An Analysis of the Changing Metaphors and Concepts of Mental Health

in Psychoanalysis.

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DEDICATION

This research is dedicated to my late Grandmother Tilly Rubinowitz and my late grandfather Louis (Yehuda-Leib) Oskowitz who would have been very "proud" of me for having completed this and who would have been even more excited at the birth of their great-grandchild.

DECLARATION

I declare that this thesis is my own unaided work. It is submitted in partial fulfillment of the requirements for the degree of Master of Arts (Clinical Psychology) at the University of Witwatersrand, Johannesburg. It has not been submitted for any other degree or examination at any other university or institution.

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ABSTRACT

There is a strong focus on defining and classifying psychopathology within a psychoanalytic paradigm. There is less emphasis on the consideration of what it means to be mentally healthy within a psychoanalytic framework. Yet, our understandings of mental health, whether implicit or explicit, inform our choices with our patients; our decisions to begin analytically oriented therapy, our treatment plans and our evaluations that termination has become appropriate. Therefore this research explores a fundamental underlying assumption that informs our work: what it signifies to be mentally healthy from a psychoanalytic perspective. In order to explicate understandings of mental health, the research explores the thought of four psychoanalytic theorists, Freud, Klein, Bion and Winnicott. The first part of the research examines the theories of the thinkers in order to extract their essential concepts and metaphors about mental health. For each thinker, a different emphasis on mental health is derived: Freud's structural model is essential to his apprehension of mental health, for Klein the ability to experience affects and work through the depressive position is vital, for Bion the capacity to think and tolerate suffering is highlighted, while for Winnicott what becomes important is an individual's capacity to inhabit transitional space. Next, these four approaches are discussed, compared and contrasted and the validity, or "mental health", of each theory is considered. Finally, some contemporary approaches to mental health within psychoanalysis are explored. It is concluded that mental health in a psychoanalytic paradigm differs from psychiatric and other psychotherapeutic approaches to mental health. Mental health is not about cure, symptom elimination or efficient functioning in the world. Therefore, it is very important that psychoanalytically oriented therapists consider what it means to be mentally healthy within the terms of our discipline. While no one single definition is offered, it becomes clear that mental health is defined more in terms of one's internal, psychic life as opposed to external functioning, is about tolerating process as opposed to

fixating on end-goals and is concerned with a certain ongoing quality of relationship rather than the foreclosed elimination of a symptom.

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1. INTRODUCTION

1.1. Research aim

What does it mean to be mentally healthy? More specifically, what does it mean to be mentally healthy within a psychoanalytic paradigm? In a psychoanalytic framework, with its own unique sets of assumptions that differ both from psychiatric and general psychological paradigms, there is little writing on the fundamental principles that determine our conceptions of mental health. Thus, this research takes a step back into the realm of the meta-theoretical, where an examination of underlying assumptions takes place, and considers the mutating articulations of mental health in a psychoanalytic framework. The research explores and discusses the work of four seminal thinkers in the psychoanalytic world; Freud, Klein, Bion and Winnicott and also considers some contemporary psychoanalytic attitudes towards mental health.

In research of this nature, the scope can become very broad. For the purposes of this research report, and to keep the content focused, only four thinkers were chosen. Freud as the founding thinker of psychoanalysis is an essential inclusion. Klein, Bion and Winnicott are all theorists who can be clustered broadly as object-relations thinkers. However, they all take Freud's (and then Klein's) work and develop their own articulations. Their theoretical associations with each other as well as their divergences render this particular cluster an appropriate starting-point to begin an analysis of their approaches to mental health. However, there is scope in this field to consider the approaches of other psychoanalytic schools of thought including the ego psychologists, the self psychologists and the French schools of psychoanalysis, although these will not be considered here.

Mental health is a difficult term to define. The word "health" has immediate associations with a bio-medical paradigm (Swartz, 1998). However mental

health is not a simple, psychological equivalent of physical health. Krapf (1961) suggests that what is construed as healthy on a physical level is not simply mapped onto an understanding of health on a psychological level. A medical doctor might proclaim health in a person given an absence of symptoms, but does this suffice psychologically? (Krapf, 1961). Defining health as the absence of symptoms is a minimalist conception of health. This notion of health is challenged by the WHO (World Health Organisation) when it states, "health is not merely the absence of disease and infirmity" (cited in Krapf, 1961, p. 439). Advocating a more inclusive perspective, the WHO proposes a view of health that is a positive state of physical, mental and social wellbeing (Swartz, 1998). While symptom reduction and elimination has been acknowledged as an aim of psychoanalysis, this research is concerned with seeking an understanding of mental health within a psychoanalytic paradigm from a wider perspective.

The word "mental" can also be a complicated term. White (1982) attests, that in the term mental health, "mental" presumes a level of dualism whereby mental health is assumed to be something that inheres only in the mind as opposed to the body. The simple separation of the physical from the mental is not as tenable in some systems of psychoanalytic practice. Therefore, perhaps, it would be more fitting to seek understandings of what it means to be psychologically healthy with an understanding that psychological health includes the mind and the body. Thus, the term "mental health" is already saturated with meanings which can alter our perceptions of what mental health is about from the outset. In considering mental health from a psychoanalytic perspective, we are seeking apprehensions of mental health which are not necessarily hampered by minimalist, bio-medical or dualistic perspectives.

Some of these problems with approaching the term "mental health" are perpetuated in a purely psychiatric approach to mental health. Perhaps tellingly, the *Diagnostic and Statistical Manual of Mental Disorders* (DSM-IV-TR) does not offer a definition of either normality or mental health (Kaplan and Sadock, 2003). However, a definition of mental disability is given. Mental

disability is explained as a psychological pattern or syndrome that is associated with distress or disability (Kaplan and Sadock, 2003). Distress refers to the presence of a painful symptom while disability refers to impairment in functioning (Kaplan and Sadock, 2003). Perhaps unwittingly, because there is no definition of mental health in the DSM-IV-TR, it becomes assumed that the absence of mental disability is equivalent to mental health. Thus the disappearance of the symptom and the ability to function in society become akin to mental health. Not entirely minimalist, this approach does not pay attention to the intrinsic inner psychological processes of an individual, preferring to assess mental health by what is visible and apparent (symptoms and functionality).

This approach to mental health can also be found in psychological, non-psychoanalytically oriented thought. Krapf (1961) points out that many non-psychoanalytically trained therapists tend to express the terms of mental health in a bio-medical and minimalist paradigm, as the absence of symptoms. In addition, he suggests that non-psychoanalytically inclined psychologists seek the happiness and also the "successful social performance of the human being" (Krapf, 1961, p. 44). Typical of this school of thought is Boehm who says, "mental health is a condition and level of social functioning which is socially acceptable and personally satisfying" (cited in Krapf, 1961, p. 440). Krapf (1961) suggests that there are many who work within a psychoanalytic framework who subscribe to the definitions of mental health in mainstream psychology, focusing purely on the external functioning of a person. He suggests that while the functioning of the person is important, a psychoanalytic approach requires both a functional and structural approach to mental health.

By structural, Krapf is referring to the less visible, inner structure of the personality. What Krapf argues, and what we can claim from the outset, is that psychoanalysis is concerned with the structural and functional analysis of a person's psyche. In other words, it is not only about how mental health appears on the outside, (social and occupational functioning, general sense of happiness etc.), but about something more internal to a person that operates

at a level of both structure and function. Krapf continues that mental health is not simply about the disappearance of the symptoms, but should include a "permanent stabilization of the personality" (Krapf, 1961, p. 441). Jones' paper "The Concept of a Normal Mind" (1942) is a case in point. In this paper he starts by looking at certain assumptive understandings of mental health to do with happiness, efficiency in mental functioning and a positive social feeling. But he then moves on to a deeper, "analytic consideration" (Krapf, p. 441). Certainly it is not that external functioning in the "real" world does not matter. But it seems that from a psychoanalytic point of view, the internal informs the external and therefore an examination of mental health needs to proceed from the inside-out, so to speak. Moreover, it seems that for psychoanalytic thinkers, a level of functionality is necessary but not sufficient for mental health. Indeed, there may be instances as described in the chapters that follow where functionality is temporarily impaired, where forms of regression and lesser degrees of functioning are still part of a trajectory towards mental health. These experiences which may appear to the psychiatric or the mainstream psychological eye as poor mental health, could, to the analytic observer be an experience on a path towards greater mental health. Hence in this research, mental health will be explored from a perspective that is concerned with the structure, function and dynamics of the personality, from the inner workings of the psyche.

1.2. Rationale for Study

In a recent article, Eisold (2005) comments that the original mission of psychiatry has become an umbrella for all forms of mental health service including psychoanalysis. He suggests that psychoanalysis and dynamically oriented therapies are at risk of losing their unique identities unless they start to consider some of these issues on their own terms. It is not the purpose of this research to make a political argument about the identity and future of psychoanalysis as opposed to psychiatry or other mental health services. However, in this climate it seems important for psychoanalysts and psychoanalytically oriented therapists to consider more carefully the nature of their own terms, to explore mental health from a psychoanalytic perspective.

Are the above-mentioned minimalist, dualistic and externally oriented approaches to mental health sufficient from a psychoanalytically oriented perspective? Freud's famous dictum, that a healthy person should be able to "love and work" (1966) seems to imply that functioning is valued from a psychoanalytic paradigm. But a deeper exploration of Freud reveals the complexity of this statement. Its seeming simplicity belies the intricate inner workings of the person that are required for him to be able to love and work.

For all the differences that exist among the underlying assumptions of psychiatry, mainstream psychology and psychoanalytic thought, there has not been much written about particular psychoanalytic understandings of mental health (Jones, 1942). This might be in part because therapists have historically been concerned with extreme psychopathology, what Jones calls "gross deviations from normality" (1942, p. 1). However, with longer-term therapies and analyses and the evolution of psychoanalysis, there has arisen a need to grapple with the term "mental health" and not simply rely on definitions of psychopathology (Jones, 1942). Nor has there been much examination of ways in which different psychoanalytic theorists might view mental health differently. However, the assumptions we have around mental health form the underlying thought processes by which we treat each patient. Yet, rarely do we explore the fundamental principles that determine our conceptions of psychopathology and mental health. Rather, we employ theory and technique in order to help our patients without sometimes pausing to examine our underlying goals and the premises which inform our aims. Often, as has been mentioned, we may defer to psychiatric or mainstream psychological points of view in assessing the mental health of an individual. In addition, sometimes psychoanalysts fall into the trap of assessing what is normal by deferring to the normative social standards without examining states of health according to the theoretical underpinnings of their field (Trotter, 1916).

It is with these concerns in mind that this research has been undertaken. By exploring the shifting psychoanalytic assumptions around mental health, we can begin to examine critically the meta-theoretical constructs that inform the

way we read and interpret our patients: their symptoms, pathologies, their need for and appropriateness of analysis, their readiness for termination etc. This research can hopefully open a debate around these questions in the psychoanalytic community and make psychoanalytically oriented therapists more aware, more critical and more thoughtful, both in terms of evaluating their working definition of pathology and in terms of setting therapeutic goals. In articulating psychoanalytic approaches to mental health, this research may raise interesting questions about how psychoanalysis, psychiatry and psychotherapy can at times differ not just in terms of technique but in terms of our fundamental understandings of mental health. This research is not about comparing psychoanalytic viewpoints on mental health with others. Rather, it seeks to develop a sense of mental health that is couched within the terms and frames of reference of psychoanalysis, and to consider how psychoanalysts may differ from each other in their points of view.

1.3. Use of Terminology in the Report

In a project of this nature, we encounter terminologies which vary in meaning and interpretation. Normality, sanity and mental health are three such terms. Normality can be seen as a problematic term, implying a value judgement, varying from culture to culture and filled with ambiguities (Swartz, 1998; Kaplan and Sadock, 2003). Historically the term "normal" has been used in mental health and has even been equated with the term "mental health" (Krapf, 1961). People have been assessed to see whether they are abnormal which is defined by Swartz as "different from the norm of rule" (Swartz, 1988, p. 54). Swartz says this implies a statistical definition of normalcy and he questions whether a statistical definition (determining whether a person is average) is helpful or sufficient in approximating what it means to be mentally healthy. Thus the term "normal" with its attendant problematic associations is not under investigation in this study and I will only refer to it if a theorist uses it as a substitute for the term "mental health" in their work.

Sanity could also be seen as akin to mental health, but for the purposes of this research, I see sanity as a more clinical and minimalist term that refers to

the absence of psychotic symptoms and a person's ability to function adequately in society. In investigating the term mental health in a psychoanalytic context, I am searching for something beyond what is considered "normal" or "sane".

Mental health is the term under investigation here and therefore no one single definition can be offered at the outset. Certainly, in the literature, mental health abounds with meanings and ascriptions. It can be seen as a kind of utopic term that aspires towards an unattainable ideal. Indeed, Hartmann conceives of health as "one expression of the idea of vital perfection" (cited in Krapf, 1961, p. 439). For Freud, mental health is about arriving "at a level of absolute mental normality" (Krapf, 1961, p. 441). While Conrad states for a person to be mentally healthy, there should be some evidence "that the individual fully utilizes a capacity or is working in that direction" (Krapf, 1961, p. 440). These idealistic definitions apprehend mental health as a utopian totality and are certainly maximalist in their aspirations. But from a structural and dynamic viewpoint, these sweeping, positive definitions of mental health do not assist the therapist in seeking the nitty-gritty indicators of mental health in a person. Moreover, in seeking psychoanalytic understandings of mental health, we critically interrogate the notion that mental health is about attaining a perfect mental state.

Psychoanalysis and psychoanalytically oriented therapy are also two terms that require distinctive definition. Psychoanalysis refers to a tradition starting with Freud that attempts to understand the psyche and treat its ailments. Thus it is both a therapeutic technique and a "theoretical model of human development and ideas about the workings of and within what we call 'personality' " (Jacobs, 2004, p. 5). It presumes an unconscious in the psyche and so works with what is consciously present and also with what is less conscious or unconscious[1]. Hence psychoanalysis presumes that psychological conflicts need to be understood as the products of unconscious

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[1] The unconscious is that part of mental activity which has "no such easy access to consciousness but must be inferred, recognised and translated into conscious form" (Freud, An Outline of Psychoanalysis, 1940, p. 32).

motivations and affects (Jacobs, 2004). Understanding these deeper layers invariably gives rise to defences and resistances and exploring the origins of this resistance has become a crucial feature of psychoanalysis. As it is working with these unconscious processes, psychoanalysis is considered to be depth work and the therapy is long-term. Sessions are not limited to once weekly but can take place up to five times per week (Jacobs, 2004). Psychoanalytically oriented therapy or psychodynamic therapy as it is often called, presumes similar sets of assumptions about the psyche as psychoanalysis proper even though many of its proponents have deviated significantly from Freud (Jacobs, 2004). However, psychoanalytically oriented therapy modifies the treatment of individuals and is often more short-term in its approach in accordance with practical constraints and more limited goals. Another assumption shared by psychoanalysis and psychodynamically oriented therapies is that the internal aspects of a person are formed early on in a child's development. Therefore there is a concern with the patient's past as well as the present. Psychoanalysis and psychoanalytically oriented therapy or psychodynamic therapy may differ in terms of therapeutic treatment but they share similar sets of assumptions about the psyche. Therefore a psychoanalytic exploration of mental health is relevant to both approaches.

1.4. Methodology

This research is conceptual in nature. In psychoanalysis, conceptual research is a field of research separate from clinical and empirical research (Leuzinger-Bohleber and Fischmann, 2006). Unlike other theoretical fields, conceptual research in psychoanalysis is distinct in that it is informed by and connects with an understanding of clinical material; thus theory and clinical application are interwoven and interdependent. Yet they are also two fields which require distinction (Leuzinger-Bohleber and Fischmann, 2006). Conceptual research is defined by Sandler (2003) as "the *systematic* investigation of the meanings and uses of psychoanalytic concepts, including their changes, in relation to both clinical and extra-clinical concepts" (pp. 109-110). Leuzinger-Bohleber and Fischmann (2006) clarify the notion of conceptual research saying that

conceptual research is not limited to a specific methodology; rather it is defined by its topic, the investigation of psychoanalytic concepts. This is in keeping with the nature of this thesis where I am investigating the concept of mental health in the work of four psychoanalytic thinkers. However, unlike quantitative or even qualitative research, there is no one pre-defined methodology for conceptual research.

Leuzinger-Bohleber and Fischmann (2006) identify seven different sub-types of conceptual research. A few of these sub-types are relevant to this thesis. The first sub-type is described as "conceptual research with highly theoretical ambitions" (Leuzinger-Bohleber and Fischmann, 2006, p.1376). This sub-type refers to research which aims to develop new theoretical integrations. As Leuzinger-Bohleber and Fischmann (2006) write, "this kind of conceptual research sustains theoretical discussion within the psychoanalytic community" (p. 1376). This is the overarching aim of my research and is reflected in its methodology whereby I trace the articulations of four key psychoanalytic theorists: Freud, Klein, Bion and Winnicott, and their viewpoints on mental health. I do this by attempting to pay careful attention to the detailed explications of their theories. All of these theorists have considered what it means to be mentally healthy; some in papers which consider the appropriate time to terminate an analysis (Freud, Klein), some in explicit papers on mental health (Winnicott) and others in more allusive writings (Bion). Where there is explicit material on mental health I have used those chapters as a starting point. However, it has become clear that their viewpoints on mental health are inextricably interwoven with their own unique articulations of the psyche and their explications of theories, which sometimes build on and sometimes veer away from their predecessors. While the careful unpacking of their theories is concerned with "theoretical ambitions" (Leuzinger-Bohleber and Fischmann, 2006, p. 1376), I am also tracing the historical trajectory of this concept through these thinkers, seeking similarities as well as shifts in articulations of the concept. Thus the four explicative chapters consider how each theorist's thought contributes towards a psychoanalytic understanding of mental health. In these chapters I am reading these thinkers to identify key concepts and essential metaphors that express what mental health is for each thinker and I

unpack how these articulations are couched within the larger rubric of their theories.

