothers and father, Sandra now experienced subtle pressure from her mother and sisters to be wary of food, to be watchful of what she ate, to evaluate the food she desired and the food that entered her body. Talk at home seemed to revolve around diet foods, slimming regimes, appearance and weight. Where she had felt reasonably carefree about her body and about eating as a little girl, her appearance, her weight, her food intake came to predominate much of her experience.

Her school friends were no less preoccupied than her. Conversation with peers always included a reference to eating and dieting. Together they schemed to find the best way to become/stay slim. None of them had a straightforward relationship to food (that is to say: to eat when hungry and stop when full). They were all involved in some deprivation schema or other, most commonly the elimination of particular foods and the overriding of appetite. But this self imposed stricture brought with it painful acts of rebellion. The young women found themselves in the bakery or in the frig stuffing food

into their mouths as fast as they could; eating so quickly and so guilty that they barely tasted it; learning to induce vomiting or evacuation as though to do away with what had been taken in.

Food for these first world girls and women had become extremely dangerous territory. They fantasised about pills that would turn them off food, pills that would negate what they ate, pills that would make them into the size they wanted to be. Alongside this terror of food and their desperate attraction to it, lay an even - to non-western eyes - more curious phenomenon. Sandra, her friends, sisters and mother along with countless other women accepted at some level this stance towards food. In other words it didn't strike them as peculiar. They took it on as part and parcel of being female. They expected to diet for life, to be burdened by a fear of food, to feel guilty about their appetites, to chase one scheme after another to control their eating. In the course of their week they would read endless 'advice' in magazines, newspapers and books about diet, appearance, weight, exercise, body image. This was the normality they subscribed to.

Sandra collapses from the effects of self starvation. But, predicated on guilt about eating, the normative response of western women to food ranges from compulsive eating, to bingeing and to starving. Sandra is, sadly, not so much the oddity, but the exemplification of an attitude towards food by girls and women in our culture.

Food for many women is not only tantalising and terrifying as I have suggested, it also symbolises much of their relationship to the world. While food is something women routinely prepare and give to others, and in that context experience themselves as providing love, nourishment, nurture and care; for themselves food is dangerous, virtually off limits or at the very least to be feared. This is tragically analogous to their position in western culture where a woman has been designated to be midwife to others activities - her husband's, her children's - to be the person who makes it possible for those around her to function and partake of the world, to nurture them emotionally, service them domestically, support them in their needs and desires while not expecting reciprocal support. The world, like food, is scarcely for her. Even in 1992, twenty years

after the second wave of feminism, women and women's values are only reluctantly received by our world.

Women demanding a place in the world outside the domestic encounter prejudice of the most insidious nature. They are continually sexualised, their contributions often experienced as threatening, they are unsupported. They have to be more adequate them their male counterparts but make sure they don't show it; they have to bury the domestic responsibilities they carry lest they be thought unserious on the job; they have to define themselves in relation to standards they weren't part of creating and added to all this they are required to pay enormous attention to that marker of femininity - their appearance. If they enter the workforce (which of course most of them/us do) they need to import that stigma of female oppression, a preoccupation with meeting the prevailing dress and body standards of the day which inevitably involve a degree of obsessive concern for food and weight.

While there was a certain logic - although a deeply offensive and ugly logic - about women's preoccupation around food and body image when the domestic (reproduction of daily life) was the only sphere of activity given to women, that same preoccupation imported to women's lives as they extend into the public sphere is monstrous. It is an outrage that we women should continue to bear this hallmark of oppression; that an enduring link between a private and public existence should be an obsessive concern with food and body image.

But, it can be argued, food is a joyful matter. It is what nourishes us daily, it is an integral part of celebration, it is an act of community. Beauty you may well argue is a creative act. We dress to express ourselves, to play, to make statements. But alas this is rarely so unconflicted an activity for women. It is an area we do play in but it is an area governed by constraints. This is not free play - adornment for pleasure, costume for temporary transformation, image for fleeting effect. It is far too serious for that. Far too meaningful. The image we manage to create still represents a relationship to self that evaluates acceptability from the outside; that looks for a place in society through what

we can project rather than be; that depends upon seeing oneself as an object to be assessed rather than a subject with agency.

Sandra's collapse, a collapse bred of deep feelings of unentitlement to the food she gave others, to the care she gave others, to the life she nourished in others is a marker of the continued distress women in the first world carry around food.

Food for women is so much more than the satisfaction of appetite and desire (indeed it is rarely that). Food is a language all of its own. Women have been denied not only a straightforward relationship to food, but a straightforward relationship to their emotional lives. Schooled to process emotions for others, they often have scant recognition of their own affective lives.

Indeed for Sandra and her friends, talking about food, dieting together, bingeing together was part of social intercourse. Food talk became a way to say certain things to one another and food became an internal communicator. They didn't say directly to another that they were unhappy, they said they overate. They didn't dare acknowledge their fear, their hurt, their anger or the vast range of emotional responses to themselves. They ate instead and felt bad for 'overeating' or they didn't eat and felt temporarily good that they had avoided emotional pain. They shifted their emotional response to a manageable obsession; concern and guilt about food. But why should women - women who have taken on the task of managing emotions for the culture as a whole, be so fearful when it comes to their own that they have to be converted into the meta-language of food?

With women's designation as domestic so went the designation of emotions. To put it in 1990's terms, as industrialised society privatised the family and women, so society privatised emotions. For the last two hundred years, the split between the public and domestic spheres has relegated women in general to the care of others while denying women that care and attention themselves. Designated as possessions, as beauties, as wives, women have used their relationship to food and to the body to express the inexpressible of their experience.

CHAPTER 6. GENDERED MIND, GENDERED BODY: COUPLES

1. THE CHANGING ROLE OF WOMEN AND ITS EFFECT ON RELATIONSHIPS

For all of us, the reality of the relationships we have grown up in, the gender prescriptions we have absorbed, the images from the culture, from our individual families, from our peers, the TV shows and Hollywood make for an extraordinary disjuncture between our actual relationships, our desires and the cultural fantasy relationship in which whatever is wrong is miraculously cured by love. By love, divisions and difference are sublimely and creatively managed. What hurt existed is healed, where isolation existed there are now two hearts beating as one, the world can be faced with strength and fortitude.

This story, which inhabits all our consciousness' even while we acknowledge the ridiculousness and impossibility of it, can keep us from understanding ourselves and what is demanded of ourselves in contemporary relationships. Much as we might like to live in a place in which true love conquers all, it isn't likely for most of us, so we have to come to grips with the very considerable difficulties that can beset us in intimate relationships.

Jake and Liz have been married for twenty five years. They are just in their fifties. Liz was brought up to be a wife. Emotionally she was tutored to take care of others, to privilege their needs, to see herself as midwife to the activities of others and to seek her emotional satisfaction through giving. Her sexuality was a gift she would give her husband, it wasn't so much for her as for him and for procreation. Liz went to college in the States where she grew up but this was without the expectation that she would have a career but more with the idea that she would meet a suitable man who would both an economic provider who would legitimate her sexuality. In college she met Jake, a post graduate student who was a bit of a rake. They married, came to England, his country of origin, and he started to work in his father's chemical engineering business successfully developing an aspect of it.

Jake was, for his part, raised to sleep with other women in order to get sexual experience and to marry someone untarnished, a Madonna. In his mind women were organised into the categories of mother, whore, mistress, wife. He was looking for one who might miraculously combine all those qualities. In return he would protect, economically and through his social power, his woman and his family.

On the outside their marriage was a success. They had three children who were now well on their way, Jake's business had been successful and interesting and Liz had developed a life outside the home through involvement in community affairs. It turned out that Jake was a volatile sometimes a violent man and Liz a woman who managed her disappointments in life by developing the persona of the martyr. She was fearful of Jake and easily emotionally hurt by him. He preoccupied much of her emotional life; she felt if only she could find the key, she could make his mood swings less erratic and life would be easier. For years while she distrusted him and was wary of him, she would see the way forward in terms of how she could make life better, less stressful, more sexy, more comfy for him. She would try to ascertain his moods on the telephone before he came home, keep hassle to a minimum and smooth over his difficult rages with the children.

After a series of particularly violent incidents she came to therapy. At first the focus was on her as a victim - a victim of Jake's violence, his moods, his involvement with other women. We explored the ways in which victimhood had been a mode of survival and how it both hurt and protected her. We look at her contribution to the way her relationship functioned and in time Liz felt that she understood enough to want to change it. Liz developed the self confidence to stop Jake hitting her. She found a way to prevent him from penetrating her physical space, their relationship changed profoundly and they were beginning to change from having an unequal, dissatisfying relationship to the beginnings of a partnership in which Jake's moods were not allowed to dominate the ambience of the relationship. It was far from perfect but it was liveable with.