The term metaphor requires some careful consideration. In the traditional English sense, a metaphor is a figure of speech whereby an expression of language is used in order to describe something else. However, in literary criticism the term itself has undergone mutations and its meaning is a site of contestation and debate. In the traditional, literary sense of the word, it is seen strictly as a rhetorical and linguistic device. Abrams (1971) says that a metaphor occurs when, "a word which in standard (or literal) usage denotes one kind of thing, quality or action is applied to another, in the form of a statement of identity" (p. 61). Therefore, metaphor is a figure of speech that substitutes one term for another in order to approximate, describe and convey a sense about something else. However in the development of literary theory and particularly in its theoretical interactions with post-structuralism and post-modernism, this more narrow use of the term metaphor has been challenged; all language has come to be seen an inherently metaphorical. This has, in part, come from a questioning of the possibility that any language can be simply literal. That language is inherently metaphorical comes to render all writing, all ascriptions and assertions through language, as figurative, ambiguous and indeterminate (Eagleton, 1996). This shift in the understanding of metaphor becomes of great pertinence within psychoanalysis as will be explored below.

While metaphor has its origins as a literary device, it is a concept that is of great theoretical interest to the realm of psychoanalysis. Borbely (1998) argues that metaphor should be located within the domain of psychoanalysis because the psychoanalytic project is about restoring lost metaphoricity to our patients so that they can respond with less neurosis to their lives. He suggests that processes of metaphor occur at linguistic and pre-linguistic levels within the psychoanalytic process and he suggests that metaphor functions in psychoanalysis in a much wider sense than its traditional, literary definition. Essentially Borbely (1998) suggests that metaphor is enacted throughout the psychoanalytic process in different acts of substitution and

transference. In fact the word for transference in Greek is "metaphor" (Borbely, 1998, p. 927). For example, connecting the there-and-then to the here-and-now in the form of an interpretation is a metaphorical process whereby a temporal comparison is made between the past and the present. Linguistically, metaphor explains something in terms of something else and psychoanalytically, metaphor apprehends something in terms of a temporal difference. However, unlike post-structuralist approaches to metaphor whereby all language is rendered as metaphorical, Borbely (1998) suggests that language can be more or less metaphorical, depending on the extent to which it expands the meaning or "class category" which it refers to. Put differently, the richer a metaphor, the more its expands a person's capacity for understanding and insight. If language is poor in metaphor, it is tantamount to Freud's repetition compulsion whereby behaviour is enacted and re-enacted without incorporating new meanings. Borbely (1998) also suggests that metaphor are potentially creative acts, which translate experiences from one domain to another as opposed to simply transcribing interactions. He distinguishes between translation and transcription suggesting that the former is a creative act that recognises the similarities and the differences between one situation and another while the latter simply re-enacts or transposes one situation onto another without amplification, shift or change. Finally Borbely draws a distinction, for psychoanalytic purposes, between metaphor on the one hand and analogy and simile on the other. All three are rhetorical devices which make direct or indirect comparisons between one domain of experience and another. However, Borbely suggests that analogy or simile draw a comparison of identicalness between one domain and another whereas metaphor is more creative in that the use of the metaphor allows for the domain it is describing to be amplified in meaning, shifted and translated. A creative metaphor leads to new categories and perspectives in a given domain whereas an analogy, in Borbely's terms, leads to sameness and repetition.

This understanding of metaphor becomes especially helpful in the clinical situation. Borbely (1998) suggests that when a person is caught in a neurotic conflict, his ability to use metaphor is compromised, while when a person acts

without neurosis, he is able to preserve the rich, metaphoric and polysemic nature of his experience. Polysemy refers to the notion of more than one meaning. Borbely (1998) implies that a mentally healthy individual understands that the words, statements and events he refers to are open to more than one possible meaning. On the other hand, trauma reduces the polysemic nature of existence to one possible meaning due to the overwhelming anxiety experienced through the trauma.

In sum, the traditional, narrow understanding of metaphor as defined by Abrams is limiting within a psychoanalytic domain. Yet, the post-structuralist understandings of metaphor relate to the psychoanalytic notion that metaphor is much wider in category. However, the linguistic notion that all language is metaphor does not do enough to distinguish between different applications of language. Psychoanalysis apprehends that there are different ways in which metaphor can be employed; not all language is metaphorical in the same way.

Because this research is an exploration of psychoanalytic writings, it sees an interesting convergence of linguistic and psychoanalytic understandings of metaphor. Psychoanalytic thinkers have come up with models or concepts and also with metaphors that shift our understanding of the psyche. Therefore when I consider how theory is articulated by the different thinkers, I may refer to their "language" or "metaphors" so as to emphasise, in a post-structuralist sense, the linguistic construction of a psychical concept that is not concrete. However, more particularly, when I refer to metaphor I am holding the psychoanalytic definition in mind, which distinguishes between the enriching, polysemic nature of metaphor as opposed to the more limiting analogy or simile.

The second part of the research, the **Discussion** involves an analysis of the key metaphors that have been extracted as well as a consideration of contemporary psychoanalytic approaches to mental health. This aspect of the research fits under the sixth sub-type of conceptual research identified by Leuzinger-Bohleber and Fischmann (2006); the interdisciplinary conceptual approach. This sub-type involves the integration of psychoanalytic and

interdisciplinary knowledge with the aim of enhancing conceptual understanding in either or both fields. My research traces the metaphors of mental health and, therefore, I draw on thought from linguistics and literary theory in order to understand the significance of shifting metaphors or shifting language as an expression of mental health. Literary theory is used to enhance my understanding and analysis of the concept "mental health". Thus in the **Discussion Section**, I first consider differences and similarities among the thinkers and consider how these differences are reflective of fundamental underlying assumptions to do with the psyche and I consider the significations of their metaphors. Next I consider some meta-theoretical questions around the very nature of the way mental health is articulated through language and metaphor. Finally, I look at some contemporary articulations of mental health in psychoanalysis and consider the significations of these approaches through a literary-theoretical lens.

2. FREUD: THE BEGINNINGS OF MODERN NOTIONS OF MENTAL HEALTH

2.1. Introduction

The search for understanding the "what" of mental health starts with Freud. As the founding theoretician of psychoanalysis, his writings on mental health, on sanity and psychological illness have become the starting point for all further points of inquiry. With Freud, it seems we are not looking at the development of a language around mental health alone. Rather, Freud's contribution to psychoanalysis is the articulation of a new language for understanding the psyche in general: its structure, topography and pathology. The evolution of his understanding of mental health is inextricably interwoven with the unfolding of his theory of mind, with the notions of conscious, unconscious and preconscious, ego, id and superego as well as his positing of two central drives in the human being, *Eros* and *Thanatos,* the love and death drives. The exposition of Freud's thought evolved as he moved from a more neurophysiological explication of mental health in "Project for a Scientific Psychology" (published posthumously in 1950) to his topographical and structural models (Caper, 1988). While Freud shifted theoretically and while a synchronic development can be noted in his thought, traces from earlier models can be detected in the newer modified theories. My approach to Freud presumes the co-existence of various ideas even as his thought may shift in emphasis from one theory to another.

In this chapter, I explore Freud's central writings; in some of them he writes explicitly about mental health while in others the development of his general psychoanalytic theory alludes to what mental health might look like. Sometimes Freud refers to the psychological dynamics of a neurosis and from his writing on notions of psychopathology, ideas about mental health (or the opposite of a neurosis) are inferred. In seeking to extract Freud's essential metaphors on mental health, I argue that mental health for Freud is about an

individual being able to manage a particular balance of influence among the id, ego and superego.

2.2. Analysis Terminable and Interminable

The starting point for Freud's writings on mental health is a paper he wrote late in his career called "Analysis Terminable and Interminable" (CP, 1937/1953) where he considers the conditions under which an analysis may end. Freud seems to imply that analysis is a necessary requisite for the attainment of mental health. Many of the themes found in earlier and later writings are referred to or touched on in this paper. In speaking about the goals of an analysis he writes,

> Our object will be not to rub off all the corners of the human character so as to produce normality according to schedule, nor yet to demand that the person who has been 'thoroughly analysed' shall never again feel the stirrings of passions in himself or become involved in any internal conflict. The business of analysis is to secure the best possible psychological conditions for the functioning of the ego; when this has been done, analysis has accomplished its task'[2] (Freud, CP, 1937/1953 p. 354).

This quote captures the nuance and complexity involved in the ending of an analysis and the achievement of mental health. In the quotation Freud distinguishes deftly between so-called normalcy (an illusion of mental perfection) and mental health. Mental health is not about the ending of conflicts or passions. However mental health does require the proper functioning of the ego. What it means for the ego to function adequately will be explored in more detail further in this chapter.

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[2] This quote would support the ego psychologists in their assertions that the primacy of the ego is requisite for health. Read in context, however, it seems Freud's criteria for mental health are more nuanced and that it is more when he is pushed pragmatically to describe the end of an analysis that he talks about the strengthening of the ego. In context, it seems the strengthening of the ego is not an absolute indicator of mental health but is rather the fundamental mechanism required for ongoing exploration of the personality.

Freud starts this paper by asserting that a successful analysis is regarded as "the liberation of a human being from his neurotic symptoms" (CP, 1937/1953, p. 316). This criterion can be understood as a negative one, whereby mental health is defined as the absence of the symptom. However this seemingly simple assertion belies the complexity of Freud's writing: Freud continues by referring immediately to what seems to be a subsidiary issue; how long an analysis should take. He refers briefly to Otto Rank in the United States who sought to make analyses shorter and seems quite sceptical of this possibility (Freud, CP, 1937/1953). The length of an analysis, though seemingly subsidiary to the actual question of what is mental health, recurs as a theme throughout "Analysis Terminable and Interminable" and perhaps offers a clue as to the difficulties in achieving mental health. Certainly, Freud implies, there is no quick fix. Thus, the opening of this chapter, where Freud defines mental health as the eradication of the symptom and refers to the lengthy demand of time imposed by this process, expresses a constant tension in Freud's work. On the one hand, cure can be defined quite simply and quickly as the absence of the symptom. At the same time, Freud seems to say that the possibility of achieving this is not so simple.

Elaborating on the notion that mental health is the absence of symptoms, Freud mentions that health is the "complete" and "permanent" eradication of the neurosis (CP, 1937/1953, p. 318). In order to illustrate what he means he refers to the case of a young man whom he treated. During the course of the analysis, the patient recovered his independence and regained his interest in life. In other words, his current symptoms cleared up. Yet Freud felt the patient was not well because his childhood neurosis had not been dealt with. At this point Freud used the technique of setting a termination date and the threat of analysis ending seemed to speed up the patient's work. His childhood neurosis cleared at which point Freud pronounced him to have a cure that was "complete and permanent" (Freud, CP, 1937/1953, p. 318). From this example, it seems as if Freud sought the complete cure of all a patient's neuroses before the person could be pronounced healthy. That the patient could function in day-to- day life without this deeper "clearance" did not suffice. Freud's concluding thoughts around this case seem to suggest that a

neurotic personality structure can remain in a person, despite the absence of symptoms (Freud, CP, 1937/1953). In other words, the current cessation of symptoms does not suffice as an indication of deep, inner cure as over time further neurotic symptoms can emerge.

As the chapter unfolds, it seems that Freud's simple statement that health is the absence of neurosis is beguilingly simple. For one thing, he means the removal of all neuroses including childhood issues that may not impinge on the patient's life currently. Moreover, a person's capacity to function does not suffice as a definition of mental health. Rather, Freud includes a requisite return to and addressing of past memories and traumas in his understanding of mental health. There seems to be a prioritising of internal factors (clearing of childhood trauma) as opposed to external factors (functionality) in his paradigm of mental health.

In the above-mentioned case-study, Freud writes a postscript about this patient. He explains that a few years later the patient returned to Vienna and it seemed a part of the transference had not been worked through properly. The patient returned to analysis and Freud worked the issue through with him. Freud then reports that the patient felt normal and behaved "unexceptionably" (Freud, CP, 1937/1953, p. 318) for the next fifteen years. However even these fifteen years were not neurosis free. Freud writes that the patient required more short-term treatments throughout his life. This notion of a postscript that follows termination is revealing. While Freud regards mental health as the "complete and permanent" (Freud, CP, 1937/1953, p. 318) eradication of neurosis, this case points to the notion of the neurosis being perpetuated in the form of a trace throughout the patient's life. The "complete and permanent" eradication of the neurosis is not easily, if ever, achieved. Yet, in many ways, in spite of the neurotic traces, this person was defined as healthy. So perhaps there is something more to the definition of mental health than the complete eradication of a neurosis. Perhaps in mental health, a postscript always remains that disrupts the seemingly perfect gloss of health. This postscript suggests that mental health can be described in terms of broad, generalised principles upon which there is consensus. Yet, the trace of

pathology always remains. Thus mental health is not akin to psychic perfection. As my argument around the id, ego and superego develops in this chapter, it is important to bear in mind that mental health is not a utopian state in the Freudian paradigm.

As the chapter continues, Freud poses an interesting reflective question about the process of analysis. Instead of focusing on the question of when should an analysis end, he inquires whether it is possible to actually end an analysis.[3] This leads him to consider two conditions under which an analysis can be terminated. On the one hand a patient must no longer suffer from his symptoms and he needs to have dealt with his anxieties and inhibitions. The second criteria, perhaps more challenging to fulfil, is that the analyst needs to be satisfied that enough repressed material has emerged from the unconscious and that inner resistances have been overcome. This eliciting of unconscious material assures the analyst that the symptom will not be repeated (CP, 1937/1953). A corollary of this second condition is that the analyst needs to be certain that no real change would occur with this patient were he to continue with his analysis. In others words, Freud is suggesting that the patient has done the inner work required of him: not much else is going to happen. These mirror the criteria he sought in the above case-study.

Freud concedes that the second condition- the uncovering of repressed material- is a tall order. It implies that a person should be psychically healthy at the end of an analysis and, crucially, that his health will be maintained. Freud explains that this second condition is more easily achieved when a person with a constitutional balance of instincts and ego strength suffers from a childhood trauma which needs to be uncovered and dealt with. He says it is less easy to achieve when a person experiences their instincts as overpowering and has a weak ego. In other words, it is at this point that he highlights a particular balance of instincts in relation to ego as a criterion for full mental health. The importance of a strong ego gets taken up and

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[3] In this regard, Freud shares the anecdote that when analysts speak of someone with an obvious imperfection they may comment "his analysis was not finished" or "he was not completely analysed" as if to suggest that a thorough proper analysis will efface the imperfections from the person (Freud, CP, 1937, p, 320).

emphasised by the ego psychologists (Hartman and Krapf) and will be discussed in greater detail further on in this chapter. A further point which Freud implies about mental health is that it can be measured by longevity. In other words a healthy person is not to be measured by the success at the end of the analysis alone, but by the quality of mental health over time. This links to how Freud's work developed. He writes that as his experience as an analyst increased he realised that there was no need to rush an analysis. This is because in the treatment he sought nothing less than a "radical change in the personality" (Freud, CP, 1937/1953, p. 325).

Thus it seems that Freud's definition of mental health expands. He starts by referring to notions such as the alleviation of the symptom and the eradication of the neurosis but he then elaborates, citing the necessity of establishing the right relationship between ego and instinct and referring to the longevity of cure as an indicator of mental health. Freud goes on to make a very interesting claim. He says the relation between instincts and ego that is brought about by an analysis creates a dynamic which differentiates the analysed person from the unanalysed healthy person (CP, 1937/1953). In other words, something about the analytic process produces a state of health which so-called "normal", unanalysed people cannot achieve. This is a fascinating, even radical claim. He seems to be suggesting that a certain ideal of mental health, defined as a particular type of interaction between instincts and ego, can only be brought about through the process of psychoanalysis. In this way, Freud distinguishes between the normal unanalysed person and the analysed person. Normal is not necessarily equivalent to mental health. He might be suggesting that on some level, the processes engendered by psychoanalysis are an optimum measure of mental health. This notion that instincts need to be in right relation to ego is central to a Freudian understanding of mental health. The former should neither overwhelm nor be repressed by the latter. Precisely what this entails will be explored in the next section.

The first half of "Analysis Terminable and Interminable" is written in a reflexive mood where Freud considers the aims of analysis while simultaneously

questioning how much can be gained from the analytic process. He cites Johann Nestroy, "Every advance is only half as great as it looks at first" (Freud, CP, 1937/1953, p. 331). He uses this to explain how successful development is meant to involve mastering three phases of development, the oral, the anal and the phallic.[4] However, Freud acknowledges that even in normal development the transformation is never complete and the human being always contains vestiges of earlier fixations. This is interesting because, as he began the chapter, he seems to be suggesting that there are always traces of fixation and neurosis within the healthy person. His writing on mental health goes backwards and forwards between certainty and doubt, mirroring in some ways the dynamic and sometimes tenuous relationship between the ego and the id[5] in the sense that sometimes the one and sometimes the other seems to be in control.

Freud cites Ferenczi, "Analysis is by no means an interminable process. On the contrary, if the analyst has a thorough knowledge of his business and a sufficient fund of patience the treatment can be carried to a natural conclusion" (cited in Freud, 1937/1953, p. 50). Freud qualifies Ferenczi's statement, however, by suggesting that an analysis requires more depth and less brevity. Here again, he refers to Ferenczi who says that the chance of a patient getting better also depends on the analyst learning from his mistakes. Freud indicates that analysts themselves are often not as healthy as the yardstick of health that they set up for their patients. Yet, Freud says that the analyst does require a degree of psychic health in order to carry out his task, especially if he is to act as an analytic model and teacher. He lists some criteria which serve as indicators of when an individual is suitable to begin an analytical training. His enumeration of the criteria is telling: The analyst-to-be needs to sincerely believe in the existence of the unconscious and he needs to be able to perceive processes in himself through the emergence of

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[4] Freud's theory on sexuality and the erogenous zones was first written about in "Three Essays on the Theory of Sexuality", published in 1905 but underwent many modifications until the last edition of the book was published in 1925 (Caper, 1988).
[5] Caper (1988) writes that the libido in Freud's "economic model" became the id in his structural model. Broadly speaking both refer to the instincts, those contents of the unconscious that are undifferentiated and driven by the pleasure principle; in other words primary process.

repressed material which he would have previously disbelieved (Freud, CP, 1937/1953). Moreover, it would be hoped that at the end of the "analyst to be's" first analysis, he would not stop his process of ego transformation but that this would continue and that he would constantly be gaining new insights about himself (CP, 1937/1953).

Freud's criteria for when a person is ready to become an analyst are illuminating in terms of his discussion of mental health. In a sense they are quite basic. The person must believe there is an unconscious. Put differently, they must be aware there is more to the self than the conscious ego; they must have experienced the uncovering of some repressed material so that they know the experience of analysis and they must be willing to continue this process of ego-transformation throughout their lives. So much is this process valued by Freud that he encourages all analysts to re-enter analysis every five years. If a person is able and willing to do this, analyst or regular human being, perhaps this would be a strong indication of mental health. However, it also returns us to the paradoxical notion that analysis is actually always interminable and terminable and that mental health is an ongoing process as much as a product achieved at the "end" of one's first analysis!

Thus, from what Freud is saying, analyses do conclude but they are also, in a sense, on-going. In his paper "Analytic Therapy" (IP, 1917/1922) Freud distinguishes between hypnosis and psychoanalytic treatment and he comments that while hypnotic treatment seeks to cover up, analytic treatment seeks to expose and get rid of something. In this paper, written twenty years before "Analysis Terminable and Interminable", he writes that analysis seeks not to eliminate the symptom but to return to the root of a conflict from which the symptoms emerge and work with the conflict.[6] In this description there is an emphasis on the language of "root" as opposed to "symptoms" and a concern with "depth" as opposed to "surface". He calls analysis a "labour" and a "re-education" (IP, 1917/1922 p. 377) and writes that health is achieved

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[6] At this point, Freud had abandoned the mechanical model for explaining anxiety. In this early model, he asserted that if an individual's libido was repressed, the blocked libido converted into anxiety. He replaced this theory with the assertion that anxiety was caused by a central psychological conflict (Segal, 1988).

through overcoming resistances so that the patient's mental life is forever changed and elevated to an advanced level of development. Mental health for Freud is not about a superficial removal of a symptom but about a change that is characterised by "root cause" and "depth". Moreover, he says that analysis can only be completed when all uncertainties about a case are cleared, when the patient's memory has been filled in and the root causes have been discovered. This connects to his comment in "Analysis Terminable and Interminable" that psychoanalysis seeks the total transformation of the personality.

In this discussion, Freud offers subtle distinctions between neurotic and healthy people. He explains that healthy people are also prone to repression and that they use some of their libidinal energy in order to sustain their repressions (IP, 1917/1922). Their unconscious system also contains impulses that have been repressed and some of their libidinal energy is not at their disposal. He then says that, psychoanalytically speaking, "a healthy person is virtually a neurotic" (IP, 1917/1922, p.382) but their only symptoms are dreams. He then refines this distinction by saying that, actually, healthy people do experience symptoms throughout the day (for example the experience of unconscious slips of the tongue or common mishaps) but these are minor and not important (IP, 1917/1922). Thus, Freud returns to the criteria utilised earlier: Both the neurotic and the healthy person have repressions, they both lose some libidinal energy to the unconscious and experience symptoms. However, he asserts that the difference between the neurotic and the healthy person is about the individual's capacity for enjoyment and efficiency (IP, 1917/1922).[7]

Freud's writings in "Analysis Terminable and Interminable" and "Analytic Therapy" reveal some of the complexities of trying to apprehend a psychoanalytic definition of mental health. On one level, mental health is

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[7] It is worthwhile considering the terms enjoyment and efficiency. Both refer to Freud's notion that a person be able to "love and work". For Freud enjoyment links to the pleasure principle and the reality principle; that a person can derive pleasure at the right level of consciousness. The language of efficiency harks back to Freud's economic model and refers to the quantity of libido available to the ego for "love and work" versus the quantity of libido that is required for repression.

described as the absence of symptoms. Yet, the simplicity of this notion belies its more complicated elaboration. What emerges is not so much a definition but a set of values around mental health: depth is preferred to surface, uncovering the root is preferred to covering up and concealing, an internal clearing of the past is valued over external functionality, and the right relationship of ego to instincts is valued over an overly rigid ego or an ego that is too weak and porous. In terms of functionality, Freud values the notion of a person's capacity to enjoy things as well as his capacity for efficiency. There is also a suggestion that a person must acknowledge the unconscious and that analysis seeks the transformation of the personality. Many of these notions are elaborated more fully in other parts of his work, but what seems to emerge more and more strongly is that a mentally healthy person must be able to receive pleasure and be efficient. Experiencing pleasure and living efficiently are impeded by symptoms and facilitated by the right relationship of the ego to the instincts. At this point, I address his suggestion that the modification of the ego is a criterion for mental health.

2. 3. On the Modification and Strengthening of the Ego

According to Freud, a particular quality of ego is essential for mental health. Equally important is that an individual has an appropriate balance of instinctual energy and, as his thought developed, a particular type of superego. This is addressed further in this chapter. However the ego is central to all psychic functioning in an individual. The ego is the conduit between the id and the superego and between internal and external reality; it is the person's interface between self and world. Freud elaborates on two different qualities of the ego that are essential for mental health: flexibility and strength.

2.3.1.The Flexible Ego

In his paper "Analytic Therapy" (IP, 1917/1922), Freud explores why the neurotic is not capable of enjoyment or efficiency. The neurotic struggles with the former because his libido is not directed toward any real object and so his

pleasure is experienced diffusely and is not focused on what he really wants, while he struggles with the latter because so much of his ego's energy is utilised to ward off the instincts and so his ego's effectiveness is undermined. The ego is frightened of the instincts and so develops a rigid, defensive quality in order to ward off unconscious impulses. Freud explains that mental health is attained through resolving the conflict between ego and libido and through the ego's acquiring the energy of the libido. Health is thus achieved through the freeing up of the libido, making the libidinal energy available to the ego. Freud's notion of the freeing up of libido refers to an understanding of conflict developed early in his theoretical trajectory and later revised (Caper, 1988). However, even in this early model, he identifies something about a particular quality of ego which can free up the instincts and engender mental health. The essential quality of the ego in this instance seems to be a certain openness or flexibility.

The importance of a flexible ego is asserted throughout Freud's thought. In his paper "Analysis Terminable and Interminable" (CP, 1937/1953) Freud cites as one criterion of mental health that conflicts are resolved between ego and instinct. He explains that he does not seek the eradication of the instinct but rather the instincts need to be brought into harmony with the ego (Freud, CP, 1937/1953). Mental health is maintained as long as there is a particular type of relationship maintained between the instincts and the ego (Freud, CP, 1937/1953). He writes that it is the ego which develops defences against the id because the ego worries that the fulfilment of the id's wishes will conflict with the values of the external world (Freud, CP, 1937/1953). Now, Freud acknowledges that defence mechanisms may play an important role in protecting the ego from the id, but at the same time the defence mechanisms may be too extreme. In a hark back to Freud's earlier language he says "the expenditure of energy" harnessed in order to ward off the instincts can "prove a heavy burden on the psychical economy" (CP, 1937/1953, p. 340). This goes back to Freud's earlier work and his "economic" model where he spoke about energy systems and the need for a physiological balance of energy or equilibrium in the system (Caper, 1988). If the neurotic harnesses all his energy in order to ward off the instincts, then the neurotic will lack the

capacities for efficiency. Overly rigid defence mechanisms are reflective of an overly strong or rigid ego. In terms of mental health, this is not ideal; if defence mechanisms become too strong a person is in danger of becoming alienated from the external world (the rigidity renders the person closed off, defended against and invulnerable to all types of relationships) and does not have instinctual energy available. Here Freud offers a sentence helpful for our expanding understanding of mental health: "The therapeutic effect of analysis depends on the making conscious of what is, in the widest sense, repressed within the id" (CP, 1937/1953, p. 341). This can only happen when the ego releases its defence mechanisms, which Freud explains, are also unconscious. Freud persists in pointing out how difficult it can be to indicate a person's defence mechanisms in the analytic process, precisely because of the ego's fears of the id as described above. However, addressing the defence mechanisms makes possible the "modification of the ego" (Freud, CP, 1937/1953, p. 342). Freud's language has shifted from 1917; then he spoke of libido whereas now he refers to the id and instinctual energy. However, the importance of a flexible ego for mental health is present throughout his writing. Similar ideas are articulated in *An Outline of Psycho-Analysis* (OP, 1940/1949).

Freud concludes this section by differentiating between theory and praxis. He says that to achieve mental health, resistances need to be addressed but that this task in not easily achieved in practice. It is interesting to note the repeated equivocation. Freud describes a quality of ego that should create the psychic conditions for mental health, but he concludes his discussion by expressing the difficult task of lowering defences.

Freud addresses the modification of the ego from a slightly different angle in *The Ego and the Id* (1923/1950). Here he states very explicitly that consciousness is not the essence of mental life (Freud, EI, 1923/1950). Rather, consciousness is only one property of mental life and the unconscious must be taken into account (EI, 1923/1950). For Freud, the unconscious is "latent and capable of becoming conscious" (Freud, 1923/1950, p. 11). A person's unconscious thoughts are made into repressions and are detected

as resistances through the work of analysis. In this work, Freud explains that the ego may control libidinal discharge but it also institutes repressions. Thus, there are parts of the ego which are also unconscious. Moreover, Freud indicates that, "the quality of being conscious or not is the single ray of light that penetrates the obscurity of depth psychology" (Freud, EI, 1923/1950, p. 11). In this quote there is the suggestion that becoming conscious (and what this may entail) is a criterion of mental health. This ties in with his thought in "Analytic Therapy" where he writes that the ego's task is to make conscious that which is repressed within the id (IP, 1917/1922).

Given what Freud has articulated in *The Ego and the Id*, becoming conscious is not only about making the unconscious more conscious but about making repressed parts of the ego more conscious. He says that something becomes preconscious by coming into connection with verbal images that correspond to it.[8]

Freud cites and agrees with Georg Groddeck who claims that we are lived by unknown and uncontrollable forces. Assenting, Freud suggests that the ego is essentially passive (Freud, EI, 1923/1950, p. 27). Most contents of the human being are unconscious, either through the id or repressed contents of the ego. He says that while the lower passions may take place in the unconscious, so do more so-called "high" functions take place unconsciously (EI, 1923/1950, p. 33). Higher faculties like criticism and conscience can also be unconscious and exert a very strong hold over people. In this description of how little surface area of the psyche is actually conscious, Freud argues forcefully for the importance of making unconscious parts of the psyche conscious. It is not possible to make everything conscious; rather, Freud seems to be pointing to an on-going process of linking unconscious and conscious parts of the person as an indicator of mental health. A person requires a flexible ego, one that is open to unconscious processes, in order to facilitate this dialogue between unconscious and conscious parts.

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[8] I would suggest that this line of expression in Freud leads to Bion's development of the capacity for a thinking kind of containment as a criteria for health.

In this section, I have referred to Freud's writings where he cites the modified ego as a criterion for mental health. The modified ego is not overly rigid; it is an ego that is open to exploring what it has repressed and is prepared to look at its defence mechanisms and unconscious processes. This type of modified ego can only form, says Freud, through a tenuous and carefully unfolding analysis. Often there is reference in psychoanalytic circles to ego strength, however Freud's writing gives as much attention to ego flexibility. This flexible, open quality of the ego is crucial for mental health and, in particular, for a person's capacity for efficiency in the world.

2.3.2. The Strengthening of the Ego

If the modification of the ego to become more flexible is one criterion for mental health, a strong ego is the second and equally fundamental requisite. A flexible ego is open to instinctual energy and its defence mechanisms are not overly rigid. A strong ego however has the strength to bind instinctual energy, to be used in life.

In his discussion on the necessity of a strong ego, Freud starts by referring to trauma cases (BPP, 1920/1950). In cases of trauma, Freud describes how the mental apparatus is flooded with stimuli and the task becomes one of mastering the stimuli. Freud says that a system that is "highly cathected" can take up this inflow of energy and bind it "psychically" (BPP, 1920/1950, p. 36). A "highly cathected" system is one where the ego is strong enough to take up and integrate instinctual energy from the id and direct it towards an object. The word "cathexis" suggests a connection to an object that is propelled by libidinal energy and therefore has a vitality to it. Freud identifies the ego as the only part of an individual that is able to direct libidinal energy by sending out cathexes to objects (Compton, 1981). In contrast, the id is the repository of instinctual energy and drives but it has no direct contact with the external world and therefore no capacity for cathexis (Compton, 1981). If a person has a high capacity for "cathexis" (BPP, 1920, p. 38) there seems to be a stronger capacity for this binding force. The lower the cathexis, the less capacity the

person has to bind this inflow of energy (Freud, BPP, 1920). Thus, a strong ego is needed to harness instinctual energy and bind it to the ego, rendering the energy of the id available for the person's conscious use. The stronger the ego, the more a person can tolerate the excitation that comes with trauma, suffering and frustration.

As Freud develops his theory he writes that stimuli coming through from the id will be felt by the ego as anxiety-inducing (BPP, 1920). This is because the the id contains all the passions and instinctual drives (Compton, 1981). In the id the pleasure principle reigns without restriction and there is an absence of reason or common sense (Compton, 1981).[9] Therefore the energy arising from the id will often be in conflict with the ego whose task is to mediate between the id and external reality. The anxiety arising when stimuli come up from the id is necessary for the ego in that an individual needs to experience anxiety in order to develop the capacity to tolerate anxiety (Freud, BPP, 1920/1950). This is vital for development as in mental health a person needs the capacities to tolerate anxiety. This relates to the child Freud refers to who develops ego mastery through inducing anxiety in a gradual effort to master his anxiety, in the game of "Fort-Da" or "Here-Gone" (BPP, 1920/1950). Human beings also dream about trauma and this is done, says Freud, in order for the individual to develop mastery over anxiety (BPP, 1920/1950).

An ego with a strong binding capacity is requisite for a human being to experience pleasure and live efficiently. Freud identifies primary process with a mobile cathexis, where the instinctual energy is still free flowing, unbound and situated in the id (BPP, 1920/1950). He relates secondary process to a bound cathexis, where the ego binds the energy for its own use (BPP, 1920/1950). The ego, seen by Freud as the higher stratum of mental

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[9] The pleasure principle is, along with the reality principle, one of the two principles of mental functioning for Freud (Lear, 2005). Lear (2005) explains that the pleasure principle aims at immediate discharge of tension which results in illusory gratification. The pleasure principle can exert a force over the reality-testing functions of the mind. It is governed by primary process. In contrast the reality principle seeks realistic manifestations of wishes and impulses. This involves tolerating delays, creating compromises and in general being more practical about one's goals than if the pleasure principle were to dominate (Lear, 2005). The reality principle is governed by secondary process.

apparatus, performs this binding function. Only once the binding has occurred can a person experience pleasure at an appropriate level of functioning and the dominance of the reality principle can occur. Thus it is of fundamental importance that a person is able to bind or "master" (Freud, BPP, 1920/1950, p. 44) excitations or instincts. Until this happens a person cannot be open to either pleasure (at the right level of experience) or efficiency. If a flexible ego opens up to the energy of the unconscious, a strong ego binds this energy for conscious use in play and productivity.

The neurotic's difficulties with deriving pleasure are linked to his weakened ego (BPP, 1920/1950). Freud explains that the strong ego is able to "bind the instinctual impulses which impinge on it, to replace the primary process prevailing in them by the secondary process and to convert their mobile cathectic energy into a predominantly quiescent cathexis" (BPP, 1920/1950, p. 86). What this means is that a person with a strong ego can harness and convert instinctual energy into energy at a more conscious level. This energy can then be used by the ego in a less anxiety-producing way. This binding, then, is actually all in service of the pleasure principle being experienced at a more conscious level through the ego. The neurotic cannot feel pleasure because the neurotic has not bound up the sexual energy with the ego. The energy comes through as unintegrated, primary process and feels overwhelming. The neurotic is, therefore, not able to derive pleasure from it.

Freud explains that in all people, some instincts can't be integrated into the ego and so are split off and retained at what Freud calls "lower levels of psychical development" (Freud, BPP, 1920/1950, p. 7). If they sneak through, what is meant to be pleasurable can feel to the ego as unpleasurable. This is neurotic pleasure; pleasure which cannot be felt as such. Hence, the ability to derive pleasure is an indication of an ego which is strong, which is able to bind libidinal energy and bring it in line with the reality principle (Freud, BPP, 1920/1950). Truly felt and enjoyed pleasure comes from instincts that have been integrated into a strong enough ego.

Thus, an ego that is both strong and flexible has the capacity to help a person live according to the reality principle and to experience pleasure at the right level of consciousness. Without an ego that is in right relationship to the instincts; that is without an ego that is open to instinctual energy (flexibility) and strong enough to bind this energy (strength), the experience of mental health remains elusive.

2.4. The Right Type of Superego as Necessary for Health

Until this point, we have considered the importance of a certain quality of ego in relation to instincts that is requisite for mental health. However, as Freud's thinking evolved, he developed the concept of the superego and this psychological structure becomes vital in a conceptualising of pathology and mental health. The superego arises in relation to the Oedipus Complex, when the child is between three and five years of age. It forms as the child identifies with and then internalises the external parent figures (Caper, 1988). In order to resolve Oedipus, the superego is experienced as "above" the ego and also as separate from one's "psychological being" (Caper, 1988, p. 100). When the external world becomes internalised in the form of the superego, the superego performs the function previously managed by the external world (Freud, OP, 1949/1940). Freud presents his argument as to why he believes a superego exists in the human psyche. He regards the superego as a mechanism that ensures the perpetuation of culture.[10] He writes that an ego without the limitations imposed by the superego, would have drives towards power, which would not be in the interests of civilisation: "The desire for a powerful, uninhibited ego may seem to us intelligible but…is in the profoundest sense hostile to civilisation" (OP, 1949/1940, p. 66). In fact, it is the very process of civilisation that does much to repress the ego and helps to form the superego. He adds an interesting comment, "It is easy, as we can see, for a barbarian to be healthy; for a civilised man the task is hard" (OP, 1949/1940, p. 66). Here

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[10] I refer to culture and civilisation more or less interchangeably in this chapter. Deriving a sense of these words from Freud's writings, culture and civilisation are considered as the perpetuation of norms and standards upheld by society collectively. Opposed to them is Freud's term barbarianism, which Freud considered as a descent into chaos and disorderliness in society.

Freud is addressing the notion that mental health has to occur within a social context and that repression is to some extent required by the civilisation in which we live (Freud, OP, 1949/1940).