There was a 70th birthday party for Liz's mother who lived in the States. It fell at the same time that Jake' company had an important week long function abroad involving

his father who was now handing over aspects of running the board to him. Liz could attend both events but it would mean she would leave the company function a day or two early. This routine conflict in the life of a couple needn't be cause of much distress or even comment, but if we look at what happened between Liz and Jake I think we'll understand something about the complications of the emotional interchange between them.

Liz very much wanted to go to America. She also wanted to support her husband at the upcoming business function. She proposed that she leave on day 5, or that her husband reschedule the function so that if he wanted her there the whole time she could oblige and also if he wanted to attend her mother's seventieth that could work too. Jake said it was fine if she left two days early and that he would make the travel arrangements.

Three weeks before the events, Liz came across the plane tickets and itinerary prepared by Jake's office. There was no ticket for the States and Liz asked Jake whether she should change her ticket or he would. He looked at her as though she were crazy and said, "but it is my conference". Calmly she reminded him of the birthday party and their discussion and his acknowledgement that it would be fine for her to leave for the States after five days. He responded with an angry "Do what you want". Liz was shaken. She had remembered a joint discussion, a joint decision. Now it seemed as though Jake was reneging. She told him she felt hurt and confused. He stormed off and told her that she could never make up her mind. He didn't care either way whether she stayed with him the whole time or whether she went to her mother's seventieth.

They had agreed to something and now he was acting as though the decision was hers and the message he was sending her was that he didn't want her leaving him to go to her mother and if she really wanted to do that she would have to redo the arrangements he had made for them.

Liz would now be defying or at least challenging what he had set up. She felt that Jake was rather anxious about being with his father - a rather bullying father - at the conference after she was planning to leave and that he counted on her to smooth things for her, or be around, or even be a place he could dump whatever came up for him.

Because he was unable to declare his anxiety or to show her directly that he was disappointed that she was needed and wished to be elsewhere and because he felt bad because he couldn't give her support for going off to see her mother, he withdrew. He cut off from her, became angry and then blamed her for her indecisiveness. The following few nights he stayed out late, came home rather drunk and with the smell of sex on him.

When they tried to talk with one another about what was happening around this incident and the stories they had both constructed about what had gone on, Liz said she felt betrayed because her feelings and conflicts had not been respected and Jake said it was all her fault because she showed ambivalence and wasn't assertive enough.

You could make an argument that when Liz insisted that she go to her mother's seventieth, Jake was put in touch with his dependency on her and that it is not within his emotional vocabulary or within his self conception to see himself as dependent and needy. Consequently, Jake can't see this side of himself, let alone accept it and stand it, so he 'forgot' that Liz and he had agreed to this upcoming separation, and instead went ahead and booked the ticket as he would have wished it to be. When Liz reminded him of her departure, he unconsciously denied his need of her by first telling her he didn't care what she did and then by replacing his dependency on her or deny his need for her by taking up with other women.

There are significant issues in this way of telling that have something to do with the changing role of women and its impact on intimate relationships. Liz has reversed the position where she found survival and relating on the basis of victimhood. The nature of the relationship has changed and she is now in a position to articulate what she wants and to find a solution to getting it. She hasn't blasted ahead at full throttle callously denying her attachment or dependency on her husband or unmindful of his needs. She has tried to grapple with a situation of conflict, a situation in which opposing needs are in the picture by recognising the conflict rather than running away from it. Raised to be a woman, she is no more able to pretend that it doesn't matter to her what her husband needs and indeed a part of her need is that she be able to be there for him at the

function. But what has shifted for Liz, what the changing role of women has meant is that Liz no longer wants to either be behind her husband silently working out or even manipulating arrangements in the best possible way, nor does she want to assert the primacy of her situation, she wants rather a partnership in which conflict can be handled and in which emotional reciprocity and concern for the complexity of issues is on the table.

She wants Jake to take responsibility for his emotional reactions to the issues before them. She wants him not to give her permission to go so much as to recognise that she can see what is troubling him emotionally. She is pretty confident that there are other issues at play for him which she can't see which would fill out the picture in a more textured way but for the moment she would like him to

1. Take on board what he feels about the fact that they as a couple have a genuine conflict. No-one is right or wrong her there are circumstances pulling and pushing in different directions.

2. Recognise that he has enormous difficulties with his father; that these make him extremely uneasy, that he hasn't had a way to approach these and has relied on Liz to either distract him from them, cover them up or when they have erupted to be a treatment plant for their incineration.

3. Recognise his need of Liz rather than acting like it is nothing for her to be there with him.

4. Recognise that he will feel sad when she leaves as well as he is pleased that she is going to do something she wants to do.

5.. Recognise that she feels torn and that there isn't anything to be done about that, it can't be resolved, she is going to feel torn and that is the essence of what they need to share about this.

If the issues that are now on the table from Liz's point of view could be addressed - and we don't even know what issues Jake might want to pursue, we would begin to see a

very interesting shift in the relationship, a deepening of the experience between Liz and Jake and the mutual recognition of their need and dependence upon one another as well as their need for separateness.

If I were writing this 10 years ago, the issues between heterosexual couples that repeatedly came up in the consulting room are as follows. Women complained that their men appeared alarmed or frightened of women's distress and women's feelings. Women believed this to be the case because when women try to talk about what they are feeling or explore their confusions about a particular subject, their husbands and partners listen attentively up until the point when they rush in with pragmatic solutions. These solutions may well be extremely useful but they often bypass the central emotional dilemma the woman is presenting - the very thing the woman is having difficulty with in the first place.

Another female complaint would be the refusal of men to accept the emotional labour of their wives. Women are often not just the household workers, nurturers and carers but the cleansing and sanitation department for the emotional life of the couple and the family. This work and this contribution often goes unrecognised and women can feel very miffed by this.

A third complaint from ten years ago is embedded in Liz and Jake's interaction and it is about the man's discomfort with recognising his dependency and with his unconscious manoeuvre of the relationship into a situation in which is the woman who comes to carry the need for contact, for the relationship, for being needy and so on. Many women complain that it is only when they have withdrawn both their emotional labour and their emotional attention from their relationship that men have been able to experience a void and have - out of that void - been able to declare a need for them.

A man's complaints ten years ago would have centred around women's lack of knowing what they wanted and of being fatigued with having to guess quite how it was that he was disappointing his wife and finding it hard to go on guessing until he could get it right for them. What do women want? Another complain centred around men never feeling that what they did was ever enough: that their women always found fault,

undermined them, even showed a sneering contempt for what they offered. The third most common male complaint expressed to me in couple settings - and I'm sure that if I had been a different person I might have solicited different responses (eg if I were a man would there have been more talk about sex I wonder) - the third complaint was doesn't she know I love her, why does she have to have it all spelt out.

I raise these historic complaints not because they have dropped out of the picture but because often in the midst of a relationship taking place during the recognition of gendered mind and gendered body, the relationship can feel ghastly and heavy as though there is no movement. But the relationships that have survived, have been animated by struggles that they have now moved through. Liz's struggle with Jake or perhaps I should say her desire that he take emotional responsibility, can be seen as being several steps along from the arguments about simple assertion or emotional dependency. It takes as given the emotional dependency dynamics between women and men needs to be addressed and equalised; it rejects the position that it is okay for the woman to simply clean up the emotional mess that exists for the man with his father without the man addressing that himself or seeing what he is asking his partner to do; rather it pushes forward to try to insist that the both people in the couple take emotional responsibility for their behaviour and their desires.

Just as earlier Liz insisted that Jake not hit her but take responsibility for managing the pressure that built up in him physically in another way, so she is now pushing for him not to trespass on her emotional territory.

The reason I link this with women's changing role is that despite women's role in the family and their confidence with processing and managing the emotional lives of others, it has always been remarkable how uneasy they, we, can be with our own emotional responses and desires. In other words our emotional literacy has been at the level of decoding, understanding, empathising and caring for others rather than understanding and respecting our own emotional processes. A focus on self has been experienced by many women as shameful and difficult and it hasn't been until women have felt more entitled to acknowledge their own emotional lives that they have felt able to see how

men's lack of training to pay emotional attention to them has colluded with their own difficulties which they feel far more able to take on.

Women's struggle today is to recognise what they desire, with all its attending conflicts, to try to articulate those desires and to not hide behind their partners lack of emotional skills as a way not to get what they want, but instead to enable themselves and their partners towards an emotional literate relationship in which what each desires and what they desire together can be put on the table.

Liz did change the tickets. Jake did express his fear of being left with his father. Liz was then able to talk with him about what difficulties he anticipated and what kinds of ways he could conduct himself. Liz felt sad going off to her mother's event on her own but felt Jake's support and she felt able to ring him and help him offload and digest the bullying aspects of Jake's relationship with his father.

What stands out today in couples therapy is the strength of desire for connection and intimacy that still exists between women and men. Women come in with a great deal of yearning and longing or with rage when they feel deeply disappointed. Men come in with confusion, with a desire to change both because they want to meet what their partners are asking for but also because they know how damaging their own emotional lives often are. This is a very interesting moment between the sexes, a time when women and men are eager to learn more about themselves and what they need to develop within themselves and between them in order to have more profound and nourishing relationships.

2. THE IMPOSSIBILITY OF SEX

Contemporary psychoanalysis has bifurcated in two main areas. Firstly a theory of relationship and attachment, of the internal object world, of gender relations and secondly a theory about the practice of psychoanalysis itself, the therapy relationship the transference countertransference matrix. Neither of these bifurcations explicitly address sexuality. Contemporary thought on sexuality has found little prominence

except in the work of Person (1980), Stoller(1979), Kernberg , McDougall, Chasseuget-Smirgel and their work has tended to situate itself in the first of these bifurcations, in the relational world and not into practice issues, the sexuality in the therapy relationship.

In many journal articles, on numerous training programmes, in clinical supervisions, the notion of sexuality, biological sex, sexual practice, reproduction, the erotic, heterosexuality, homosexuality, desire, love, genital, perversion, fetishism, gender relations are collapsed under the word sexuality. Sexuality - considered to be a crucial, overarching, compelling force - is rarely explicitly defined except by references to sexual practice. In addition Sexuality is used both to describe the development of masculinity and of femininity as in Freud's Three Essays (1905) i.e. what we today we would call gender, as well as the course of erotic attachment and the course of perversions.

In using the language of Freudian psychoanalysis, and in employing psychoanalysis as social theory and critique, contemporary psychoanalysis unwittingly side-steps the complexity of issues packed into the word sexuality. By focusing its concerns in two main areas, the acquisition of a gendered subjectivity that is to say the psychic construction of masculinity and femininity and a study of what might be called the so-called perversions: transexualism, transvestism and so forth, we have an epistemological sleight of hand. The discussion is gutted of the erotic and replaced by a theory more related to contemporary clinical and cultural concerns - gender, sexual practice and sexual refusal.

In the move from drive theory to object relations, from oedipal to pre-oedipal concerns, from the preoccupation with transference to investigations of the countertransference; a vacuum has been created. Relational concepts in psychoanalysis are superseding much of libido and instinct theory but in their succession we are left with the need to define and reproblematise sex and sexuality particularly the erotic.

The Freudian conceptual framework sits uneasily into a relational or object relational context. The Kleinian effort to resituate the oedipus complex in the first year of life is

the bridge position between instinct theory and libido theory. Mitchell's (1988) valiant attempt to reformulate Freud's metaphor of the beast in relational terms goes as follows:

Forms of relationship are seen as fundamental, and life is understood largely as an array of metaphors for expressing and playing our relational patterns: discovery, penetration, domination, surrender, control, longing, evasion, revelation, envelopment, merger, differentiation and so on. The body is still centrally important. Sexuality and bodily experiences are viewed as particularly apt arenas for this activity, since sexuality is enormously multiform and plastic. The number of body parts, the variability of interactions, the poignancy of sensations, the immense number of combinations - the almost infinite variety of human sexual possibilities makes this an enormously fertile reservoir of metaphors for expressing different types of relationships, different configurations of connections between self and others. Thus, the way the relational model construes the relationship between sexuality and object relations is the precise inverse of the way in which it is construed in the drive model.....sexuality and other bodily processes are the realm in which relational configurations are expressed or defended against Mitchell (1988 p91)

But even with situating sexual desire within a relational context we are still seeing sex and sexuality as givens. In stating this, I recognise that I am setting up a difficulty for that many others may not experience. But I have been keenly aware of not really knowing what we are talking about when we speak of sex. Are we speaking of the erotic and if so what is it? Are we speaking of the relations between women and men? Are we speaking of the circumstances of reproduction? Are we trying to understand the taking on of heterosexuality in the majority of women? Are we talking about sexual excitement: about how when and why it arises? Where for Freud sexuality was a given in one way - instinctually - but had to be psychically found and constructed, modern psychoanalysis has no such certainties and few pathways for understanding what sexuality is.

I find deep concern about the meaning of gender, of sexual morality, of reproduction, of sexual preference. I find my patients and colleagues occupied with issues of attachment,

of jealousy, of abandonment, of masochism, of the loss of desire, but the evidence from my clinical practice in relation to women hints to me that there is something deeply forbidden about sex per se. There is a lack of material about the erotic lives of my patents. Nancy Friday's polymorphously fantasising respondents barely enter my consulting room.

While I encourage all my supervisees to observe the erotic, to not overlook the sexual elements in the transference-countertransference drama in woman to woman therapy, to explore their own fears about sexual feelings, fantasies and desires in the room, the evidence so far shows that erotic transferences in the classical sense, and even erotic transferences as a defence against contact are few and far between in female to female therapeutic dyads. They exist but they are not the norm or even expectable. A troublesome sexualised transference-countertransference is a much rarer phenomenon than one might have expected.

In wondering about this, this lack of explicit sex in the material of patients and the dearth of sexuality in the transference countertransference relationship of female to female analyses I want to consider two related questions - reports of the early death of sexual activity in many lesbian relationships and the lack of sexual activity in committed heterosexual relations of long standing.

For Freud, the problem was how, in the service of the construction of femininity, the girl could detach her erotic link from her mother, give up her active sexuality and find a way through to a receptive heterosexuality. His line of thinking - the tortuous route by which a girl gives up agency and diverts or represses her pre-oedipal sexual strivings would suggest that psychoanalysis between women should encounter without too much difficulty the enormous sexual longings that still exist in daughters towards their mothers.

But, as I say, this erotic component, the power of the female to female bond, the desperate longing expressed in the consulting room, the intense wish for recognition so wanted by women from women is rarely expressed by heterosexually inclined women in erotic terms in the therapy relationship. This is intriguing. If eroticism, if sexuality is

first experienced in the mother child relationship, if that relationship organises our physical responses becoming a template for intimate relating, if adult genitality is a recasting of the physical ambience of infancy and childhood into the adult couple relationship, if heterosexuality involves the negotiation of complex intra-psychic pathways, why wouldn't it emerge more insistently, more readily and more frequently within the consulting room? How might we understand its absence? How might we understand the powerful contrast many of my female colleagues have experienced between the seductions, the highly erotically charged nature of the transference countertransference in heterosexual dyads and the desexualised, de-eroticised nature of female to female transference countertransference?

If we read the transference-countertransference as an account of the intersubjective field between analysand and analyst, what is it then that at we are saying about the nature of sexuality, sexual feelings, erotic feelings in women and between women in the analytic relationship? Have they have become so very deeply repressed that they fail to emerge in many female to female analyses? If not repressed then how sustainable is the idea of infantile sexuality and sexuality in the mother daughter relationship? And how can we account for those woman to woman analyses that are sexually charged in both the transference and countertransference.

If one accepts that heterosexuality and homosexuality are both possible outcomes of psycho-sexual development we might suppose that in the transference-countertransference aspect of the clinical relationship, there would be little of significant difference between the erotic nature of heterosexual or homosexual the transferences.

And I pose a further thought. Why is it that in an analysis between a homosexual or bisexual female analysand and a heterosexual female analyst, the erotic can be induced, felt, aroused in the countertransference. If it is so easily invoked in such circumstances how is it so apparently effortlessly repressed or perhaps I shouldn't prejudge the matter and just say easily absent in female to female heterosexual therapies. Where does it go? Or why doesn't it appear. What would be transgressed if it were to emerge? What would

be imperilled if it were to appear? What makes same sex erotic feelings so dangerous in the consulting room?

I want to hold those questions in mind while I go on to discuss the two phenomenon I mentioned earlier. And I hope to be able to suggest an alternative way of understanding sexuality by way of my excursion.