Thus there is a tension between the evolution of the ego on the one hand, and the societal restrictions imposed on the ego on the other. Here he contrasts the role of the early ego and the later ego. The early ego needs to mediate between the id and the external world while the later ego's tasks become more complex as it has to mediate between the id and the superego (Freud, OP, 1949/1940). When a person has internalised social prohibitions in the form of the superego, then conscience or guilt develops (Freud, EI, 1950/1923). Freud noticed that sometimes a superego was overly harsh or severe. For example, he observed that the neurotic is held in thrall by guilt and lives with an excessively strong conscience (Freud, EI, 1950/1923). In addition, he noticed that this guilt was not about feeling remorse after a particular instance because of a crime committed but about a pervasive sense of ongoing guilt. This led Freud to explain neurosis not only in terms of a conflict between the id and the ego but as a conflict between the ego and an overly harsh or punitive superego (Caper, 1988). In addition, he observed that an overly harsh or critical superego was not always correlated to an individual's experience of strict or overbearing parents (Caper, 1988). Therefore, Freud suggested that it was the child's own aggressiveness towards the parents, alloyed with the child's perception of the parents that formed the superego (Caper, 1988). In Freud's structural theory it was the superego which became particularly associated with aggression (Compton, 1988). Hence Freud, (NIP, 1933) writes that in the case of an overly harsh superego, "There is no doubt that, when the super-ego was first instituted, in equipping that agency use was made of a piece of the child's aggressiveness towards his parents…and for that reason the severity of the super-ego need not simply correspond to the strictness of the upbringing" (p. 62). Thus mental health becomes about a particular quality of relationship among a tripartite psychological assemblage. This relationship is, in turn, informed by the characteristics of each of the three structures. The ego, as discussed, requires both flexibility and strength in order to manage the instinctual energy

of the id on the one hand and (now) the demands and restrictions of the superego on the other. In addition, the quality of superego should not be overly harsh or extremely critical.

When excessive guilt is present in a person because of an overly harsh superego, renunciation is used to get rid of the guilt (Freud, EI, 1950/1923). A person renounces instinctual wishes to avoid fear of punishment from outside. But renunciation is not sufficient, for a person continues to desire and the superego knows of this, and so guilt remains (Freud, EI, 1950/1923). Freud describes a pattern where renunciation gives rise to conscience, which then gives rise to further renunciations. This is not to say that any experience of guilt is detrimental to a person. In fact, the presence of some guilt is essential to mental health. Guilt contains within it both love and aggression (EI, 1950/1923). It is an expression of ambivalence, of the conflict between *Eros* and the death instinct. Guilt allows for life to continue and for people to relate to each other in a civilised way, but it also imposes restrictions on desire (EI, 1950/1923). Thus an excessive amount of guilt is an indicator of poor mental health. This quantitative factor of guilt, in turn, links to a particularly severe superego.

As Freud puts it, the superego inhibits the happiness of the ego. The superego does not understand that it is difficult for the ego simply to obey it; the superego does not grasp the force of instinctual craving (EI, 1950/1923). Thus one therapeutic goal is to moderate the demands of the superego (Freud, 1950/1923, EI, p. 139).[11] What seems to emerge as a pattern through Freud's thought is that a balance needs to be achieved between the id, ego and superego for mental health to be attained. He warns that the superego cannot be used to control the id by way of ignoring or repressing it. He writes, "This is an error even in so-called normal people, the power of controlling the id cannot be increased beyond certain limits" (Freud, 1950/1923, EI, p. 139).

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[11] A similar battle needs to be waged culturally to lessen the demands of the "cultural superego". The "cultural superego" presumes that the ego has "unlimited power over the id" (Freud, EI, 1929, p. 139). In describing a cultural superego, Freud refers to cultural norms or societal values that impose overly harsh restrictions on its members, creating a society that is overly controlled and regulated.

This helpful sentence refines the notion of what it means to have a strong ego. In mental health, the ego should not seek simply to rule the id or ignore the superego (the latter being an indicator of psychopathy). Indeed, this is not possible.

If things go well between ego and superego then there is a degree of harmony between them and they almost collaborate in terms of choices made in the world (Freud, EI, 1950/1923). But often the ego lives by the values and demands of the superego, feeling frightened of its punishment or hopeful for a reward if it feels it has done well (Freud, OP, 1949/1940). While there is often an emphasis on the ego's relationship to the instincts, with the discovery of the superego, Freud emphasises that the superego is another unconscious part of the personality that frightens and intimidates the ego.

Therefore the task of the ego becomes to relate to the id, the external world and the superego and, at the same time, to preserve its own integrity and unity (Freud, OP 1949/1940). If the ego is weakened, its tasks cannot be fulfilled and this inclines a person to pathology. The ego can be overwhelmed by the instincts as discussed in the earlier section on the modification of the ego. But, equally, the ego can become paralysed and inhibited by the relentless demands of the superego. The ego tries to "cling to reality in order to retain its normal state" (Freud, 1949/1940, OP, p. 50). If either the id or the superego alter the ego's organisation, it can lead to a loosening of the ego's hold on reality (Freud, OP, 1949/1940). This would be a substantial disturbance in mental health and could be the beginning of psychosis. The cure for Freud is "to give his ego back its mastery over lost provinces of his mental life" (OP, 1949/1940, p. 50). This would include being able to relate to, negotiate with and manage unconscious aspects of both the id and the superego.

At this juncture Freud refers to the neurotic and says that the neurosis is the type of pathology that responds best to analysis because the neurotic is able to maintain his functioning in real life (OP, 1949/1940, p. 50). Yet even though he is functioning, more or less, there is something about his internal life that is

not right: there is something about the neurotic ego's relationship with id and superego that is out of balance. Therefore the neurotic needs to be in analysis to reveal, as Freud puts it, not only what he knows but more importantly what he does not know so that the ego can gain knowledge of the unconscious (Freud, OP, 1949/1940).

Freud's comment that the neurotic may be functioning adequately externally but is struggling internally is instructive. As mentioned earlier, it seems Freud is more concerned with inner life than external functioning. He privileges the internal mental apparatus of a person over their external behaviour in his understanding of what it means to be mentally healthy. This is not to disregard external functioning, but to emphasise that external functioning alone is not an indicator of mental health. External functioning may reflect or misrepresent the internal dynamics of a person. Therefore it is more the internal psychological dynamics that are assessed as criteria for mental health in the Freudian paradigm.

This notion of privileging the internal over the external also leads to a valuing of thinking over acting. Freud emphasises the notion of remembering (thinking) as opposed to acting out[12]: "We think it most undesirable if the patient acts outside the transference instead of remembering" (Freud, OP,1949/1940). In analysis, the first step is to strengthen the ego's self-knowledge so that it can better handle the onslaught from the id and the superego (Freud, OP, 1949/1940). This self-knowledge allows the ego to think and remember instead of acting out unconsciously.

As Freud's theory develops, the notion of the healthy Freudian individual becomes rich with meaning. The characteristics of ego, id and superego are vital in an achievement of mental health but the relationships among the three components of the personality are equally important. The ego requires the capacity to be flexible to unknown, unconscious contents, but also the

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[12] Acting out is a specific term used to denote an action that an individual takes that expresses in its action what has not yet been thought about consciously. When the action can be thought about consciously and understood in terms of what it means, the compulsion to act out can be managed.

capacity to bind these contents and raise them from primary to secondary process. The ego needs to be a container which is both flexible and firm, not rigidly repressive, nor porously open. It needs to be able to do this so that it can think instead of acting out or behaving impulsively. The ego needs to be willing to become enlarged, that is, it needs to be able to explore and include contents from the id and the superego. The superego must not be overly harsh and critical and this in turn links to a person's aggression, while the instinctual energy from the id should not be overly excessive or overwhelming. Moreover, there is an indication that an ongoing internal dialogue between the ego, the id and the superego, within and then beyond an analysis, would be a good understanding of mental health. Therefore the assertion that the ego should be master of the house is not a simple notion of an ego that strictly controls the other domains of the personality. Instead, the healthy Freudian ego needs to be able to relate internally to id and superego, and externally, to other people and its life's tasks. This internal composite enables a life of pleasure and efficiency.

2.5. Eros and Thanatos: the Life and Death Instincts

Freud's suggestion that mental health be measured by one's ability to receive pleasure and be effective requires a tenuous balance of psychological organisation as has been described thus far. Living with pleasure and efficiency is an indication of not only a healthy relationship among id, ego and supergo, but also of a mix of both "good" and "bad" within the person. Although we have come to associate notions of good and bad, love and hate with Melanie Klein, her theory was grounded in Freud's dual instinct theory. In *Beyond the Pleasure Principle* (BPP, 1920/1950), Freud postulates that there are not only sexual instincts in a person but also a death drive. The death drive evolved, in part, from Freud's work on the superego where he theorised that the fantasy of internally terrifying parents represented a child's aggressive impulses (Caper, 1988). He also based this thesis on the repetition compulsion (BPP, 1920/1950). Freud writes that in children, both the compulsion to repeat and playfulness are linked and are pleasurable

(BPP, 1920/1950).[13] The instinctual compulsion to repeat occurs in play and in the transference work in therapy, but in analysis repetition is antithetical to the pleasure principle in every way. For the patient, the repressed memory trace is not bound and so will not obey the secondary process. As has been described in the section on the ego, this means that because the memory is repressed and unconscious it exerts a force over the ego which leads the ego into a repetition compulsion. Like other unbound energies in the id, the ego has not integrated or bound the memory trace. Hence the unbound instinct can have a conservative nature, propelling not towards life and change but towards entropy. This leads Freud to posit that there is a group of instincts in the human being which tend towards an earlier state of things and move towards death. He calls this the death drive or referring to Greek mythology, *Thanathos* (BPP, 1920/1950). The word "death" in this context is complex and has led to much debate among Freudian scholars (Caper, 1988). At times Freud referred to an "aggressive drive" and at other times a "death drive". Some scholars prefer to reduce his assertion of the death drive to a description of human aggression. However Caper (1988) suggests that in Freud's use of the word "death drive" he was referring to a pernicious force, one which was fundamentally "antisexual and antiself-preservative, destructive of that on which life depends, and ultimately of life itself" (Caper, 1988, p. 114). Lear (2005) situates the death drive as part of Freud's later thought and defines it as "a basic tendency toward decomposition and death" (p. 253). It is used by Freud to "explain aggression as the (temporary) deflection outwards of this internal tendency to fall apart" (Lear, 2005, p. 253).

Opposing these instincts are the sexual instincts. Freud calls them "the true life instincts" or *Eros* (BPP 1920/1950, p. 53). Lear (2005) defines *Eros* as "a basic force for life, love and development" that "seeks the formation of greater differentiated unities" (p. 254). Existing in opposition to the death drive, Freud uses the sexual instincts to explain the human propulsion towards "development, differentiation and integration" (Lear, 2005, p. 254).

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[13] In the case of a child it is linked to mastery over a traumatic experience; they have more chance of this mastery by being active as opposed to passive. For a child the repetition compulsion and pleasure are intimately linked in play.

Hence there are two groups of instincts at odds with each other. One group rushes towards death and another group seeks to prolong life. A mentally healthy person must be able to employ his life instincts strengthening his capacity for *Eros* all the time. A person requires strong sexual instincts, which are well bound to the ego, in order to express love in the world (BPP, 1920/1950).

However Freud explains that the healthy expression of *Eros* is never unalloyed (BPP, 1920/1950). Rather, *Eros* is mixed up with the death instinct (BPP, 1920/1950). Paradoxically, it is not simply the presence of strong sexual instincts but rather the mix of love and death instincts (what Freud and later Klein call a state of ambivalence) that becomes a crucial indicator of mental health (BPP, 1920/1950). Freud suggests that if nothing has gone wrong in a person's development, or when the original sadism of a person has not been mitigated, we find "the familiar ambivalence of love and hate in erotic life" (BPP, 1920/1950, p. 74).

Freud uses this discussion of the life and death instincts in order to elaborate on the necessity of healthy sexual expression. He refers to sadism and masochism as instances where libidinal energy has regressed and gone beyond the parameters of the ego (BPP, 1920/1950). In these instances, a person cannot harness their libidinal energy for object love in a healthy way, they can only express it sadistically or masochistically. Through this discussion, Freud speaks about how conjugation and sexual union are vital for the individual (BPP, 1920/1950). When a person seeks union with living substance, intercourse with a human being, a tension is produced which produces "vital differences or potential" (Freud, BPP, 1920/1950, p. 76). In other words, in the act of sex, one experiences the capacity to mitigate the influence of the death drive. Here he expands and says that the dominating principle of mental life and perhaps of nervous life in general is the effort to reduce, to keep constant or to remove internal tension due to stimuli (BPP, 1920/1950). This leads to a person seeking the pleasure principle in order to alleviate tension (BPP, 1920/1950). Were the death instincts to be employed

without the counter-force of the life instincts, then the death instincts would alleviate tension altogether. Thus, the ultimate ability to derive pleasure is about the ability to express oneself sexually with another (BPP,1920/1950). This explains why Lear (2005) argues that Freud ultimately saw the human being as essentially erotic.

As Freud elucidates his theory, it becomes clearer why sexual expression would be an indicator of mental health. A person's ability to express himself sexually indicates that there is a proper mix of life and death instincts that have been harnessed and bound by the ego. Thus a full expression of sexuality indicates that a person is able to derive pleasure at the right level of consciousness, at the level of ego. This relates to a comment mentioned earlier in the chapter, that a mentally healthy person needs to be capable of enjoyment and efficiency. For Freud, a significant indicator of the capacity for enjoyment is sexual expression but it would be reductive to claim that Freud posits sexual expression alone as an indicator of mental health. As with his understanding of mental health in general, each of Freud's descriptors are articulated at particular levels, but each descriptor is indicative of further capacities and layers within the mentally healthy person. In *Beyond the Pleasure Principle* (BPP, 1920/1950), Freud draws on the myth of Aristophanes to point to the primacy of the sexual instincts. Yet in his linking mental health to the myth of Aristophanes, which is not only a story about sex but also about love and relationship, he creates a link between sexual instincts and relating to the other or the capacity for object love. This capacity for love is the higher category, which emerges from Freudian notions of "enjoyment" and "sexual expression". For Freud, the capacity to love another seems to be an overarching signifier for mental health.

In *Beyond the Pleasure Principle* (BPP, 1920/1950) the importance of a strong yet flexible ego is linked to a person's capacity to derive pleasure, specifically sexual pleasure. The necessity of a balance of both the life and death instincts within the ego is articulated as paramount in order to experience *Eros*. Therefore *Eros* is not a simple, sweet and unadulterated love. It is a complex interaction of relatedness and aggression that creates

mental health. Yet Freud concludes by saying that there is not a great difference between the neurotic and the so-called normal person. He has identified certain criteria for the mentally healthy person but he also seems to imply that though we may aspire towards these conditions we are never free of neurotic constraints.

2. 6. *Civilisation and its Discontents*: The Human Being's Capacity to Withstand Uncertainty and Suffering

Thus far, particular qualities and a balance of relationship have been elucidated among the id, ego and superego as necessary for mental health. These qualities, in turn, enable a person to live with pleasure and efficiency. Drawing on his more philosophical writing in *Civilisation and its Discontents* (1929) Freud refers to the human being's capacity for withstanding uncertainty and suffering as indicators of a certain quality of mental health. He also refers to *Eros* and *Ananke*, love and necessity (the latter often linked to work) as the two fundamental qualities of being human. In *Civilisation and its Discontents*, he discusses different ways to express *Eros* and he points out that, ultimately, a full expression of *Eros* is also limited by the norms and rules of civilisation. Therefore the understanding of mental health becomes further refined; it is not about a person being able to express *Eros* in all its fullness. Rather, mental health becomes about managing the disappointment of failed or restricted expressions of *Eros* because of civilisation's normative limits. This links back to the central premise of *Civilisation and its Discontents*, that mental health is about managing suffering and confronting the human condition and the limits of happiness.

Freud argues that in order to manage uncertainty, many people live under illusions or in regressed states (CD, 1929). He compares a religious person's belief in G-d to a child's sense that he is being watched by a benevolent father. He describes this kind of religious belief as "infantile" and "incongruous with reality" (CD, 1929, p. 23). Instead of retreating from reality, facing reality with all its accompanying goodness and suffering is an indication of mental health. Freud argues that religion is really a response to suffering that protects

people from reality. He speaks about how all human beings struggle with the vicissitudes of life, but that we respond to suffering in different ways. Instead of facing the suffering of life, we divert ourselves, substituting the pain with gratification, turning to drugs or turning to religion (CD, 1929).

Freud says that people seek meaning as this is linked to being happy, eliminating pain and experiencing pleasure (CD, 1929). Religion is concerned with giving purpose and meaning to life. However, it is not easy to be happy and to remain in pleasure states. Freud suggests that suffering is inevitable; we suffer through our own body, from experiences in the world and from our human interactions (CD, 1929). In his discussion of what occasions happiness and lessens suffering he says that it helps when the instincts are kept in check and not given free reign. However, this state of repression is not ideal because it also brings with it a reduction in actual pleasure. He then refers back to religion and explains that religion imposes certain restrictions in order to ward off imagined punishments (CD, 1929). Thus religion is an attempt to avoid the inevitable sufferings of life (Freud, CD, 1929). The use of phantasy or illusion (religion being an example of illusion) is another method people use in order to avoid suffering (Freud, CD, 1929).

Another, and for Freud, more laudable way in which people avoid suffering is through sublimation. Sublimation, a defence mechanism, occurs when a person is able to obtain pleasure from mental and intellectual work and transmute their instincts into higher wishes (CD, 1929). This refers back to the notion that mental health requires the ability to raise the instincts, something that begins when the id impulses are bound by the ego. For Freud sublimation is a "higher and finer" defence mechanism (Freud, CD, 1929, p. 33). Through sublimation a person seeks to become happy through the inner workings of the mind and is no longer dependent on external factors (Freud, CD, 1929). Lear (2005) explains that for Freud all artistic, scientific and philosophical endeavours are manifestations of sublimation.

These "higher and finer" (Freud, CD, 1929, p. 33) ways to manage suffering refer to an ego capacity that can transform and bind instinctual energy. If a

person is unable to do this, he will retreat into pathological ways of managing suffering, including addiction and psychosis (Freud, CD, 1929). In this discussion Freud seems to be hierarchising different ways to manage suffering, starting with religion, addiction and drugs, and moving into "healthy" forms of sublimation. He now mentions a further way to avoid suffering as one which embraces happiness and pain through the willingness to love. He says that love is an embrace of both happiness and pain because, on the one hand, sexual love gives us an intense experience of overwhelming pleasure, but at the same time, when we are in love, we are most vulnerable to being hurt and suffering (CD, 1929).