If sex and sexuality typically fails to appear in the transference countertransference, this contrasts with its appearance in the manifest material presented by patient. Although the concerns I shall speak of are not necessarily foremost in mind when people seek treatment the fact is that a significant number of people in committed partnerships lament the loss of sexual desire and consistent sexual activity in their relationships. Even where they experience the relationship as deeply sustaining, they feel disturbed about their lack of sexual engagement. They take it as a judgement on the relationship, a failure.

Within certain sections of the lesbian community the early demise of sex in woman to woman relationships is being recognised and talked about. In this way the stigma is removed from a phenomenon thus allowing us to think into its significance without undue prejudice. Although I don't want to oppose lesbian and heterosexual relationships, I want to reflect on one aspect of difference that I have observed clinically, that when lesbians couples experience the demise of sexual activity in their primary relationship, there frequently occurs a sexual liaison with another by one or both parties which rather than threatening the primary relationship per se seems to have the function rather of managing the merged attachment between the couple that is often intensified by a shared gender[13].

The blissful merger so sought for in the beginning of the relationship, the search for recognition, for identification, for love, caring, attention, nurture, erotic and sensual

[13] Since my evidence is anecdotal rather than statistically relevant, I think it is worth adding in Gore Vidal's (1993) observation. He writes that his 50 year old relationship with his partner Harold Arden was possible only because they didn't have sex.

exchange attempts to heal problematic aspects of the original merger experienced in the mother daughter relationship.

But the fact of the merger, the longed for aspects of it, the way in which it both mirrors and disrupts the psychic template of that earlier intimacy propels its own dynamic.

There may be an attempt to escape its engulfment; there may be a desire to stay forever velcroed inside of it; there may be a developmental push from both or either party to metabolise the positive aspects of the merger in such a way that one can move on into a more autonomous subjectivity; there may be a mutual wish to reposition the relationship.

Shadings of these positions could be occurring simultaneously. But often a vehicle for the expression of the conflicts around these desires is sexual disengagement. Issues of merger and differentiation; issues of self and other are expressed through the sexual.

Now this may not be so different in heterosexual relationships. We know that monogamy is hardly the norm in heterosexual relationships. My anecdotal finding that lesbian couples in difficulty seeking treatment tend to arrive in the consulting encumbered by actual other partners could be pure chance. But if it isn't we could speculate that the issue of difference, the excitement of difference is recast in same gender sexual relations and that while similar issues of merger and differentiation occur in heterosexual relations, the fact of gender difference allows for, indeed forces, some degree of difference. If in intimate relationships what we all seek is some version of the intimacy we experienced in our very first intimacy, if women know themselves within the parameters of mother and daughter, if sexually intimate relationships imply a revisiting of that earlier intimacy then we become and our lovers become for all us somewhere, our mothers and our daughters.

To put it crudely mothers and daughters can have sex but as adult daughters get what they need from their current love objects (mothers) and transform the internalised mother-daughter relationship, they grow up. And when one is grown up one can't have sex with one's mother anymore. It is experienced as incestuous. If mother is our first

love object, then if we are no longer infantile in the relationship we risk breaking the incest taboo. We can only maintain the relationship at the cost of de-eroticisation.

That's one clinical understanding. Another that emerges clearer is the difficulty of differentiation and what Luise Eichenbaum and I (1988) have called a separated attachment. The difficulty of sustaining personal boundaries within the couple - of maintaining a membrane between self and other - becomes concretised by the refusal of sexual engagement. If the bodies stay separate then in fantasy the psychic merger can be resisted.

At the level of manifest content - which also finds its derivative in the transference-countertransference - in sexually dormant heterosexual relations of long standing similar incestuous fantasies are evident although they may be mediated by the actual opposite sex of the love object. The boundaries that initially excite the heterosexual couple that dissolve in the experience of sex and long term commitment are replaced by similar experiences of merger described in lesbian relationships. The projections on to one another, the imagined melding of needs and desires, the union between two people, can be as intense as in same gender relationships.

The merger may similarly propel the individuals to seek to reposition themselves vis a vis one another, to attempt to differentiate, again not only as a defensive manoeuvre but as a result of psychic repair produced by the merged attachment. But the psychic mechanisms for doing this, for managing a degree of separation and thus implicitly renegotiating the shape of the intimacy may falter. The withdrawal from or withholding of erotic exchange becomes the defensively erected boundary through which the repositioning occurs. As one patient put it: In the beginning the boundaries between you are what is exciting. Piercing them and penetrating them divine. The strength that comes of this bonding frees me up but in the process of my feeling myself securely held in the relationship, barriers build up between us that are hard to dissolve, we become close and estranged all at once. The distance between us instead of being erotic becomes blah.

Sex becomes the way into intimacy and merger and sex becomes the way out of its stickiness. Sex becomes a practice that binds and separates, that connects and ruptures.

Or as another couple put it: we are so close. Having sex like we did in the beginning isn't practical. Then love, rather than life was our project. We were searching for ourselves in one another, we were creating something out of nothing, We were in fairyland, re-adjusting our pictures of ourselves experiencing ourselves as capable of loving and of being loved. If we remained so engrossed now we couldn't live. Sex would be too intimate now. We've reached a homeostatis where we can live.

I think this last statement encapsulates the issue quite well. As long as the person's internal world is filled in a Fairbairnian sense with exciting and rejecting objects, the possibility of attachment is blocked. As adhesion to the internal world eases and the sexual activity comes to be about connecting with an other in the present and digesting the emotional and physical interchange with an other rather then an essentially autistic connection, the facts of a real and actual other has constantly to be psychically re-assimilated. There is a strong pull to defensively retreat from real relations to a world of inner objects. The difficulty of sustaining a new intersubjective experience leads to many attempted escapes. There is a tension between the pull to escape and the attempt to assimilate the new intimacy. Accompanying the attempt to assimilate new intimacy is a precarious shifting of the boundaries between the two people. In this delicate process of managing more closeness a sexual encounter may threaten these establishing new positions. It can't be risked because it threatens to push the relationship back or into unknown and felt to be unassimalatable territory. Hence the decrease in sexual activity in many committed couples or the search for other sexual partners to hold the intimacy at a manageable level.

This might be a more satisfactory way of beginning to think into the impossibility of sex than to modernise the old Freudian paradigm as does Stoller when he writes:

" it is hostility - the desire, overt or hidden to harm another person - that generates and enhances sexual excitement. The absence of hostility leads to indifference and boredom. The hostility of eroticism is an attempt repeated over and over, to undo childhood

traumas and frustrations that threatened the development of one's masculinity or femininity." Stoller, R. (1979)p.6

Stoller's account fails to account the findings I've outlined in both the manifest material and in the transference countertransference. I think we are more along the right lines when we take Ethel Person's (1980) paradigm and see the role of the erotic in the defensive construction of masculinity but even in her important paper our understanding is still incomplete. While I see plenty of evidence for sexuality as the mainstay of masculine identity I find this a problematic formulation for feminine identity. Sexuality, the erotic for many many women who seek therapy, is , I will suggest, an artefact of self rather than an integrated aspect of self.

But to return to my original question: how to fill the vacuum that exists in contemporary psychoanalysis in regards to its understanding of sexuality. I want to reserve the term for the erotic. We have, I believe, quite adequate and convincing accounts for the construction of gender and for understanding reproduction. It is the specificity of the erotic libido that needs reproblematizing.

How might we understand the erotic experience. What kind of a model might we construct to explain or account for it? Some have posed the notion of sex, the erotic as an appetite, a hunger. But I find shortcomings with this formulation because we can clearly go without sex. Sublimation of sex is possible and may or may not be deleterious. Indeed one might argue that there isn't sublimation simply the absence of the erotic.

I prefer instead to think of the erotic as an emergent property of the human species, a collective capacity akin to language and intelligence. Sex, the erotic - as opposed to sex, the reproductive - occurs in a relational context and is relationally constructed. Perhaps we might argue that sexual reproduction is to the erotic as eating is to dining. To push this line of thinking a bit further we might ask, what is the history of the erotic? Does its' emergence coincide with the emergence of language or with the emergence of agriculture? Do you need, surplus, as it were, to have erotic feelings? Was early homo sapiens erotic? How did the cave people get turned on?

As has been well documented, wild children develop few of the characteristics we associate with being human and specifically they don't appear to masturbate or have experiences that we would deem erotic. If we consider for a moment the analogy between language and the erotic I think it opens up ways of thinking that could be productive.

Language is created within culture, and language acquisition is specifically transmitted within the mother child relationship. Stern (1985) has demonstrated the proto languages that exist between mother and child before the infant can enter into symbolisation proper. Proto language and language are expressions of relationship. The capacity and desire to verbalise speaks of the essentially relational nature of language. We don't apprehend speech outside of relationship - indeed that is again what distinguishes us from wild or autistic children - and it is only through the internalisation of a relationship that we come to speak.

Language emerges from relationship and it is an instrument in the relationship for exchanging pleasure, creating understandings, misunderstandings, for power, for transcendence and so on. We create words and ideas with one another. Language becomes a way we develop together either through fusing, disidentification or through a form of separated attachment. When we speak or write on our own we do so because we embody an inner world of relationships that acts as referents to our thoughts. Language is a mechanism for self expression and self reflection. It can be damaging or healing, an expression of closeness or distance; of connection or of separation.

So too with the erotic. It is apprehended in relationship. It is an instrument in the relationship for exchanging pleasure, creating understandings, misunderstanding, power, transcendence and so on. We create a sexuality together through fusing, disidentification or through a form of separated attachment. When we masturbate we do so with reference to an inner world of real of fantasised objects and/or relationships. The erotic is a mechanism for self expression and self reflection. It can be damaging or healing, an expression of connection or a retreat from connection.

And this then is perhaps where the conundrum comes in. The erotic becomes not an integrated aspect of self experience but almost an artefact of self. The erotic for many women, is an expression of false self. There is a false erotic that is employed rather than an organically occurring erotic. For many women, the false erotic, which is culturally fashioned in particular ways crucial to the maintenance of a feminine identity, excludes the development of an authentic erotic.

The extent to which the taboo on female subjectivity constrains a woman, constrains a mother's capacity to experience herself as authentically sexual, in so far as sex is for her an instrument rather than an integral attribute of self like language, then sex, the erotic is not necessarily woven into her experience of self and her experience of mothering an infant. It can be excluded; disassociated, absent or split off. While the mechanisms are in place in the infant that make the erotic a form of potential expression, (just like language) a mother's discomfort or disassociation from her own sexuality could be transmitted in such a way that her infant's and later child's sexuality lays undisturbed. It is dormant. Thus when an adult intimacy that emotionally mirrors the ambience of early infancy occurs as in analysis or in a merged attachment between lovers there is not so much a taboo on maintaining sex it is rather that with the re-evocation of infant like states, sex, the erotic, fails to enter the picture.

Thus in the countertransference transference between heterosexual woman to woman therapy, the erotic is not so much repressed or taboo, it simply isn't stimulated. It is a pre-emergent property.

At the level of the manifest content, we have further clues to the taboos on sexuality. Many women experienced the repressive hand of their mothers attitudes towards sexuality. The mother's sexuality has been disavowed or hidden. Sexuality becomes a source of deep tension between mother and daughter. The mother may seek to contain her daughter's sexuality much as she has contained her own but at the same time, she may unconsciously transmit a message that encourages the daughter to act out a prohibited sexuality for which she then reprimands the daughter.

This prohibited, pre-emergent erotic within the mother-daughter relationship creates the condition: The Impossibility of Sex. The issues that constrain the development of an authentic feminine subjectivity in turn constrain an authentically sexuality. While we have access to some aspects of the sexual, for many the erotic within an ongoing committed relationship proves hard to sustain. Not because we are bored but because we are afraid of the deeper intimacies it expresses.

3. LOVE IN THE COUNTERTRANSFERENCE

In the clinical situation with couples, I am aware of needing to create a relationship with both people which can recognise the different humanities they express in the room. My inclination on hearing a woman's complaint about her man's inability to give, to be emotionally available, to take for granted and not recognise the emotional labour she provides, would be to arouse an empathy in me. The structural arrangements of heterosexuality, as I and others have written about, so often set the development of masculinity and femininity in ways which mean that women can often feel unnurtured within an intimate relationship. So a woman's complaint, voiced in the consulting room about being undervalued, or her husband failing to take the emotional initiative are familiar themes with which I have considerable sympathy.

However, invariably, in the clinical setting, after the women feels that her pain has been acknowledged and her desires legitimated, perhaps due to my efforts to connect with the men, perhaps because the hurt of women turned bitter is so painful and distasteful, perhaps as a way to infantilise the men - and this I throw out as a question because I am not entirely sure what I think is going on here - I have discovered that I am repeatedly drawn to the man's point of view and feel an enormous surge of love for the man - who at another level and in another setting I might consider a bit of an nincompoop, or even pathetic.

Now why is this? Why are loving feelings aroused in me? What do I mean by loving feelings? Is it that if I experience a cross gender empathy or identification the

compelling nature of heterosexuality means that I don't simply like the man but sexualised parameters hone my feelings in a specific direction?

For us to consider this I need to share more with you about the man's response to being criticised or denigrated by his partner. My 'love', as it were, arises when the man, having taken on board the complaint - one he has doubtless had hurled at him several times before but somehow hasn't been able to absorb or understand until the couples treatment - makes the move from a mea culpa stance "Oh I'm just a clumsy bloke who can't get it right" or a flinging it back on the woman -"you want too much" to an attempt to meet what is asked from him. At that moment, the man moves to recognising an area of underdevelopment, contacts his desire to meet what he rationally believes is a legitimate request on the part of his lover and haltingly exposes his vulnerability and inexperience as he attempts to give emotionally, not through diamonds and flowers but by hanging in with his lover, trying to be with her in whatever emotional space she is in rather than manage her feelings or concealing his feelings from her. Let's say that as a threesome we have enunciated the uselessness to the woman of the pragmatic interventions the man is wont to give and he, taking on board that there is a different way to relate, attempts to do so, but in the first instance he is a bit awkward. He goes from shushing her pain to listening, albeit robotically rather than reflectively.

Now at the point in the treatment, just when it seems to me something is shifting in the process between the couple and the woman has managed to start up a dialogue that begins to address her dissatisfactions, her focus can turn to her partner's clumsiness rather than a relief that her agenda is now between them. This is the time that I can feel, in the countertransference, an extraordinary impatience with the woman and great feelings of love for the man.

Well we might ask, is this purely idiosyncratic. Is it simply that I, identifying with the woman and aware of my own ghastly impatience, enter as Racker (1968) would have called it a concordant Countertransference? Is it that what turns me on in a man is the revealing of vulnerability? Yes I am sure both of those are true. I do dislike my own

impatience and I do appreciate when a man is open and vulnerable. But what else is going on here?

I wonder whether the contempt the woman may feel for the man's inadequacies, which in the clinical setting I feel tender towards, is worth understanding. I wonder whether my love in the countertransference protects and defends the treatment against the toxicity of the woman' contempt and denigration of the man. I wonder whether, if I allowed her contempt to instigate my own, - which must surely be stimulated somewhere - the infantilisation or hate that might enter the treatment situation would be so overwhelming that it would contaminate the possibility of working through any of the problems between the couple. In other words, I am wondering whether in order to work with the couple as a lone psychotherapist, I need to keep a modicum of love circulating in the room. And as a female psychotherapist, I need to hold in some way, the possibility of loving feelings for the man, while the woman in the couple is unable to do so.

We shall take up a piece of this point - the holding of feelings for the couple in another issue - but before we go onto that, we need to recognise that I have left hanging a strand about my love as a defense for myself against the contempt that I might feel for the man. I can only highlight what I mean by, in the first instance, putting this in the negative.

I have considerably less difficulty in the clinical situation with acknowledging to myself, within the countertransference, the negative feelings, the downright critical feelings, the dislike I can experience at times for the women in the couples. These negative feelings, although extremely uncomfortable are familiar enough to me as the transmission of misogyny, the wish to separate myself form another woman's negativity at the moment when we are struggling to move the situation forward, the ambivalences in my relationship with my mother where hate was not an unknown feature of the relationship and so on. I have a facility with handling such feelings. They may not please me but they don't alarm me and they co-exist with sets of powerfully loving

feelings for members of my sex and empathy for the struggles we face, the situations we survive in and so on.

However with men, my experiences are more limited, more stereotyped as a response and more bifurcated. I am not so able to handle feelings of dislike or contempt when they arise in me in the clinical situation towards men. I feel distinctly uneasy and try to understand in my head, the phenomenon with the tools I have at hand, interpreting the projective identification, the split off self contempt and so on. In other words, I find it too dangerous to actually hold the dislike inside of me undigested or unthought through for a prolonged period of time - i.e. over several weeks. I have to do something with it. Is it possible that what I do with it, is turn it into love?