It is at this point that Freud elaborates on using love in order to manage the inevitable suffering of life. He makes the claim that essentially human life is based on two foundations, the necessity to love and to work. In this comment, he refers to the Greek terms *Eros* and *Ananke* (Freud, CD, 1929, p. 68). *Eros* and *Ananke* hark back to the language of enjoyment and efficiency which are discussed throughout this chapter. In *Civilisation and its Discontents* Freud elaborates on the different ways to love or express *Eros*. While *Eros* evolves from the experience of genital sexual satisfaction, it has become an indication of overall satisfaction and happiness (CD, 1929). He writes that at first a person becomes dependent on the love from his chosen love-object, thus depending on the outside world. This dependence may cause him suffering as it makes him vulnerable to rejection or loss. This type of person is focused on receiving love. On a higher level, Freud refers to some people who are more concerned with giving love than receiving love. They derive happiness not from being loved but from loving (CD, 1929). In this way they avoid uncertainties and disappointment, so the sexual instinct becomes more inhibited. He writes about how Saint Francis of Assisi may have used this method of love, which is not like its superficial genital counterpart, although it stems from it (CD, 1929). A third level of loving is for Freud about an ethical way of being in the world. He says that there is a way to love which is "an all-embracing love of others and of the world at large" (Freud, 1929, p. 70). He expands that this "is regarded as the highest state of mind of which man is capable" (Freud, 1929, p. 70). From this discussion it

seems that Freud is distinguishing between two different approaches to the suffering of life; the one approach is to try and avoid or escape suffering, the other approach (expressed through sublimation, the arts and love) is to transform suffering.

While *Eros* is one of the two fundamental indicators of mental health, Freud comments that the full, unadulterated capacity to love is interrupted and inhibited by the restrictions of culture and civilisation (Freud, CD, 1929). Firstly, the family demands that the child leave the home in order to evolve. This shakes the bonds between child and family and shows the clash between love and culture. Indeed, the impositions of Oedipus and the acceptance of the incest taboo are arguably the child's first experiences that love (and hate) in their full expression must be reigned in (Lear, 2005). Freud adds that there is a limited amount of libido and men take their libidinal energy to work, depriving women of it (Freud, CD, 1929, p. 73). Women are thus forced into the background because of cultural norms. There is also the fact that culture sets restrictions on sexual life, establishing heterosexuality as normal and imposing practices like monogamy. Culture makes it very difficult simply to love freely (Freud, CD, 1929). Freud cites a story called "The Apple Tree" (Freud, CD, 1929, p. 77) which explores how simple natural love between human beings is impossible in today's society. This connects to a comment he makes in *An Outline of Psychoanalysis* (1949/1940); that mental health is easy for the "barbarian" and more complex for the civilised man. So his simple idiom, to love and to work, *Eros* and *Ananke*, is not easily achieved. Mental Health remains a process. While the capacity to love is an indicator of mental health, a further indicator of mental health is to manage the disappointments that come with love lost or love restricted. The human being yearns to unfold and express itself in a certain way and needs to manage with the limitations imposed by society. Perhaps Freud is indicating that health is about managing a constant dialectic between the capacities for *Eros* and aggression and the restrictions imposed by civilisation. Mental Health is neither about surrendering to the restrictions of civilisation, nor about capitulating to the whims of uninhibitedness, but in managing the tension between the two.

In this fascinating discussion on the human's achievement of happiness, it is clear that Freud values some paths to happiness over others. He speaks about sublimation as the raising of the instincts and the capacity to transform an id impulse into a more refined and more subtle manifestation (CD, 1929). Freud does not explicitly hierarchise the different ways to achieve happiness and pleasure. But a close reading of his text suggests that he values sublimation and the human's capacity to love as well as aesthetic and intellectual pursuits, as ways to achieve happiness and alleviate suffering. He considers the use of narcotics and drugs as a poor, even pathological way to achieve happiness, and religion seems to be an illusory way to manage suffering. Crucially, for Freud, religion compromises one's intelligence and veils the reality of human suffering. Freud's writing in this text points to different levels of mental health. He understands that not everyone can sublimate their instincts in the same way and that not everyone has available to them aesthetic and contemplative means of developing happiness. Still, the capacity to transform the instincts and to be uncompromised in one's intelligence and unflinching in confronting reality, seem to be indicators of a high level of mental health for Freud. We have come a long way from the simple alleviation of the symptom. We are now talking about "higher and finer" (CD, 1929, p. 33) capacities of the human being which may be indicators of superior levels of mental health. These higher capacities allow a person to make meaning out of suffering.

The inevitability of suffering also relates to ambivalence, and the human's need to accept that neither humanity nor life is all good. Freud makes a comment that those who love fairy tales do not like the assertion that there are innate tendencies in mankind towards aggression, destruction and cruelty (CD, 1929). In this comment, he reinforces his point that something of facing reality, and not opting for illusions is part of a robust mental health. So aggression is an innate tendency in man and is the greatest opposition to culture. Culture is the work of a sublimated *Eros*, which aims at binding together individuals, families, tribes, communities while the in-built instinct of aggression opposes the project of civilisation (Freud, CD, 1929). Culture, for

Freud, is essentially a struggle between *Eros* and death (Freud, 1929, p. 103). This notion echoes the internal psychic struggle Freud refers to in *Beyond the Pleasure Principle* (1920/1950) between the life and death drives. Neither one triumphs over the other. Rather there is a constant interaction and struggle between the two forces, in the individual and in society. Living with the two is about living with what Freud describes as ambivalence. It seems to be an indicator of mental health that a person can live with this ambivalence, using neither repression, nor addiction, nor religion, nor psychosis as a way to avoid the reality of happiness that is intermingled with suffering (Freud, CD, 1929).

Freud then explains that guilt is the inner human experience of the conflict between love and hate, expressed at the macro level between *Eros* and the death drive (CD, 1929). Living with guilt (described earlier as inevitable and to some degree, important for mental health), the human being does forfeit some happiness in order to participate in civilisation. We are often aware of our own remorse but this is not what Freud is referring to when he speaks of a sense of guilt (Freud, CD, 1929, p. 124). In some maladies like obsessional neurosis, a person's guilt is felt very clearly. But in most other forms it is unconscious but its effect remains great. An "unconscious sense of guilt" (Freud, CD, 1929, p. 125) is inevitable and accompanied by an unconscious seeking of punishment. Freud says that guilt is a form of anxiety and that anxiety is hidden behind most symptoms. Religion promises to relieve people of this sense of guilt, which it calls sin. Freud seems to suggest we need to become conscious of our guilt and not try to escape it. Being able to bear a certain amount of guilt in a conscious way is suggestive that a person is managing his instinctual drives in relation to the external world and is a measure of mental health.

Civilisation and its Discontents finds Freud in a more existential mode where he can be likened to Sartre or even Schopenhauer in their adages that suffering is the meaning of life; that there is no escaping it. Freud's discussion on guilt leads him to consider anxiety and states of uncertainty and ambivalence. He seems to be saying that one cannot escape the essential anxiety of living. Freud concludes *Civilisation and his Discontents* by saying

that he has no consolation to offer people who want to know what needs to be done in order to preserve or improve civilisation. He says, "I bow to their reproach that I have no consolation to offer them" (CD, 1929, p. 143). Here his writing, not offering easy answers or false comforts, mirrors his ideas on the capacity to withstand anxiety, uncertainty and ambivalence. He speaks about the inevitability of suffering that accompanies the civilising of the human being (CD, 1929). He does not seek illusions and denies the role of the prophet who comes with the easy answers (Freud, CD, 1929). But at the end of this book, Freud asserts that he does believe in the force of goodness. He says we are at a moment where the aggressive instinct may destroy us all.[14] But he comments that as a society, we need to employ *Eros* to fight against the aggressive instinct.

2. 7. Conclusion

From these central texts in Freud's *oevre*, certain themes for the understanding of mental health are established. There is the centrality of a certain type of ego in relation to an id and superego that are functional but not overbearing. There is the ego's capacity to think and not simply act, its capacity to bear guilt and anxiety and not retreat, its capacity to hold an ongoing tension between *Eros* and the death drive. Freud's writing on mental health is inextricably linked to his emergent description of the psyche. It is linked to notions such as ego, id, superego, conscious and unconscious, the pleasure and the reality principles as well as primary and secondary process. Expressed at another level, however, one could grasp the essence of Freud's notion of health as the capacities for *Eros* and *Ananke*, for enjoyment and efficiency, as the capacity for love, the ability to accept and tolerate ambivalence, uncertainty and the co-existence of good and bad, and an ability to think. In that case, the detailed descriptions of the ego, the instincts and the superego would be a mere elaboration of the conditions that are necessary for the above to occur in the individual. Regardless, Freud's writing is permeated with a questioning doubt and self-reflexivity. He constantly refers to the

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[14] Given that he wrote this in 1929 in Europe adds a historical poignancy to this comment.

difficulties in the achievement of mental health. There is a strong sense that normalcy is an illusion and to be utterly symptom free is a vain quest. At the end of it all, it seems that we are left with the importance of an ongoing dialogue between conscious and unconscious, and between the life and death drive. The capacity of an ego to serve as a portal for these dialogues would then become a distilled definition of mental health for Freud!

All of Freud's notions become developed and refined further by the thinkers who succeed him. Each psychoanalytic theorist takes up a slightly different angle and articulates notions of mental health in different ways, with diverse emphases. Klein develops Freud's notions of ambivalence in her depressive position, Bion takes Freud's comments about thinking and develops a thesis about a particular type of thought that is necessary for health, Winnicott explores among other things, the role of culture in the healthy individual. However, all of them, from Klein through to Bion and Winnicott, contain traces of Freud's original metaphors concerning the psyche and its capacities for mental health.

2.8. Key for Freudian Texts:
BPP: Beyond the Pleasure Principle
CP: Collected Papers, Volume 5
CD: Civilisation and its Discontents
EI: The Ego and the Id
IP: Introductory Lectures on Psychoanalysis: A Course on Twenty-Eight Lectures Delivered at the University of Vienna.
NIP: New Introductory Lectures On Psycho-Analysis
OP: An Outline of Psychoanalysis

3. MELANIE KLEIN AND THE FOREGROUNDING OF AFFECTS

3.1. Introduction

In a letter to Hinshelwood, commenting on the differences among the various schools of psychoanalysis, Sandler writes, "What I find so interesting in your paper is that it illustrates so clearly the difficulty we have in our society to understand each other because different groups use the same terms to indicate very different concepts" (cited in Hinshelwood, 1997, p. 884). Sandler's comment is well illustrated in the elucidation of Klein's theory. While Klein's writing seems to emphasise the continuities between herself and Freud by employing his language, a closer analysis reveals that she uses Freudian terminology in different ways (Stein, 1990). The shift from Freud to Klein is filled with discontinuities sometimes appearing as continuities as Freud's terminologies acquire a life of their own in the Kleinian lexicon. As Klein starts to form a new language to describe her theory around the paranoid-schizoid and depressive positions[15], her shift from Freud becomes starker.

The shifts in articulation from Freud to Klein come to inform nuanced and varied understandings of what it means to be mentally healthy. Klein's psychoanalytic language becomes important in her understanding of mental health. At the outset of this chapter, let me suggest that for Klein, mental health is about developing the capacities and qualities to live in the depressive position. The thrust of this chapter attempts to address the question; "what does it signify to be in the depressive position?" Following the work of Ruth Stein (1990), I wish to argue that the experience of the depressive position is fundamentally about the ability to feel affect. This

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[15] Klein used the terms position in the thirties but her notion of psychological positions emerged as something more concrete in her essay *The Psychogenesis of Manic-Depressive States* (PMD, 1950). Where Freud is more structural, Klein's positions become more developmental. A position is an "always available state" (Mitchell, 1986, p. 116), not something one passes through. This notion, that a position is never completely finished, is important to bear in mind in Klein's material. In this chapter I refer to the infant's struggle through these "positions". However, I write with an understanding that these positions are states that people return to throughout their lives.

comes from Ruth Stein's claim (1990) that Klein's work is essentially about affects; what she calls the "implicit Kleinian theory of feelings" (p. 500). Working with Stein's theory I argue that mental health for Klein is essentially about the ability to feel affects fully. The conditions and processes that allow for the full feeling of affects become the preconditions and indicators of mental health.

The aforementioned claim is supported by a short and to-the-point article *On the Criteria for the Termination of a Psycho-Analysis* (1950), where Klein states that mental health is about a person's ability to tolerate two types of anxieties (persecutory and depressive respectively) and the feelings accompanying these anxieties (TA, 1950). She explains that each anxiety is experienced in one of two psychological positions, the paranoid-schizoid and depressive positions respectively (TA, 1950).[16] While mental health can be identified as the capacity to experience feelings and anxieties stemming from both positions, Klein explains that persecutory anxiety must diminish before depressive anxieties and feelings can emerge. That persecutory anxiety must diminish before depressive anxiety can be experienced implies a directional movement from the paranoid-schizoid to the depressive position even if the person does not remain fixed in the depressive position. Therefore, in essence, working through the depressive position becomes the salient indicator of mental health (PMD, 1935; Stein, 1990).

Broadly speaking, the paranoid-schizoid and depressive positions are best identified as contrasting clusters of phenomena including differing ego states, internal object relations, types and intensities of anxieties, as well as differing defences (Stein, 1990). But more than that, Stein (1990) suggests that the two positions are built around contrasting affective structures and adds that the two positions can best be delineated as two different ways in which the ego can tolerate and handle unpleasant feelings.

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[16] In Klein's writing she mostly refers to psychological stages as experienced by the infant. Yet her writing on infancy can be applied to adults at different stages of psychological development and in different states of anxiety. Therefore in this chapter, I will be referring to persons and not infants in my exploration of Klein's views on mental health.

3.2. The Developmental Importance of Persecutory Anxiety in the Unfolding of Mental Health

Persecutory anxiety emerges in the first few months of life in the paranoid-schizoid position and is experienced both externally and internally (Klein, TA, 1950). Externally, from the moment of birth the infant experiences the birth process as a form of attack while internally, the death drive is felt to be an annihilation of the self.[17] Persecutory anxiety is anxiety that is felt to be threatening to the ego and can lead in its extreme form to a sense of disintegration. (TA, 1950). The threat is perceived as stemming both from the ego's own internal sadism and from the object which it has attacked (SF, 1930). This fear of being attacked is the paranoid aspect of the paranoid-schizoid position. The schizoid aspect emerges because the ego defends against and denies persecutory anxiety using primitive defences such as splitting its objects starkly into good and bad, persecutory and idealised, and projecting these qualities of the ego onto its objects such that the object becomes "infused with exclusively good or exclusively bad feelings" (Stein 1990, p, 505).

This notion of projection is developed in Klein's work into projective identification. Projective identification is a mechanism (unconsciously) employed by a person in order to cope with the intensity of persecutory anxiety and regain an illusory sense of control and omnipotence. According to *Hinshelwood's Dictionary of Kleinian Thought*, projective identification occurs when part of the self is attributed to the object: "Thus part of the ego - a mental state, for instance, such as unwelcome anger, hatred or other bad feeling - is seen in another person and quite disowned (denied)" (Hinshelwood, 1991 p. 397). Moreover, in locating this part of the self in the

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[17] Freud's notion of the death drive was more passive and quiescent in a person while Klein's death drive, in accordance with her increased emphasis on aggression is understood as a more active hatred of life and relatedness.

other, the ego believes it can manipulate these parts in phantasy [18] (Hinshelwood, 1991). As Stein puts it, in projective identification the self shifts "ego and object boundaries, so as to realign the parts of self and object which contain the good and bad feelings" (1990, p. 505). Projective identification is a defence mechanism that is used in different ways in different stages of development. When a person is overwhelmed with persecutory anxiety, projective identification is used concretely - the other is seen literally to contain parts of the self. Caper (1997) cites Segal who writes that the psychotic's projections (and the psychotic aspects of healthy people) function so as to collapse the distinction between self and object in a literal sense. The mechanism of projective identification, when used concretely, can enact and reinforce splits in one's personality; impeding the process of integration necessary for mental health. When a person uses the delusion of projective identification in this way, it is an indicator that the anxiety and feelings of the paranoid-schizoid position are intolerable to the person.

On the other hand, Klein indicates that projective identification can be the infant's first step towards relating to the external world (cited in Stein, 1990) and is a person's first experience of empathy in that it relaxes the boundaries between self and other allowing for emotional connections to take place (Segal, 1988). In addition, projective identification provides the basis for the development of the symbolic function (Segal, 1988). This is because when a person projects part of the self into objects and when a person identifies parts of the object with the self, the earliest, most primitive forms of symbols are developed (Segal, 1988). Thus, projective identification can be a delusional conviction, concretised so that the distinction between inner and outer reality no longer holds, or it can become part of experimental play (Caper, 1997). The way in which projective identification is used by a person conveys a

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[18] Klein's notion of phantasy is not directly related to this research. However, some mention of this important Kleinian concept is required. "Unconscious phantasies underlie early mental process, and accompany all mental activity'" (Hinshelwood, 1991, p. 32). Klein saw that after interpretations in analysis, phantasy production tended to increase. She saw this release of phantasy and the analysand's relaxing vis a vis the analyst as important therapeutic indicators (Hinshelwood, 1991). Hence, a release of phantasy was accepted by Klein as an indication of a healthily functioning mind (Hinshelwood, 1991).

sense of how he can manage the intensity of his feelings, most notably anxiety, and therefore indicates the state of a person's mental health.

Developing capacities to first defend against (using splitting, projective identification etc.) and then tolerate the early and at first overwhelming anxiety of the paranoid-schizoid position facilitate the development of symbolic functioning (Klein, SF, 1930). Klein's well-known patient, Dick, is described as being unable to develop symbolic functioning because of his incapacity to handle anxiety (Klein, SF, 1930, p .101). Indeed, Stein suggests that for Klein, anxiety is a precondition of mental development and not simply "an inhibitor of capacities" (1990, p. 501). Caper (1999) expounds on the adaptive nature of persecutory anxiety and suggests that anxiety assists in symbol formation because the anxiety a person feels towards the original object because of the aggression it has projected onto the object pushes the person away from an exclusive relationship with that object towards new objects. This ushers in the beginnings of substitution and symbolism.