My second point is at a tangent to this point. It relates to the therapists' holding of feelings for the couple and within the room, that the couple are unable to hold for or between themselves, namely love.

For many couples in therapy, bitterness and anger, conceal the hurt and deep disappointment that has brought their relationship to a critical juncture. They squabble, accuse, withdraw, insult, demean, moralise to such an extent within the therapy as part of the process of sorting through, that it is as though the love that may have once brought them together has been vacated. With some couples it seems obvious that the adhesion of the two people is a reflection of their fidelity and devotion to bad internal object relations. The anger, resentment and bitterness in the relationship is the cement that confirms for both parties the impossibility of a connection not built or adhered to by conflict.

But it is the former of these two couples that is most relevant. I want to address the countertransferential feelings of love engendered in me when I am with a couple who are fighting. I don't mean by this literally fighting in the moment, but in that phase of the therapy where the discontent and hurt are most manifest, rather than even a glimpse of the feelings of positive attachment. In thinking about how frequently warm, tender, friendly feelings occur for me, I have wondered whether what I experience in the countertransference, since this is so seemingly at odds with what is in the ambience in

the room between the couple, is in essence apposite. It is apposite precisely because it is the split off affect of the couple - their positive and hopeful feelings for one another which need to be held by someone but have to be temporarily suspended and put in a bubble while they work through their rages, misunderstandings, dissatisfactions and so on. Both parties are so determined not to give in on what they feel to be justifiable struggles for recognition from one another for differing sets of grievances, that they have to cover their compassionate feelings for one another or steel themselves against them. Because they actually do have strong positive and loving feelings, they entrust them unconsciously to me. They export them over to me who is both within and without the couple where they can be held until such time as they can be re-encountered.

I think that in this process, they, while feeling helpless, hopeless, angry, weary, ensure through the projective identification - my forbearance of their painful feelings by unconsciously passing on the love - that they can survive such painful feelings and struggles. They create the conditions in which I am stoked up and fortified by enough love to allow the three of us to work on and through the tremendous distress that is in the room.

I, consequently, am not frightened by their distress or made anxious about the potential for destruction in their relationship, because I have been lent their good feelings for one another. When they have resolved or clarified a piece of the conflict between them, they reconnect with a piece of their love. This reclaimed and reshaped love, because it now takes on a different character than it had when it was created between them in the first instance, re-balances the feelings in the consulting room. The warm and tender layer inside of me that reassured me that we could proceed without too much danger, is now diffused. It re-inserts itself into the relationship via the individuals in the couple and there are many interesting technical issues that accompany this reinsertion.

I wouldn't go so far as to say that my countertransferential feelings of love were a diagnostic, although perhaps that could be argued. But we might think about whether the absence or presence of such feelings when with a couple in difficulty is significant

or barometric. Certainly when I am with a couple who are exhibiting hate and I too feel pessimistic, I don't make the assumption that they have unconscious love for one another. Of course that is possible, of course they may be too fearful of trusting love, too fearful of maintaining intimacy if created and more familiar with the contours of dissatisfaction and emotional betrayal. In such instances I am inclined to look at how attachments and their internal object worlds has compelled them towards the compromise of destructive relationships.

There is a third area that coalesces around love in the countertransference when working with couples. And this bears somewhat on the previous discussion but possibly undercuts my argument. This is the knotty matter of erotic transferences, or as I shall demonstrate, the curious lack of erotic transferences that I experience when working with couples.

Tansey (1994) writes of the phobic dread which surrounds the recognition of and the discussion of erotic countertransference. In a series of engaging papers Tansey (1994), Messler Davies (1994) and Hirsch (1994), take up problematic occurrences of erotic transferences and the ways in which they have used these to further the psychoanalytic enterprise. While there is much to sympathise with in their approaches there does seem to be a void or absence of erotic or eroticised countertransferences in work with couples.

If we take what I consider to be the overly broad definition of erotic as posited by Wrye and Welles (1994) then of course I would subsumed my loving feelings into this category. But if we focus on the erotic within the countertransference, I find the situation strikingly devoid of explicitly erotic feelings.

Many of the couples I've seen in couple therapy have had as a point of concern, the diminishing of sexual desire and sexual activity within their relationship and by implication these feelings might be absent in a couples therapy. I have had patients whose sexuality is the means by which they attempt to establish a connection, who may actively seek to flirt or turn me on in a session. This rather obvious interaction isn't what I would call the kind of wildcat countertransference that seeps into one, is compelling,

and disruptive in the ways that Vincent (1995) has so beautiful elucidated. These manoeuvres on the part of patients are more akin to what the Sandlers (1976) have termed role responsiveness. They aren't confusing when thought about and they aren't disturbing or especially illuminating about the erotic. What puzzles me about couples work is where does the erotic go to? Or perhaps we should say, where does it come from?

As we have seen, in an interpersonal object relational view of human development and interaction, the sexual, the erotic, is not simply a given. To be sure it is vital, important and in intimate relationships an often very crucial medium of expression both for contact and for the negotiation of conflicts, struggles around merger, around mutuality, recognition, separation and so on.

But neither from observing the manifest or latent material between couples or the emotional ambience with the three of us, or the transference countertransference can I locate anything but the disappearance of the erotic. How does it goes so far underground? Does it vapourise? Why isn't it palpable in some sentient form in the room? If there is a negation, this is surely interesting.

Perhaps an interesting point of departure is how being a lone psychotherapist working with a couple means that one is potentially the recipient of at least three different countertransferential scenarios - his, hers and theirs in the case of a heterosexual couple or hers and hers/ his his and theirs with gay couples. The volume and density of countertransferential material and the capacity to sort through the differing strands are intriguing and remain a relatively unexplored area of the way gendered body and gendered mind plays out in psychoanalytic work with a couple.

4. COUPLE THERAPY.

In the late 1970's the North American psychiatrist and analyst Jean Baker Miller[14], contested the usefulness of the developmental model that privileged separation. She questioned the progression of neonate from birth to individuation as desirable. In this she anticipated the arguments that were shortly to be made by the Kohutians, the Interpersonalists, the Relational psychoanalysts as well as those made by feminists such as Chodorow and Gilligan, arguments which were being made on yet another terrain by structuralists and family therapists.

Other workers in this area, while sympathetic to Jean Baker Miller's arguments about the influence of culture and the ubiquity of masculinist models of development, were less ready to jettison a model of human development that saw selfhood as achievement. Indeed Luise Eichenbaum and myself argued that while there was some merit in the argument that women's identity and sense of self could be found in connection, - The Stone Centre's 'Self in Relation', this view was not per se a corrective to the masculinist view. We felt that this model of attachment was simply descriptive of women's attachments, that it was in danger of valourising rather than problematising women's relational capacities while simultaneously obscuring the severe difficulties many women had in experiencing themselves as existing apart from a literal connection.

But we did agree with Miller that Mahler's model of separation-individuation may well be flawed in itself. We have argued that it may represent for boys and men, particularly, not so much the achievement of a separate subjectivity, but the operations of a defensive separation: a psychic constellation that protects a pre-individuated or prematurely separated self from the dangers of disintegration, and fragmentation. And that for women who appear to have attained this presumed elevated position of separation and individuation, the defence structure is similarly harnessed to protect an embryonic self which has found itself engaged in a precocious separation.

Over the last twenty years there has been much psychological, political and intellectual energy invested in a paradigm shift from the notion of a discrete self impelled by drives to a more intersubjective, interpersonal conception of individual development that views

[14] Discussions at The Women's Therapy Centre in 1978

the development of self, of subjectivity, not as a process in which the baby emerges out of merger into the phase of separation individuation but rather as one in which the self is only found and formed within relationships of meaning. Extending Winnicott's statement that there is no such thing as a baby, only a mothering pair, and reflecting on the infant research of Stern, contemporary psychoanalysis has come up with many formulations about how we to understand the self including Stolorow & Atwood's 1991 formulation which sees individuality and uniqueness as embedded in relations with others.

This formulation in which the notion of the uniqueness of the individual is understood to come from the inevitable attachments, conflicts, desires, tensions, longings, search for personal idiom and connection does not merely represent a paradigm shift from drive theory to interpersonal and object relational theory. It also encapsulates an understanding of how people develop both within dyads, within the couple and within the therapy relationship.

While couple therapy and marital therapy have, as it were, worked on this premise at one level, at another level, psychoanalytic work with couples or with individual who are in couples has been constructed on the back of a model in which relational theory is implicit rather than explicit.

But lack of an explicit theory has then meant that there is often a confusion when working with individuals who are in couples or couples in therapy about who is the patient; is the individual in therapy or is the couple relationship in therapy? The perils that might rain in on a couple where one partner has sought therapy are well known. Potential gains can accrue if the strivings of the individual can be allowed to take their course outside the constraints of a marriage or relationship which has developed highly elaborated interlocking patterns. Individual psychotherapists can be ready to encourage the individual to enact in the transference countertransference the problematic patterns first learnt in childhood and then refined in the couple relationship. Quite seductively, a psychotherapist can offer in the intimacy and safety of the individual therapy relationship, a more satisfactory mode of relating that in its satisfactions casts a shadow

over a conventional marriage. For in the therapy marriage, if I may call it that for a moment, needs are respected, the multiple self states greeted with interest and curiosity, unconscious desires heard, defenses deconstructed, and attention given steadily and so on. The individual therapy in providing a privileged space for the individual gives them a version of the kind of attention they may have sought in their adult intimate relationship. But where the intimate and sexual relationship may have floundered or been unable to undo the knots that arise from unconscious identifications that impair relating and so on, the therapy relationship is designated as the place in which such knots get attention.

Although many relationships are reinvigorated and repaired as a result of one party entering therapy, it is not without powerful disruptions to the existing relationship. Couple therapy which is an attempt to address a wider system, gives one permission to address the unconscious and conscious transactions of both parties directly and thus using the relational paradigm offered by Stolorow and Atwood, gives a particularly effective way of working with couples.

But before I go on to discuss the issues that lesbian couples struggle with in therapy, I want to acknowledge that in the paradigm shift to a more relational model of development, we still have a fuzzy account of psychic structural development. In our account of what has manifestly gone wrong, or right even, we are still confused about the meaning of gender, of sexuality, of the particular pressures that bear on daughters that make the attainment of a subjectivity that is both secure and related often problematic.

If as Luise Eichenbaum and I do, reject the formulation of self-in-relation as being too descriptive of present conditions, too fluid and ultimately too undifferentiated to be of much help to women, we are thrown back on inserting gender into a development model that still regards the attainment of the capacity to separate and individuate, or the depressive position, as desirable. I think I have to declare my own prejudice towards this view as most probably desirable, even though I think from the evidence of the consulting room, this state is rarely achieved. That's to say I have in the course of my

practice over 27 years seen only three people who I would say have achieved separation and individualism and have problems at the oedipal or neurotic level. All the others, women and men have had difficulties at a much more profound level - difficulties in conceptualising a stable but permeable self who is both open to relationship but not overwhelmed by either their need for it or their need to protect themselves from it. My patients have sought relationships in order to find a self, to lodge and then access aspects of their inaccessible selves in another and to continue a process of psychic development which may have been stalled and then defensively hedged in through many years of coping with a pre-differentiated self.

For women especially, due in large part to the unconscious gender identification leading to special features within the mother-daughter relationship, their often appears to be an overdeveloped capacity for identification with the needs and desires of others in, I would argue, the service of a search for self. Although mothers and daughters can be very close, as of course can mothers and sons, the nature of the closeness can be observed to be tainted in gender linked ways.

There is a different flavour to bringing up one who is potentially the same as one, from one who is anatomically and socially different. This very obvious remark is not to imply that there is one way to bring up sons and one way to bring up daughters, although one is staggered by the convergence in each sex of particular defense structures, it is to say rather that in a daughter's development, the internalisation of the mother's subjectivity, may contain within it the ingestion of a pre-differentiated maternal imago. This means that within the early relationship two things may be going on which conspire to make it difficult for a daughter to achieve a separated subjectivity. One stems from the actual experience of relating which is imbued with a sense that the mother needs the daughter because she is herself unseparated and in need of a merged relationship to psychically prop her up. Secondly that projected into the relationship is a sense of the danger of separation, and if not exactly the danger, then the impossibility of it. It isn't within the conceptual framework. This taint shapes feminine psychology in a particular way vis a vis the path to individuation. When working with women either on their own, whether heterosexual or homosexual, the constellations around the wish to merge, the fear of it,

the wish to defensively separate, the fear of separation, the difficulty in bringing personal needs to a relationship rather than resentfully or compulsively responding to the needs in the other, are at the heart of women's struggles to find a subjectivity that is both whole and related.

While Eichenbaum and I have postulated the rather uneuphonic notion of separated attachments as an expression of a desirable state for mutually stimulating and enriching relationships, the women we have seen in individual or couple therapy come into therapy underequipped. Rather than separated attachments, they have merged attachments. While these have made for the most delicious and gratifying episodes in the early part of intimate relationships, the relationships are in difficulty because the next stage of development cannot be easily accessed. The merger is now no longer satisfactory but there is tension in the individuals and in the couple as they attempt to use the richness and reparative qualities of the merger to reposition themselves psychically both as individuals and as a couple.

If the model I use inclines me to see women in treatment as suffering from an overevaluation of relational skills and a deficit of psychic autonomy (however independent they appear to be), then I am going to want to approach the therapeutic relationship as a place to further the developmental process towards subjectivity. I am going to use the therapy for purposes of deconstruction and reconstruction. Through that lens and with that perspective I evaluate some of the difficulties in couple relationships as stemming from the desire for individuation and in which paradoxically each person in the couple designates consciously or unconsciously the other as either ally or impediment in their personal struggle.

If we now look at the work with lesbians I want to focus on a rather narrow definition of that work. I wanted to address the difficulties and potentialities in working with same sex couples around the struggle towards differentiation. I want to say at the outset that I don't think there is such a think as a lesbian psychology. However in these post-modernist days it has become fashionable to talk of a multiplicity of selves and the escape from categorisation, so that we can no longer think of femininity and masculinity

as fixed categories and so on, at a psychic structural level as opposed to a sociological level, I do still think gender is a useful category under which we can analysis certain psychical operations because gender is still a category through which certain psychological propensities become shaped in particularized ways. Furthermore as individuals, consciously and unconsciously, we collect ideas around gender and in the schema that I follow, the developmental phase of separation individuation is initiated at the same time as the apprehension of gender identity. Thus these two great overarching markers of psychic existence are temporally aligned and the achievement of subjectivity is coincident with the knowledge of one's self as a boy or as a girl or as a not girl or a not boy. For this reason I am uneasy about floating off into a eulogy of post-modernist fluid selves. This for me fits too easily with the post-modern condition which reveals a tremendous problems around a stable sense of self and I for one do not wish to promote this as an ideal.

Although there are significant consequences attached to being gay, to being out, to defining oneself as a lesbian, not the least of which is the homophobia of the society and the internalised homophobia of the individual which needs acknowledging at some level, the aspect of lesbian relationships or the struggle of a woman with a homosexual sexual orientation that I am looking at here is her struggle to individuate and create separated attachments.

This struggle is especially sharpened in female to female relationships because there are unconscious and conscious assumptives at work. A particularly acute assumptive is the idea that is shared individually by both parties that "the other should make this/me better". There is a penetrating longing for the other to repair - a sort of emotional elastic that goes from each one to the other in which is inscribed the imperative to look after. Now this longing is not exclusive to lesbian couples, but what is especial is the reception of the idea. In other words there is no one to say: look here darling, I love you, but it isn't within me to make you/live better. I can't do this. There is rather a receptor who feels yes, I should be able to make this better...I should be able to comfort and soothe and take away my lover's pain.

Many will say that men also feel this demand: a demand they may have first encountered in the mother-son relationship. And yes, there is a male female version, but it is different and it is worth recognising that it is, because the relational requirements that are part of the construction of a feminine psychic structure mean that - in my clinical experience - women find it much harder to shrug off this assumption because to deny to soothe is to deny a central aspect of self. The embedded nature of the relational imperative makes this cross identification, disidentification especially difficult.

Unsatisfactory or non-existent sex, clashes over money, a feeling of a constrained emotional repertoire, differing ideas about what children require, expectations of emotional fidelity and confusion over the place of external relationships are the main issues that I have seen presented in couple therapy. These issues could be classified under the umbrella of the struggle for separated attachments. The women I see come in grave difficulty. Perhaps when their relationship is perceived to be in greater difficulty than their heterosexual counterparts. Apart from the couples who come to break up using the therapist as a kind of third force, an outside witness or unmerged female whose presence somehow sanctions or makes it possible to effect a literal separation, the couples come rather angrily or despairingly to try to mend; to unfreeze the distance between them and to restart a dialogue.