If the capacity to symbolise is suggestive of the fact that persecutory anxiety can be tolerated, the symbolic function is also an indication of mental health and a prerequisite for higher order functioning (Klein, SF, 1930). Symbolic thinking is linked with the development of healthy object relations, normal development and creativity (Caper, 1999). From symbolism emerges the subject's relation to the whole world and to reality in general. Symbolic thinking relies on a person's being able to preserve a distinction between the symbol and what is symbolised (Caper, 1999). This faculty of discrimination enables the symbolic function (Segal, 1988). In addition, this capacity to make distinctions is tied up with establishing healthy processes of projection and introjection which require a certain playful and experimental link as opposed to a concretised and/or collapsed connection between objects and self. As Caper (1999) writes, "normal play, a normal sexual life and normal intellectual functioning all require a capacity for a certain type of playful or experimental projective and introjective link with one's objects" (p. 85). If a person cannot allow projective and introjective processes to occur in a playful and experimental way, in a way that is symbolic and not concrete, a person will

equate his projections with a sense that he has actually altered another object's state of mind and will feel that an external object's state of mind can invade, alter and control him (as with introjective identification). Thus splitting and projective identification (as defences against persecutory anxiety) can be transformed and used in the development of the symbolic function. It is interesting that symbolic functioning emerges at the same time that projective identification is being used as a defence: the emergence of symbolic functioning can help shift the quality of projective identification from a concretized to a symbolic interaction, á la Caper, while the experiences of projective identification assist in the development of the symbolic function á la Segal.

Symbolic functioning also allows a person to establish a true relation to reality (SF, 1930). As Klein's patient Dick develops the capacity to tolerate his anxiety and develop symbolic functioning, his capacity for object-relationships unfolds. The object-relation is described as Dick's being able to show affection to people, to show an attachment to these people, to desire their presence and feel distressed when they leave (Klein, SF, 1930). He also develops a desire to make his internal world known and understood to others. As Dick heals through his therapy, his relation to reality becomes established (1930, p. 106). Klein comments that a sign of health is thus "an increasingly firm relation to objects in general" (Klein, SF, 1930, p. 106). Thus, the paranoid-schizoid position is a period of psychological development where a person can learn to tolerate paranoid feelings and where the defence of splitting can be developed into a tool for discrimination (discussed further in this chapter). This period can usher in two crucial and interlinked developmental capacities; symbolic functioning and an experimental type of projective identification. The abilities to distinguish between self and other and between symbol and what is symbolised become essential building blocks for higher levels of functioning that develop in the depressive position. The ways in which early, persecutory anxiety is modulated foreground the unfolding of mental health for an individual.

3.3. The Depressive Position and its Centrality for Mental Health

The tolerating of persecutory anxiety assists in the development of the symbolic function which is important for mental health and the unfolding of object-relations. Yet, the ability to bear and work through depressive anxiety is the crucial indicator of mental health for an individual. The depressive position sees a shift in a person as the ego and object relations become more whole and one becomes able to hold an amalgam of feelings which differ in quality and intensity from the paranoid-schizoid position (Stein, 1990). The feelings that arise in the depressive position are the ability to mourn and feel guilt on the one hand, and to feel concern, feelings of reparation and love on the other. But these feelings emerge because the earlier split- off feelings of hate, aggression and envy are now made more conscious and integrated.

Whereas Freud considered mental health to inhere in what we do with our sexuality, Klein regarded what we do with our aggression as a more important index measure of mental health. If persecutory anxiety is experienced as a threat to the ego, depressive anxiety occurs because of perceived harm caused to one's loved object due to a growing awareness of one's own aggression (TA, 1950). In healthy development, the ego starts to strengthen and can contain different, even oppositional, feelings and experiences that were felt to be intolerable in the paranoid-schizoid position. As a result the defensive splitting and projective identifications of the paranoid-schizoid position start to lessen. First, the ego has to introject the whole object (and not split off bits) and establish a better relationship to the external world and real people. Once it does this, the person is able to see the other as other and recognise its own sadism (Klein, PMD, 1935). The ego's sadism is the person's innate capacity for aggression, cruelty and hatred. Klein's work describes aggression and cruelty as psychological givens; active forces in a person that have an effect on himself and his objects (PMD, 1935). In infancy and in states of poor mental health, these aspects are very split off in a person, even denied. However denial does not eliminate these aspects. They simply emerge in the unconscious, in harmful ways to the person and his/her objects. Therefore, for mental health, a person needs to consciously confront

and then painstakingly integrate his capacities to harm. It seems that only this type of full acceptance of the self and one's feelings can lead to true mourning, self and object love and a working through of the depressive position.

According to Stein (1990), the core of Klein's theory revolves around the inner movements in a person between hate and love. These two overarching affects manifest differently at different points and in different degrees in a person's development. Envy (an aspect of hatred) and its opposing pole of gratitude (an aspect of love) are two core emotions that are present from early on but may emerge into consciousness and be acknowledged through a working through of the depressive position. For Klein, envy emerges very early in development but is defended against in the paranoid-schizoid position using omnipotence, denial, splitting and idealisation (Hinshelwood, 1991). As Hinshelwood puts it, envy is "an attack on the sources of life, on the good object, not on the bad object" (1991, p. 167). Envy is held to be innate in origin (like hatred) and part of the instinctual endowment (EG, 1956; Hinshelwood, 1991). While jealousy involves at least two people and is concerned with a person gaining love which the person feels is his due, envy is more pernicious. Envy is the experience that someone has something desirable and good, but instead of wishing to gain it, the envious person wishes to have it removed or to destroy it (EG, 1956).

Klein describes the importance of establishing and rooting the good object in the psyche as a criterion for mental health (EG, 1956). As she puts it, "if the good object is deeply rooted, temporary disturbances can be withstood and the foundation is laid for mental health, character formation and a successful ego development" (EG, 1956, p. 224). However, envy can impede the establishing of the good, "whole" object and thus hinder the capacity to love.

The experience of unacknowledged and unworked through envy prevents the acquisition of mental health. Envy's destructiveness can disturb the life, work and activities of people (Klein, EG, 1956). Yet, it is extremely difficult for a person to admit to his envy as envy is often a deeply hated part of the

personality and is split off from consciousness (EG, 1956). Thus Klein explains that envy is not overcome in one interpretation or one moment of insight. Rather, she refers to Freud and says that envy needs to be integrated through the repetitive effort of working through. Bringing about an integration is necessary and Klein says the aim in analysis is to help the patient achieve a better balance (EG, 1956). It seems that the unconscious, split off presence of envy in the psyche can be described as the primary obstruction to working through the depressive position. In order to address envy, it is important to work through defences and acknowledge and integrate the envy that underlies the defences. However, it is also important to acknowledge that in a Kleinian framework, because envy is constitutional, it is sometimes presented as unchangeable (Hinshelwood, 1991). Therefore a total or perfect integration of envy might not be possible. As Klein puts it in working with a patient's envy, "as always when we reach the deep strata, it appeared to me that whatever destructive impulses were there, they were felt to be omnipotent and therefore irrevocable and irremediable" (cited in Hinshelwood, 1991, p, 176).

A person whose envy is very strong can defend against his hatred through defence mechanisms such as splitting between loved and hated objects and through idealisation of the good (Klein, EG, 1956). In an adult, the defence of splitting is an indication of regression and refers back to early infancy and a splitting of the ego and the object.[19] As Klein writes "a very deep and sharp division between loved and hated objects indicates that destructive impulses, envy and persecutory anxiety are very strong and serve as a defence against these emotions" (EG, 1956, p. 217). The quality of love that occurs when objects are split into good and bad is of an idealised nature. Idealisation (a defence, characteristic of the paranoid-schizoid position) is about the assumption that a perfect object exists that can be internalised and identified

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[19] As mentioned earlier, there are important differentiations to be made between what is considered normal in early infancy and in adulthood. In early infancy the capacity for splitting is important for development. The infant needs to be able to separate the good and bad object. This is what Klein calls a "primal division" (EG, 1956,p. 217) and it can only happen if there is an adequate capacity for love. If there is too much envy, the good object becomes contaminated and differentiation between good and bad is disturbed. But if the split is too deep between good and bad, then ego integration and object synthesis is impeded, and it is hard to mitigate hatred with love. This then makes it difficult to work through the depressive position.

with. Yet behind idealisation, there is always persecution and envy. When a person idealises, his objects remain caught in idealised or denigrated states in accordance with the defence of splitting. This then makes it difficult to do any of the work of the depressive position, including shifting the idealised part objects to realistic "whole" objects in his internal world (Klein, EG, 1956).

Klein explains that the presence of envy makes attempts at constructiveness such as creativity very difficult (EG, 1956). In Klein's terminology, when a person aims to be creative, he is attempting to restore the good object but this restoration is repeatedly undermined by attacks and devaluations from the envy (EG, 1956). The process of establishing a good object in a person is not linear. Klein describes that the good object needs to be able to be lost and re-found, gained, lost and re-gained, again and again (EG, 1956). This enables the establishing of the durable and internal good object and lays the foundations for stability and a strong ego (EG, 1956). The good object is taken in through the capacities to enjoy, to derive pleasure and to be gratified (EG, 1956). The ability to receive pleasure implies a shift in relation to the good object. The person has a sense that the object is available and freely given and this arouses feelings of care, consideration and gratitude (Hinshelwood, 1991). Thus, being able to receive pleasure is linked to the feeling of gratitude (EG, 1956). Gratitude includes both belief and trust in good objects (EG, 1956). Stein explains that as a person trusts in good objects, he is able to "accept and assimilate the loved primal object without greed and envy interfering too much" (Stein, 1990, p. 503). Moreover, being able to receive goodness brings about a feeling of generosity, as the person feels a sense of inner wealth, which he wishes to share (Stein, 1990). Hence Klein suggests that an authentic feeling of gratitude is psychologically linked to a wish to return the experience of pleasure (EG, 1956). Thus, displays of gratitude and generosity are an indication of mental health; reflecting that a person has assimilated the good object (EG, 1956). This then allows a person to be generous and share goodness and gifts with others (EG, 1956). Hinshelwood (1991) suggests that this sense of gratitude (and its corollary,

the mitigation of envy) characterises object-relations theory and is realised fully and poignantly in the depressive position in relation to a "whole"[20] object.

Klein has been criticised for her theory of envy being too pessimistic about human nature (Hinshelwood, 1991). Yet, it seems a person with an excessive amount of envy can work through the envy to an extent, provided the person has the capacity to acknowledge it. Klein describes a patient who had envy but was able to recognise and gradually integrate it (EG,1956). Interestingly, Klein described this patient as "normal" in that she had the capacity to become "more and more aware" of her envy (EG, 1956, p. 223) and was able to recognise previously unacknowledged parts of herself. Becoming aware of one's envy and integrating it into consciousness leads to feelings of guilt (and would be an indication of depressive position functioning) (EG, 1956). As this patient became aware of her envy, splits in her ego diminished and a fuller integration occurred. In the above instance, it is the patient's capacity to recognise and acknowledge her envy that distinguishes her as "normal" as opposed to unhealthy. It is not the presence or absence of envy that consigns one to the perpetuities of mental or ill health but the ability or inability to confront and acknowledge these feelings. This type of integration can only happen in the depressive position and is a further suggestion that the recognition of feelings is a cornerstone of mental health for Klein.

Klein explains that when a person recognises his split-off envy, the feelings of guilt induced by this realisation can lead to a depression (EG, 1956). In this instance, the patient's depressive symptoms are not pathological (EG, 1956). Rather, the depression is part of an integration process, not an expression of pathology. Instead of the depression, Klein cites megalomaniacal defences

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[20] As the term implies, whole object relations refer to a quality of relationship where a person can relate to themselves and their internal and external objects as "whole". In relation to the self, this signifies that a person sees themselves as good and bad and as combining love and hate. In relation to the other, this signifies that a person does not relate to the other largely through projective identification but because he can own his full self he is able to see the object as a separate "other". Caper (1999) points out that when the self and the object are fused, there can be no real relationship while Ogden writes that when a person denies the separateness and otherness of the object and relates only through projective identification, the relationship between ego and object has a "thin two-dimensional" quality to it as opposed to a "lively, robust one" (2002, p. 773).

such as omnipotence and persecutory phantasies as unhealthy pathological responses to the recognition of envy. As greed and envy diminish in power, other difficult feelings emerge such as guilt. However, the more integrated ego is able to tolerate feelings of guilt and responsibility. These feelings in the appropriate context and balance are not an instant sign of pathology but, rather, are part of a process leading towards mental health.

The process of integration, of assimilating split off parts of the self (including aggression, hatred and envy), is essential for mental health and a working through of the depressive position. On the process of integration Klein writes, "the enrichment of the personality by integrating split-off parts of the self is a vital process. Together with hatred, envy and destructiveness, other important parts of the personality had been lost and are regained in the course of the analysis" (EG, 1956, p. 227). It is as if, in integrating the split off parts of the personality, a person becomes more whole, more authentic. Klein also refers to the importance of insight and suggests that insight is gained through the process of integration (EG, 1956). That integration leads to insight is an interesting order of events. The move from part to whole objects, characteristic of integration, involves a shift in perception, in seeing which then leads to insight. Insight and integration allow a person to accept his hated parts. With integration, love increases and hate and envy are mitigated (EG, 1956). The process of integration is simultaneously painful and healing. In fact, Klein suggests that the pain which the patient goes through in uncovering the splits is diminished by processes of integration. This is because integration allows people to use their gifts more freely, releases their capacities to make reparation and facilitates the derivation of pleasure and the feeling of hope (EG, 1956). Returning to the notion of installing the good object, Klein writes that integration allows for the person to receive and integrate the good object more securely than in infancy when envy marred the process (EG, 1956). On the one hand, Klein acknowledges that envy can be constitutional and that not all envy can be mitigated by psychotherapy. Yet, she says it is possible to produce "fundamental and favourable changes" (EG, 1956, p. 228). When a person can establish the good object, he can enjoy

things and appreciate gifts received from the good object. Envy is diminished and gratitude towards the other does become possible.

The first stage of the depressive position involves the confronting of difficult feelings such as aggression, hatred and envy. As the ego becomes aware of its aggression and/or envy, it discovers that its good object is in bits because of the attacks made on it (Klein, PMD, 1935). This realisation leads to depressive anxiety consisting of guilt, remorse, responsibility and sadness, which can cause depression and inhibit work (creativity) (PMD, 1935). However, these feelings also need to be tolerated for the depressive position to be worked through. Once defences are surrendered a person's sorrow can be expressed in full strength (MMD, 1940). Klein writes, that when a person in the depressive position can release his defences he "is able to surrender to his own feelings and to cry out his sorrow about the actual loss[21] (MMD, 1940,p. 162). When these feelings of guilt and sorrow can be felt, fully, then a different quality of being emerges. The person feels greater security in the internal world, "feelings and inner objects can come more to life, re-creative processes can set in and hope can return" (Klein, MMD, 1940,p. 163). In addition, love for the object can swell and the person feels that life inside and outside will go on again. Pining and its associated feelings of grief and mourning imply a kind of suffering that is productive and even meaningful. Painful experiences can bring out sublimations or gifts in people. People can become "more capable of appreciating people and things, more tolerant in their relation to others- they become wiser" (MMD, 1940, p. 164). In a successful mourning, there is a deepening in the individual's relation to his inner objects, "in the happiness of regaining them after they were felt to be lost" (MMD, 1940, p. 164). In the depressive position, the ego then comes to a realisation of its love for a good object, a "whole" object and a real object (Klein, PMD, 1935, p. 125). As Klein writes: "These emotions, whether conscious or unconscious, are in my view among the essential and fundamental elements of the feelings we call love" (PMD 1935, p. 125).

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[21] In the specific context of what Klein was writing, she was referring to a mourner who had experienced a loss. However, the process she elaborates applies to actual and perceived loss.

Perhaps if we could summarise Klein's writings on mental health, we could suggest that mental health for Klein is, in essence, about the processing and transforming of feelings, from "regressive" to "mature" á la Stein (1990, p. 504) thereby enhancing the capacity for love. From this capacity to love, one could argue, all other abilities emerge, including even the capacity to work and create. However, Klein's notion of love, as captured in the above quotation is far from sentimental, sweet or pure. It involves the ability to integrate and tolerate a complex amalgamation of difficult feelings that direct one's attention in a particular manner towards an object. To love in this way implies a capacity for strength and depth in the ego as described in Klein's writing "On the Termination of an Analysis" (1950). It is the pinnacle of work arrived at through the depressive position.

The integration of a person's aggression and the move to mourning and then love can also be described in terms of a person's shifts in ego and object-relations. In the paranoid position, the ego is loosely organised and unconsolidated. As the ego becomes more developed, it becomes more whole and more integrated and is able to tolerate and hold the possibility of its own "goodness" and "badness" (PMD, 1935). If the constitution of the ego differs from the paranoid to the depressive position, the subject's relationship to the object also shifts as the subject moves towards the depressive position. In earlier development, the introjected objects are part objects and are not seen as separate to the self (Klein, PMD, 1935). Put differently, the objects at this time are not seen as whole objects that contain a blend of characteristics. Rather, they are constituted along an either/or axis of opposing qualities, good and highly idealised or bad and persecutory. This splitting is maintained via the processes of projective identification. In Klein's work there is a strong correlation between quality/robustness of ego and quality of object relationships (PMD, 1935). Therefore a person who is impelled to relate to objects as parts, betrays through this poor quality of object relationship, the state of a disorganised, less robust and less integrated ego. In this fused state, there is no capacity for whole object relations. The move from the paranoid-schizoid to the depressive position allows for an object to become

whole and crucially, separate. Caper (1999) highlights this separateness between subject and object as essential for whole object relations and for mental health. It is essential that the ego comes to relate to a whole object. In fact Hinshelwood (1997) describes that in modern psychoanalysis, the depressive position is seen crucially as "a development of whole object relationships out of earlier part-object relationships" (p. 879). Relating to a whole object implies that the full gamut of human affect has been recognised and integrated.

When a person has the ego capacity to relate to itself and an "other" as a whole and not a part, the type of anxiety experienced by the person as well as the defence mechanisms employed shift (PMD, 1935). Realising that it has the capacity to love and to hate, to protect and attack, the ego realises that the object it attacks is both separate and also the good and beloved object. Therefore the subject may also feel anxiety about taking the good object inside, because inside he could destroy the object through his own aggression (PMD, 1935). Recognising the "wholeness" of the object and adjusting to something being both good and bad, the person may worry that the objects it has destroyed will be a source of poison inside its body and will be mistrustful of them, yet want to incorporate them (PMD, 1935). In this process there is a lessening of the splitting characteristic of the paranoid-schizoid position. However as the good and bad objects are perceived more ambivalently, it leads to some paranoia.[22] Beforehand, employing the defence of splitting, the person can split objects into good and bad and inside and outside. Now what is inside is both good and bad, which makes the person uncomfortable, and the ego responds in two ways to this discomfort. One response is to continue with the mechanisms of splitting and projection (PMD, 1935). Hence, feelings of fear and distress and the paranoid defences which accompany them can exist in the depressive position (MMD, 1940).