The struggle to individuate and create separated attachments rests critically in woman to woman couples who don't have recourse to gender difference, on their ability to find ways of creating psychic boundaries between one another. Now, in individual therapy the process may proceed in which the defenses against merger with the therapist are evoked in the transference countertransference in such a way that old relational configurations can be worked through and the false differentiation expressed either through pseudo independence and the denial of dependency needs or the defense of insatiability against unmeetable needs, can be challenged. Then through the simultaneous ingestion of a relationship in the present that can bear witness to the conflicts and desires and the defenses against relationship that accompany such a developmental pattern, the grief and mourning that has to attend the prising away of self from adhesive internal object relations can occur. The therapist utilises the

therapeutic milieu and role, their understanding of the shifting transference countertransference to create the necessary boundary between self and other to provide for the self behind and embedded in the defense structure to emerge and exert direct agency. Thus does individuation occur. Positioning, distance, boundaries, merger, intimacy, the toleration of disappointment, the articulation of felt experience form the ebb and flow of the analysis such that a subjectivity can be achieved. The issue of the shared gender of therapist and patient although enormously significant if artfully handled is utilised in ways that come to facilitate separation without the loss of connection - a kind of connected autonomy.

But within a couple therapy however, the couple has to be used in a complex way to facilitate the separation. The therapist uses the couple relationship to work through these issues.

If I were to draw a map of what occurs schematically I would say that one possible scenario is as follows:

First the couple have to remove their defenses against intimacy that have emerged in the course of their relationship and connect with one another again. They have to be able to re-encounter their love for one another. The therapist as an outsider to the couple can facilitate their reconnection, by holding the position of separateness so that they can, as it were, surrender to the love again without a phenomenal fear of being immersed in the merged state.

Secondly in the exchange of love, contact and caring, the need and wish for the other, which has been tortuously disavowed or defensively acted against during the difficult aspect of the relationship, resurfaces. This may terrify and excite them and it is here that the therapist's skills and theory come especially into play. The couple may not comprehend why connection is problematic or fearful. They may not understand their defences against closeness.

Thirdly a repositioning occurs in which the recognition of the shared nature of the dependency, the mutual desire for each other, the importance of the relationship are

acknowledged. Most couples effect a scenario in which one partner is the carrier of need and dependency. But an essential part of the couple therapy is a challenge to these positionings. This is a poignant moment in therapy because it confronts the denial of dependency on the part of one member which may have been enacted in the couple. Denial or cha-cha, since this is often a changing pattern, at one moment Hilary wants Linda, then at another Linda is hungry for Hilary but not when Hilary is available and so on, has been a way in which a psychic equilibrium of distance has been maintained by the couple. The use of projection within the couple, the enactment of previous relational patterns in which each person gets to play out their rejecting and rejected parts is well known. But here we are struggling towards something different. We are making the psychic space that might allow for mutual acceptance and exchange of attachment, of need, of desire. In this, the couple is confronted with its joint fear of intimacy and asked to find new ways to struggle with this as a shared project rather than retreat into an asymmetrical response.

This psychic struggle, the acceptance of personal need, attachment, desire, and the acceptance of that by the other, is the psychic nourishment for the stalled processes of individuation to occur. In other words, if a transitional space can be created between the two people, which we might call the relationship in which their attachments, needs and desires can play, then that external to both but attached to both, created by both, can become the psychic compost for the ingestion of substances which facilitate individuation: i.e. recognition and love. Into this space, a space of acceptance, the process of genuine difference and differentiation can be explored and tolerated. For a couple who has come to therapy, difference has emerged out of the need to create boundaries and to shatter the merged state of engulfment in which differentiation is experienced as dangerous and yet where the merger is suffocating. Difference has meant antagonism and threat rather than the precursor to loving another who is separate. The sameness which allowed for love now needs to accommodate for difference so that one can move from loving oneself, to loving another.

This struggle pertains to all sexual relationships, not simply those between women but the particularly merged nature of the pre-differentiated construction of femininity in

which a daughter's psyche is sought for an ability to complete a mother's struggle towards subjectivity, predisposes women to attach from this position. The more defensive but equally pre-differentiated alliance that masculinity often offers as a protection against merger is unavailable. Thus the women are pulled on the one hand to fall into a vortex or on the other to feel a certain guilt for abandoning the other by asserting a need to differentiate.

These aspects of the dynamics between women require special attention. The guilt and worry over abandonment are counter posed with the urge to merge. If a therapeutic frame can be held in which these tendencies, and the fear that difference implies abandonment can be worked through, the relationship has the chance to provide the wherewithal to provide both parties with the means to psychic separation and subjectivity which does not preclude attachment.

CONCLUSION

Psychoanalysis - developed at the close of the 19th century - was the first discipline to address explicitly the gap between the mental and the physical without reducing the mental to the physical. In Breuer and Freud's hands pathways could be seen to exist between the mind in the sense of lived human experience and expressions of that experience in bodily form. Psychoanalysis both as a treatment and a theory of hysteria as the somatisation of traumatic experience, established an intimate linking between the mind and the body, the body being a receptacle for the unwanted or unassimalatable experiences of the mind. Expressed both in men and women, characteristically in women as a response to the straightjacket of Victorian repression and in men as response to the trauma of mechanised war and killing of World War I, war hysteria and so-called shell shock, told a section of the medical profession that the body was expressing horrors that could not be spoken of otherwise.

Throughout the 20th century, psychoanalysis remained the theory of this one-way bridge between the mind and the body - the body as receptacle and expression of events originating in the mind whereas nineteenth century materialist biology viewed the mind as a "mere" biochemical/neurological organ whose special properties properly understood would be seen as no more than physics and chemistry. In a creative reversal, Freud's mind and the mind in psychoanalysis, took on agency and the capacity to profoundly influence the body through tic, convulsion and paralysis. But aside from a few unusual neurological disorders the body was not seen to have psychological properties in its own right. In particular it could not be seen that the body could be constructed by its social experience and by the impact of gender as much as the gendered mind could be recognised to be a result of social experience.

In the 1970's psychologists, psychotherapists, sociologists, anthroplogists and analysts, (Chesler 1972), Money & Erhardt (1973) Broverman 1972, Oakley 1973, Rosaldo & Lamphere (1974) Strouse (1974) came to understand gender – the set of roles, the psychological, social, political and economic conscious and unconscious expectations

that we visit on biological categories - as a *social* category. This new understanding looked at the relationship between biological sex, gender, gender roles and sex role stereotyping. The impact of gender and the psychological impact of sex role stereotyping were then applied to the construction of a gendered psyche (Orbach 1978, Eichenbaum & Orbach 1982) with the lens of gender reviving interest in the psychology of women casting it in new terms. Feminine psychological development begun to be seen as an outcome of the complex relationship between social role and psychological demand rather than 'failed masculinity'. Femininity was viewed as a result of the particular demands of the mother-daughter relationship (Orbach 1978, Chodorow 1978 Eichenbaum & Orbach 1982) rather than as normative and inevitable.

With the wide acceptance of new theory on the psychological development of women, new treatment modalities evolved which 'heard' what women said and within the therapy the perspective of the necessarily ambivalent nature of the mother–daughter relationship emerged as a key feature of women's psyche. An emphasis of viewing women's psychological difficulties as primarily to do with separation individuation now shifted to problems in the original merger between daughter and mother and to the defenses that developed in response to conflicts and disappointment in that relationship. The therapeutic relationship and the transference countertransference became the site for the examination of the nature of attachment and its difficulties. Gender conscious psychotherapists became increasingly aware of the impact of the maternal psyche on of a daughter's development of self including the development of a body self. This thesis looked at the following implications of this understanding of a socially constructed gendered mind and body:

- The meaning of the maternal introject in the psychology of the daughter
- The meaning of the maternal introject on the body and body sense of the daughter
- Pressures on the countertransference at both a psychological and physical level
- Dependency issues in heterosexual and lesbian relationships.

The thesis argued that an expanded view of women's psychology and scrutiny of the phenomena of bodily countertransference in the psychoanalytic consulting room adds an enriched dimension to our understanding of the gendered mind, the gendered body and the construction of the psyche-somatic subject. Extending Winnicott's false self, I have attempted to show that the bridge between mind and body is a two way bridge. The body rather than the receptacle of unwanted emotions from the unconscious mind is the site of lived experience in its own right. There is corporeal development and there is psychological development which are both separate and entwined with neither serving as handmaiden to the other. The body has an integrity or a lack of integrity of its own, not simply as the container for psychological or unconscious distress.

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NOTE

Pages 80-101 and pages 119-130 were written with Luise Eichenbaum