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[22] While it seems that paranoia should be more part of the paranoid-schizoid position, Klein writes that the depressive position is framed by paranoia on the one hand and mania on the other. The positions are not as boundaried and defined as described and it is possible for a person moving into the depressive position to feel guilt and concern about the loved object and get pulled back into paranoid defences, fearing it will be attacked for the harm caused.

However, a second response is introjection. As good and bad objects become closer in a person's mind a person may worry that the good object will be expelled with the bad object. Hence, a person turns less to the mechanisms of expulsion and projection (PMD, 1935). Introjection, or taking the good object in, becomes associated with a refusal to expel the good object, even at the price of tolerating more bad inside oneself (PMD, 1935). The ego introjects the good object because it believes that the object will be kept in safety inside him. Therefore introjection becomes associated with making reparation to the object (PMD, 1935).

As the ego introjects the whole loved object and starts to live with greater ambivalence in relation to its objects, anxiety is not eliminated (PMD, 1935). Rather, the quality of anxiety shifts. Ostensibly, the subject is worried about the wellbeing of the other. This might be because the subject depends on the object for its own survival. But this anxiety could also refer to one's own ethical capacity to be and do harm. Either way, at this point, the notion of reparation emerges. Unwilling to reduce it to a mere reaction formation, Klein avers that reparation is not simply a defence (Klein, PMD, 1935). Rather, she suggests reparation is the first step towards developing the capacity for sublimation (PMD, 1935). Reparation occurs once the ego becomes aware, because of its identification with the good object, that it has made sadistic attacks on the good. As with depressive anxiety, it is not clear whether reparation is selfish or altruistic; whether it is about the person's worry that he will lose his good object or whether he is genuinely concerned about the well-being of the other and about his capacity to do good. Perhaps, in accordance with the complexity of the depressive position, care and concern can be both selfish and altruistic at the same time. Klein's notions of integration and ambivalence can assist in this meta-reflection: Even ethical goodness cannot be found in a purified form. Rather, a healthy mix of the ethical and the self-concerned constitute the amalgam of mental health.

The above ideas capture the core of mental health for Klein: a withdrawal of concretised projective identifications and a movement towards introjection, the acknowledgement of one's capacity for aggression, hatred and envy,

integration of ego and objects, an experience of guilt concerning perceived harm caused to the other, an ability to mourn the various losses experienced, a desire for reparation, a swelling of love and the unfolding of whole object relations. Crucially, the shift to the depressive position ushers in the notion of genuine care for the other and less paranoid worry about the self or ego. With the expanding range of object relations that accompany the depressive position, the ego begins to establish good, internalised objects (TA, 1950). This can only occur because a person is able to tolerate an ambivalent mix of "mature" feelings (Stein, 1990, p. 504). Much of Klein's theory is an explication of the qualities of psychic readiness and the developmental processes required for full affects to be felt so that whole object relations can take place. As Klein puts it "the whole gamut of love and hatred, anxiety, grief and guilt in relation to the primary objects has been experienced again and again" (TA, 1950, p. 79).

3.4. Some Defences and Processes Encountered in the Depressive Position

For a person to enter fully into the depressive position, he needs to relinquish paranoia and mania. Klein explains that paranoia can prevent a person from entering the depressive position. In addition, the sufferings of the depressive position can thrust him back to the paranoid position. The paranoiac has feelings of persecutory anxiety, and worries about being attacked by the object into whom he projects his own aggression (PMD, 1935). Moreover, the paranoiac can't endure the additional anxiety and guilt and remorse for a loved object (PMD, 1935). Hence Klein suggests that paranoid fears can be used as a defence against the depressive position (PMD, 1935). As a person surrenders paranoid or manic defences, an extremely deep love and concern emerge as well as sorrow and depression. These affects, both love and sorrow, are signs of mental health in the depressive position.

Mania is another state that can prevent a person from entering into the depressive position. Manic defences are used as an attempt to escape both depressive and paranoiac states. In mania a person uses a concert of

defences, omnipotence, idealisation and denial which all serve to reinforce one another (Klein, PMD, 1935; MMD, 1940). In a manic state, the person may feel omnipotent and have violent phantasies which are motivated in order to control and master the bad and also to preserve and save the good (Klein, MMD, 1940). Because of the omnipotent, controlling aspect to mania, Klein says that mania can hinder and stifle a rich phantasy life (PMD, 1935). The controlling, humiliating and torturing of one's objects can be destructive, disturb the reparation process and impede the recreating of a peaceful, inner world (Klein, MMD, 1940). The quality of triumph associated with mania can impede the work of early mourning as triumph obliterates any awareness of loss and so loss is not felt and mourning cannot be experienced (Klein, MMD, 1940).

In addition, "manic" defences are associated with what Klein calls a shallow ego (TA, 1950). She comments that a person with manic defences may have a measure of stability and even ego strength (TA, 1950). But if a person's persecutory and depressive anxieties are reduced, the result will not only be ego strength but also ego depth (TA, 1950). The capacity for ego depth takes mental health to a different level (TA, 1950). This is because an ego may have strength and even stability but if it lacks depth, the individual lives with manic defences, eschewing full contact with his feelings, and mental health is not achieved. In Klein's language, the capacity for depth is linked to having worked through the depressive position. Thus, manic defences can be an obstacle to the particular quality of mental health engendered by the depressive position and the full experience of affects (PMD, 1935).

The reduction of persecutory and depressive anxieties can shift the phantasy imprints of a person from infancy. Destructive objects that have held the individual in thrall for years can become integrated into and mitigated by good objects (Klein, TA, 1950). Integration of objects facilitates the changing and softening of more aggressive objects as they are mitigated by goodness. This creates an inner world for a person that feels safe (TA, 1950). Klein's notion that phantasy imprints from infancy can be shifted has echoes of Freud's comment that analysis seeks nothing less than the full transformation of the

personality. In Klein's sense, the full transformation of the personality is suggestive of a significant, internal change in a person. This change may not be permanent as objects can mutate, but it can enable a person to experience their inner world and therefore their lives in an altered way.

Moreover, there is a fascinating notion that as depressive and persecutory anxieties diminish, "good objects – as distinct from idealized ones- can be securely established in the mind" (TA, 1950, p. 80). Hinshelwood writes that for Klein, the whole of the personality develops according to the process of internalisation. Objects are taken into the mind of a person to establish an internal world. These objects are both integral to the self and are seen as separate and sometimes quite concrete objects in the body (Hinshelwood, 1997). For mental health to exist, something good needs to be established in the mind, internally, not externally. Hence for Klein, perhaps more than Freud, mental health is about a particular type of inner world, with a particular mitigation of the good by the bad.

A further concept relevant to Klein's articulation of the depressive position is that of ambivalence. Klein explains that living with ambivalence refers to a particular quality of object relations whereby one relates to objects as "whole". The notion of a whole object has been described in the previous section. Ambivalence occurs through a splitting of the imagos. She says that the "unification of external and internal, loved and hated, real and imaginary objects is carried out in such a way that each step in the unification leads again to a renewed splitting of the imagos" (PMD, 1935, p. 144). It seems that there is a splitting, then a coming together and then a further strengthening of the good object but this time the good object is more "whole" (PMD, 1935). This "whole" goodness refers to a goodness that has been tempered and alloyed with some bad. Hence there is an understanding that goodness and badness are eternally intermingled and thus ambivalence is experienced.

 As the person becomes more attuned to reality, the splitting becomes more at one with reality. In other words, the person acquires a realistic perception of his objects, seeing them neither as terrifyingly persecutory nor as idealistically

good. This process continues until love for the real and internalised objects and trust in them is well established. Then ambivalence, which is a safeguard against hated and terrifying objects will in normal development diminish. Therefore, for mental health it seems that people need to be able to tolerate the conflict of good and bad being intermingled but also live with a sense of internalised, "whole", unidealised goodness.

While Klein speaks about ambivalence and the coming together of good and bad as part of the depressive position, she also writes that eventually a well-marked cleavage emerges between good and bad objects (PMD, 1935). This is interesting as it sets up a tension in Kleinian mental health between the toleration of ambivalence on the one hand and the capacities for discernment and distinction-making on the other.

Because of this delineation between good and bad, hate can be directed to the bad object and love and reparation towards the good (PMD, 1935). This is not a hark back to the splitting of the paranoid-schizoid position. In the paranoid-schizoid state, the subject relates to its objects as either good or bad and tries to keep the good and expel the bad. As the person moves towards integration, the ego becomes strong enough to hold that good and bad objects exist simultaneously, both inside and outside the person. In this instance frustration and anxiety can menace both the good and bad objects. Every experience of hate and anxiety can overwhelm the good and deny the differentiation, resulting in a "loss of the loved object" (PMD,1935, p. 120). When hate and anxiety overwhelm the good, the loss of the loved object recurs, again and again throughout this phase as the ego moves from part to whole. Hence differentiation is also an indication of mental health. Differentiation in this sense implies a capacity to separate, distinguish and discern. It differs from manic splitting which is an unconscious and primitive defence against facing reality, more associated with the paranoid-schizoid position. Differentiation allows the good to be preserved and enables hatred to be bound and mitigated by the good. Thus the incorporation of "mature" affects involves a series of complex processes including the reduction of

paranoid and manic defences, integration, internalisation, differentiation and the ability to tolerate ambivalence.

3.5. Klein's Superego and Mental Health

Freud's superego is comprised of one's internalised parents representing social standards. It emerges after and through the resolution of the Oedipus Complex (Hinshelwood, 1991). Klein differs from Freud in terms of both the structure and development of the superego. For Klein, the superego forms much earlier on in development and comprises a number of internal objects which relate to each other and to the ego (Hinshelwood, 1991). In early infancy, the processes of introjection and projection allow the infant to take in objects which are felt either to be good or bad (Klein, MMD, 1940). These objects and the ego become organised and in the higher strata of the mind become discernible as superego (Klein, MMD, 1940). At first Klein understood the superego as an archaic structure which emerged from the death instinct.[23] This link with the death instinct helped Klein explain, in part, how superegos can be punitive, even to the point of being savage and assisted her in understanding the origins of guilt. Initially, the ego can fall prey to difficult and contradictory claims from within which are experienced as bad conscience (PMD, 1935). This is because the infant may not be able to discern whether a superego demand is coming from a good or bad object. But even if the demand might be coming from a "good" object, the early ego perceives these demands to be strict and exacting (PMD, 1935). These demands can feel particularly punitive because of how a "good" object is perceived by the ego prior to the experience of the depressive position.

This relates to a distinction made earlier in this paper between "whole" and "idealised" goodness in Klein's work. The notion of "whole" goodness implies a goodness that has integrated "badness", including aggression, instinctual impulses and hate. This type of goodness can only emerge during the depressive position. "Idealised" goodness is both defensive and illusory and

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[23] This conception would mean that the superego originated much earlier than in Freud's theory (Hinshelwood, 1991).

suggests goodness free of all impurities. Obedience to the idealised goodness of a superego sets up impossibly high standards and can be crippling to a person and compromise his happiness (PMD, 1935). Thus, the tempering of the superego requires a modification of the early, "idealised" good objects (PMD, 1935). The less idealised the good object, the less powerful and exacting is the superego (PMD, 1935). A relationship to a modified superego whose goodness is more "whole" could be an indicator of mental health á la Klein. This can only occur through a working through of the depressive position and through an acknowledging of the less valued feelings in a person such as aggression, hate and envy. This results in an interesting difference in approach between Freud and Klein in terms of mental health. For Freud, the structural modification of a severe superego is necessary for mental health. For Klein, a shift in relationship to one's object will in turn alter the severity of the superego. While Freud's focus is on structure, Klein's emphasis is on a particular quality of object-relationship.

3.6. The Persistence of Loneliness

The final area that I will be addressing in Klein's work is her consideration of a particular feeling that cannot be eschewed; loneliness. In *Civilisation and its Discontents* (1929)*,* Freud explores the notion that the existential reality of being human consigns us to a certain amount of anxiety that cannot be avoided. In her work *On the Sense of Loneliness* (1963), Klein makes a similar claim, suggesting that loneliness can only be mitigated to a point. Klein says that the work of integration is a life-long process as a person constantly works to lessen splits and become more whole. Yet, in spite of some psychic wholeness that can be achieved by integration, loneliness is not a condition that can be evaded. Rather, being able to tolerate a degree of loneliness becomes a measure of mental health and paradoxically, opens people to healthy object relationships (Klein, OL 1963).

Klein defines loneliness as a feeling of being alone and isolated, regardless of external reality and circumstances (OL, 1963). She explains further that an inner sense of loneliness is a yearning for "an unattainable perfect internal

state" (OL, 1963, p. 99). Klein avers that no person is immune to such experiences and indeed, all human beings are subject to the feeling of loneliness. Klein says that the experience of loneliness is linked both to paranoid and depressive anxieties. As has been described in this chapter, the ego in early infancy is dominated by processes of splitting and projection. Ordinarily, as the ego strengthens, splitting and projection lessen. But if the ego is weak, the capacity to integrate will also be weak and there will be a greater tendency to split in order to avoid the anxiety brought on by destructive impulses. This incapacity to bear anxiety means that the ego and object remain in a state of being split which can give rise to loneliness of a paranoid-schizoid kind. Klein refers to the schizophrenic who feels a deep sense of loneliness (OL, 1963).

Loneliness in the depressive position is of a different order. In order to work through the depressive position a person integrates splits and faces the possibility of losing and re-gaining the mother or loved object (OL, 1963). This fear of possible loss is never entirely assuaged and throughout life, contributes to a feeling of loneliness. In addition, the pain of integration, necessary for the depressive position, augments feelings of loneliness. Integration requires that one face destructive aspects of the self which seem uncontrollable and seem to endanger the good object (OL, 1963). Hence there is a fear that with integration the destructive impulses may endanger the good object and good parts of the self (OL, 1963). People may feel the pain of integration in terms of feeling lonely and deserted, essentially by their good internal objects (OL, 1963). Ironically, as integration develops and a person adjusts more and more to reality and his sense of omnipotence decreases, a person may actually feel more pain. This is because with less omnipotence, there may also be less unrealistic hope. In addition to the loss of omnipotence, integration challenges a person's tendencies to idealisation. Idealisation of oneself and one's objects is lost (OL, 1963). Thus more "regressed" feelings give way to more "mature" feelings (Stein, 1990, p. 504), even though these bring discomfort and loneliness.

Full and permanent integration is never possible for there is always some polarity between love and hate and this remains the deepest source of internal conflict (Klein, OL, 1963). Since one can't achieve full integration it is also impossible to have full and complete understanding of one's emotions, phantasies and anxieties (OL, 1963). The longing to be understood is linked up with a need to be fully understood by the good internal object (OL, 1963). Yet, the feeling of ever being wholly understood by an internal or external other is not fully realisable. Klein says that loneliness also exists and persists because a person will always feel as if certain parts of himself are split off and not available. Some of these parts are split off into other people, and leave one with a feeling of alienation, as if a person does not belong to himself or to others (OL, 1963).

In this chapter I have described some of the criteria for mental health; that it requires a working through and transformation of affects, an integration of envy and other aggressive impulses, the installation of the good object which enables a sense of inner security and trust and gives rise to good object relations. However, in Klein's essay *On the Feeling of Loneliness*, she points to the continuous, ongoing processes of mental health. Because full integration is never possible and because there is always continuous work to be done on internalising the good object, at times, all human beings experience feelings of loneliness. As Klein puts it, our yearning for a perfect state of being is endlessly deferred (OL, 1963). This experience of unsatisfied longing is loneliness.

While it cannot be avoided, Klein mentions a range of affects that arise (or diminish) in the depressive position that mitigate loneliness (OL, 1963). The loss of omnipotence can feel frightening, but it can also help a person to feel that his aggressiveness and hate are less dangerous. This also allows a person to accept his shortcomings and can shift resentments about shortcomings in the past which improves one's relation to the good object (Klein, OL, 1963). This opens up the possibility of deriving enjoyment in the external world which, in turn, eases loneliness (Klein, OL, 1963). This improved relation to one's first object and the internalisation of it means that

love can be given and received more readily (Klein, OL, 1963). Klein says there is a close link between a feeling of enjoyment and of being understood. At the moment of enjoyment, anxiety is lessened and a person feels closeness to and trust in the good object (OL, 1963). As Klein explores in her paper *Envy and Gratitude* (1956), the experience of enjoyment leads to feelings of gratitude. If this gratitude is felt deeply the person wants to return the goodness that is received, which leads to generosity (OL, 1963). The experience of gratitude and the desire to return the good feeling link to an increased openness to receiving and giving. Both capacities are linked to a positive relation to the good object and both counteract loneliness. In addition, generosity can lead to creativity (OL, 1963). The capacity for enjoyment also allows a person a degree of resignation; he enjoys what he has without too much greed for unattainable gratification. Resignation is linked to an experience of tolerance and a feeling that destructive impulses will not overwhelm love and goodness and life may be preserved.

In the above paragraph, we see an example of how Kleinian feelings move in what Stein (1990) terms "emotional cycles" (p. 508), how a diminishing of one feeling can lead to an increase in another feeling which then links to an experience of multiple other feelings. Thus the regulation and fluid movement of feelings is again pointed to as the essential definition of mental health for Klein.

However, feelings can be harnessed in multiple ways. Klein warns that the above-mentioned feelings can also be deployed as defences against loneliness. In addition, an excess of either dependence or aloofness can be seen as defences against loneliness (OL, 1963). People can also idealise the past or the future in order to defend against loneliness. Seeking approval from others can also be used as a defence against loneliness and this can undermine the development of trust in oneself (Klein, OL, 1963). The denial of loneliness, in itself a defence, is likely to interfere with good object relations. A healthy approach to loneliness is that it is "actually experienced and becomes a stimulus towards object relations" (Klein, OL, 1963, p. 114). When a person is able to feel loneliness fully, it can be allayed to some extent by external

relationships. Essentially loneliness can be diminished by contact in the external world but it can never be fully eliminated. As a person tries to integrate throughout life, he needs to be willing to experience loneliness. Moreover, the willingness to feel loneliness actually enables a person to enter fully into object relationships. This is perhaps because being willing to feel loneliness implies a capacity to be truly vulnerable with oneself and therefore with others.

3.7. Conclusion

In this chapter, Klein's central concepts around mental health have been elucidated. In Kleinian terms, an understanding of mental health relates to a working through of paranoid and depressive anxiety. In the former, two significant processes that have been discussed are the development of the capacity for symbolic thought and an eventual shift from concrete to more playful projective identifications. However, the central work for the achievement of psychic health takes place in the depressive position where split objects and the ego become integrated and more whole allowing for the installation of a good, internalised object and the establishment of whole object relationships. This description of a movement towards psychic health can also be articulated as a fundamental shifting in the quality of affects as they move from paranoid and split to accountable and whole. In the Kleinian trajectory, feelings traverse a full gamut in the development of a person's health from persecutory through to a recognition of aggression, hate and envy which in turn enables a full capacity to mourn and then to love (with a host of more nuanced feelings in between). Whole object relationships are enabled through this movement from "regressed" to "mature" feelings (Stein, 1990, p. 504). Yet, these processes are never final or complete and therefore a person needs also to be able to tolerate the feeling of loneliness and the desire for a perfection that is always deferred. The ability to feel loneliness (as with grief and anger), facilitates a deepening of a person's vulnerability which opens them up to even deeper object-relationships, internally and externally. Ultimately, it is the toleration, assimilation and transformation of feelings that is the final indicator of mental health in a Kleinian model. These capacities

make possible the connection between self and other; the opus that is the whole object relationship. The minutiae of what this requires psychologically is the work of this chapter.

3.8. Key for Kleinian Texts:

EG: A Study of Envy and Gratitude
MMD: Mourning and its Relation to Manic-Depressive States
OL: On the Sense of Loneliness
PMD: A Contribution to the Psychogenesis of Manic-Depressive States
SF: The Importance of Symbol Formation in the Development of the Ego
TA: On the Criteria for the Termination of a Psycho-Analysis

4. BION: THINKING, THOUGHT, FORBEARANCE AND MENTAL HEALTH

4.1. Introduction

If Klein's theory of mental health is about the shifting of affects as expressed through the working through of the depressive position, Bion develops the notions of shifting affects as well as the experiences of Ps and D[24] in ways that use, deepen and also veer away from Klein, ushering in new metaphors and apprehensions of mental health.

In a short undated entry published in *Cogitations*, Bion writes, "the man who is mentally healthy is able to gain strength and consolation and the material through which he can achieve mental development through his contact with reality, no matter whether that reality is painful or not" (1991, p. 192). In general, through his writings, Bion does not articulate a specific model of mental health. However, using this seminal piece of writing as a starting point, it is clear that mental development and a courageous contact with reality almost regardless of the pain involved are important indicators of mental health for Bion. Referring to ideas implicit in his theory, I wish to suggest that for Bion mental health is about a human being's capacities to bear frustration so that a specific kind of thinking about himself and his environment can ensue, in what becomes a life long evolution of mental growth.

Using the work of Britton (1998) and De Bianchedi (1991), I will show that for Bion mental health is a life-long unfolding that sees a constant movement

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[24] Bion's formulations of the paranoid-schizoid and depressive positions are developed from Klein's use of the terms. Yet, he distinguishes his understanding of the paranoid-schizoid position from Klein's conception of the position which saw it as developmentally primitive (Britton, 1998). Thus he tried calling Ps "patience" and D "security" (Britton, 1998, p. 69). These terms never took off but to distinguish his use of these concepts from Klein's, I will refer to them as Ps and D in this chapter unless referring to Klein.

between the Ps and D positions. Each time this movement takes place, previously unknown knowledge is integrated, allowing for a shifting that is both "back and forth" but also evolutionary. Thus the D a person returns to again and again is a familiar but also different and evolved psychic territory.

Bion disliked the word "cure", associating it with the medical model and with messianic allusions to an ultimate redemption (De Bianchedi, 1991). Rather, Bion speaks of "evolution" which refers to a dynamic movement in a person and connects with the image of a spiral (cited in De Bianchedi, 1991). If Klein is concerned with a working through of persecutory and depressive anxieties, Bion also feels that it is important to tolerate the vicissitudes between states of Ps and D and that as a person is able to bear this movement, meanings accrue and a person acquires the ability to name and understand his experiences (De Bianchedi, 1991). This build-up of meanings allows a person to think creatively, engendering a mind which is in a constant state of development. In contrast, "ungrowth" can also happen in a person whereby emotions such as envy and greed strip thought of its meanings so that a thought can be nullified or invalidated by the destructiveness of the feeling, while if a person cannot tolerate frustration the object which could promote growth is attacked. Using Bion's theory, De Bianchedi suggests that a person's ability to think about emotional experiences and the concomitant emergence of creative meaning-making and ideas-formation, allows an individual to become different from what he was before. A person can become emotionally wiser and expand his capacities while certain things remain unchanged (De Bianchedi, 1991). Mental health becomes about a capacity for a mature, thoughtful, meta-perspective on one's own feelings and an ongoing ability to engage with and reflect on these feelings.

As with Klein, simply to assert that mental health for Bion is the flexibility and strength to oscillate between the Ps and D positions such that each time one arrives at D there is an evolved shift in one's growth, is to express mental health in the jargon of a theory. Affect and an essential struggle between love and hate can be extracted as the essence of Klein's departure from Freud and as the crucial index measure through which she traces her understandings of

mental health. What is Bion's essential articulation of mental health? Two crucial factors emerge from his writings; the capacity for thought and the related ability to tolerate frustration. Bion sees the essential conflict in the human being as a tension between a desire to know and apprehend the truth of his own experience versus an avoidance of this knowing and apprehension (Waddell, 2002). In this chapter, I shall explore in detail some of Bion's elaborations of what it means to think and consider the complex relationship between thought and frustration-tolerance.

4.2. Container-Contained and the Alpha Function

On the interplay between the no-thing and the realization that is felt to approximate to it depends the development of thought, and by thought I mean, in this context, that which enables problems to be solved in the absence of the object (Transformations, 1965, pp. 106-107).

Bion postulated that the evolution of thought is fundamentally inter-subjective[25] and occurs at first between infant and mother (De Bianchedi, 1991). This originary interaction between mother and infant facilitates the emergence of the personality out of a primal dynamic whereby an infant in pain seeks the mother's breast (Symington and Symington, 1996). However, the infant's discomfort is not always alleviated by the breast and therefore, in the interaction with mother and breast, the infant will inevitably feel pain, anxiety and frustration (Waddell, 2002). Bion believed that what enables a baby to tolerate this pain is a very basic form of a thought. This thought can only occur if the desire to evade the pain is not too strong and if the experience of pain is not too overwhelming (Waddell, 2002). Initially the mother facilitates this process by holding the emotional state for the child and not acting overly quickly to allay a frustration, nor prolonging the frustration unnecessarily (Waddell, 2002). Through this interaction the mother assists the child to recognise what it was unable to before (Waddell, 2002). Importantly, this thinking nexus does not remain externalised between infant and external

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[25] Such development is based on the Bionian idea of links, specifically, the L, H and K links which will be exposited further in this chapter.

other. With time, this link becomes internalised, so that a person introjects a function of his own "mother" and can thus form and use symbols, and be in an inner process of self-inquiry and self-understanding. However this internal, introjected dynamic is still based on the notion of twoness. In order to explain this process, Bion developed the concepts of the container and the contained, where the mother is the originary container and the child's experience is the contained. In healthy development, a person comes to internalise his own container-contained.

Expressed in simple terms, the contained are elements of thought in a basic form while the container is the structure and function by which these thoughts can be held, processed and assimilated. In Bion's terms, the contained is a pre-conception that seeks a realisation in the container (Symington and Symington, 1996).[26] The union of contained and container, or realisation and pre-conception, leads to a new thought, in Bion's terms, a conception. The movement of Bion's container – contained is both dynamic and mutually active, as Symington and Symington put it, "there is a contained seeking a container and there is an intercourse between the two" (1996, p. 52). On the one hand, the container seeks a contained, but a contained can also seek a container as in Bion's articulation that thoughts can seek a thinker (Symington and Symington, 1996). This process occurs as a person's primitive, sensuous impressions move towards psychic experiences, becoming less material and more abstract. Thus, thoughts can seek a purification or abstraction process in looking for a container to move them from more primitive to more abstract experiences (Symington and Symington, 1996, p. 53). Once a contained finds a container, a conception can take place. The word "conception" is a sexual metaphor and evokes the notion that the development of thought ushers in the possibility of new life. However, this movement from pre-conception to realisation to conception is unending. A newfound conception becomes the

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[26] It is worth considering how Bion's notion of container-contained differs from Freud's conception of the ego. The container-contained is an inter-subjective process while the ego is more unitary. The ego is Freud's metaphor to describe a mediator in the psyche among external world, superego and id while the container-contained is a specific concept developed by Bion to explain thoughts and thinking. However, it is important that neither concept becomes too reified. The ego does possess thinking functions and there do seem to be conceptual overlaps between the two.

next pre-conception that searches for a new realisation (Symington and Symington, 1996). Thus, thoughts move from lesser to greater abstraction,[27] using the inter-subjective process of container and contained.

It is important to note that thought is not a *telos*, a final end-goal but is rather always in process. This is why one conception formed by container-contained becomes a new pre-conception searching for a realisation (Symington and Symington, 1996). This is Bion's understanding of human development; thought moves in cycles from conception back to pre-conception searching for a realisation and so on. As a person develops the on-going capacities to think, his potential for mental health evolves.

In terms of mental health, the container-contained dynamic interaction can take on varying forms. There are parasitic container-contained interactions where the object produced by container-contained destroys them both (Symington and Symington, 1996). There can be symbiotic interactions where the dynamic between container and contained leads to a furthering of expression between the two. If there is a commensal link, the emotions developed by container-contained enable an individual to create language forms which then aid emotional development (Symington and Symington, 1996). In this way, development becomes a spiral and the emergent language and emotions further the development of the person (Symington and Symington, 1996). This type of commensal link between the container and the contained is optimal for mental health. It is interesting to note that the healthiest form of interaction between container and contained helps engender a person's language and a deepening of his emotions, reiterating the connection between thought, emotions and expression in a Bionian framework.

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[27] The term abstraction also requires some explication. It is not simply a move from something more concrete to less concrete, but it is also the binding of phenomena which are recognised as belonging together. When a pre-conception mates with a particular realisation, it means that other realisations had to be rejected or distinguished as the incorrect realisation. Thus thought develops through a binding process and in this way meaning accumulates (Symington and Symington, 1996).

The image of the infant who experiences just enough pain to produce a thought is instructive in grasping the processes of container-contained. In order to develop this capacity for thinking within the dynamic of container and contained, a person needs to tolerate a certain amount of anxiety. The anxiety experienced in this raw form seems to generate the impulse to think. Yet, the relationship between thought and anxiety is reciprocal: as sensuous satisfaction is denied, the capacities for thinking as lived in the container-contained dynamic assist in the very bearing of anxiety (Symington and Symington, 1996). Indeed, thought becomes a way of tolerating the feeling of frustration. In denying sensuous satisfaction, strong emotions can be aroused such as rage and resentment but they have to be managed through thinking about them (Symington and Symington, 1996). This is not in Freudian terms simply a way to delay pleasure so that a greater measure of pleasure can be achieved later on (Symington and Symington, 1996). Rather, the denial of the immediate sensuous experience engenders for Bion the very possibility of emotional growth, the articulation of one's own language and the expression of one's feelings.

The connection between the experience of frustration and the development of thought requires some elaboration. For Bion, a frustrating experience is first experienced concretely, as the realisation of an absent object. However, if the frustration is tolerated, the absent object becomes represented as a symbol in the person's mind. This symbol is indicative that the "absence" is being changed into thoughts, rendering the frustration more tolerable (López-Corvo, 2003, p. 108). When a person can represent the frustrating object in its absence, the capacity for thought can be said to be developing. Developing this capacity is a substantial psychological achievement and is explored further in this chapter.

4.3. Alpha and Beta Elements and the Alpha Function

The notion of container-contained is an accessible metaphor for starting to grasp the inter-subjective process of thought in Bion's writing. However, the question remains; how do thoughts move from primitive to more psychical

elements in the dynamic of container-contained? Specifically, what does the container do to the contained in order to generate thought? Bion developed scientific terms in order to apprehend the nature of thought as he envisioned it and to explain what occurs in the container-contained interaction.

For Bion, thought is facilitated through the capacities of the alpha (α)-function. Sandler succinctly explains the α-function as "a mental function that transforms sensuously apprehensible stimuli into elements useful for thinking, dreaming, memory" (2005, p. 24). In *Learning from Experience* Bion writes that α-function "operates on the sense impressions, whatever they are, and the emotions, whatever they are, of which the patient is aware" (1962, p. 6). In mentally healthy people the α-function renders pre-verbal unconscious impressions and conscious rational events accessible to the personality, allowing them to be used for the integration of thoughts and memory (Sandler, 2005). Bion was interested in the processes whereby sensory stimuli transformed into psychic "facts". He grasped that people's first apprehension of reality is through sensuous stimulation but that reality can only be comprehended at psychical (non-sensuous) levels. He was interested in the human capacity to take in raw, sensuous impressions and translate or transform them into something that was for him, "immaterial" (Sandler, 2005, p. 25). In his language it was about taking the sensuous impressions and shifting them so that they become "de-sense-fied" and interpreted and therefore more abstract psychic facts (cited in Sandler, 2005, p. 25). Thus the α-function shifts forms from a more concrete, material energy into something less material (Sandler, 2005). This less material thought is of a higher abstraction or meta-awareness. The concrete material in the sensuous realm is "not human thought" (Symington and Symington, 1996, p. 71). It is known as beta (β)-elements.

These sensuous, concrete, material human experiences known as β-elements are without meaning; they are sensations that cannot be named but are experienced in a person as frustration. As an undigested "thing" they feel foreign to a person and need to be evacuated into the body or the world,

through primitive defence mechanisms such as projective identification[28] (Symington and Symington, 1996). There is also an impersonal quality to β - elements (Symington and Symington, 1996). While they form the matrix from which all thought develops, in beta form, they are not yet thoughts (Symington and Symington, 1996). Hence they are called "sensuous impressions".

As the β-elements move from concrete experience to something immaterial that could become a thought, they become α-elements and have the possibility of becoming psychic facts, available to a person's awareness (Symington and Symington, 1996). The move from β to α-elements is facilitated through the α-function. The shifting of experiences from β to α-elements through the α-function occurs at a very early stage of the thinking process whereby more crude experience is translated into something that can be thought about.

Bion has used the analogy of the digestive system, as well as sexual union, to explain the α-function. In terms of the digestive system, β-elements need to be processed, digested and transformed to become α-elements (Symington and Symington, 1996; Waddell, 2002). Put differently, α-function operates on the data of all of a person's emotional experience, including sensory input from external and internal sources. It renders this information, consisting of sensory, auditory and olfactory impressions, useable (Symington and Symington, 1996). These become elements which can be stored in memory and used in dreaming and in thinking. Crucially (and linked to Klein), an image that arises in a person's mind which has been rendered from sensory input is now also in a useful form to become a symbol (Symington and Symington, 1996). In sensation being subject to α-function, it becomes "assimilable to the

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[28] Bion's understanding of projective identification differed fundamentally from Klein. He recognized the existence of pathological forms of projective identification, as in the above instance where the β-elements are summarily evacuated into objects without thought developing. In these instances, projective identification is a primitive defence mechanism that starves the mind as thought becomes blocked. But he said that projective identification was also the beginnings of empathy. This is because projective identification begins in the inter-subjective matrix between an infant and its mother (López-Corvo, 2003). Normal projective identification needed to be separated off from pathological types. Healthy forms of projective identification are used for understanding and conducting psychoanalysis in a Bionian framework (Hinshelwood, 1989).

mind" (Symington and Symington, 1996, p. 61). Importantly, once a person can think about himself, the α-function affords the mind a sense of subjectivity, an inner space in which meaning can evolve. This enables a person to respond in a personal way to emotional experiences.

An additional role of the α-function is that it allows the contact barrier (first conceived of by Freud) to remain intact, maintaining a healthy, semi-permeable barrier between conscious and unconscious activity (Symington and Symington, 1996). If β-elements dominate a person's experience, the existence of a functional contact barrier is disallowed and another structure forms, a "beta screen", which has a deleterious effect on one's thinking and mental health (Symington and Symington, 1996, p. 66). The beta screen stops a person from thinking and instead encourages acting out, based on the frustrations caused by the experience of nameless β-elements.

The α-function is a vital psychic function in the development of mental health for Bion. It determines whether a person is able to tolerate anxiety or attempts to escape it in the form of a symptom or abnormal projective identification. A painful emotion will either be transformed through the α-function into something that can be thought about or the experience will be expelled through activity that is determined by the person's anxiety (Symington and Symington, 1996). Moreover, α-function shifts the concreteness of sensory data, creating the possibility for symbolic and abstract thought while β-elements can only be used for projective identification (Sandler, 2005).

As with all of Bion's terms, it is easy to imagine the α-function as something tangible in the psyche and equate it with thinking or dreaming. However, α-function is not a thing-in-itself; it is a concept that describes a "permeable boundary" that transforms the unthinkable into elements that can be used for thinking, dreaming and remembering (Sandler, 2005, p. 28). For Bion there is something distinctively human and mentally healthy about being able to transform the non-mental into the mental, thereby refining and symbolically elaborating one's experience.

The development of α-function is linked back to the primary relationship between mother and infant in the interaction of container-contained. For the infant's α-function to develop, a mother must be capable of reverie. Reverie is linked to the mother's love of the infant. In Bion's words, "Leaving aside the physical channels of communication my impression is that her love is expressed by reverie" (Learning from Experience, 1962, p. 35). In other words, reverie is not equivalent to love; indeed love can be expressed in the physical holding and handling of an infant. Rather, reverie is a way to express love. As Bion writes, "reverie is that state of mind which is open to the reception of any 'objects' from the loved object and is therefore capable of reception of the infant's projective identifications whether they are felt by the infant to be good or bad" (Learning from Experience, 1962, p. 36). In other words reverie refers to the mother's capacity to contain anxieties in the face of the infant's feelings of annihilation. If the infant is exposed to its mother's reverie and the mother is able to share her α-function with the infant in a way that removes the β-elements from the child, returning them as transformed α-elements, the infant absorbs not just the α-elements but is able to introject the process that created them. The infant discovers that it can remain contained in the face of anxiety using the α-function. The β-elements are the contained and the mother processes these elements for the child through the α-function (Sandler, 2005). This interaction between mother and infant is an example of a commensal type of container-contained and facilitates the mental development of both mother and child (Sandler, 2005).

4.4. Interference in the Container-Contained Process and the Devolution of Thought

Bion articulates three types of links or connections which inform and characterise the quality of interaction between container – contained; the K (knowledge) link, the L (love) link and the H (hate) link.[29] The L and H link are considered subsidiary to the knowledge link; Bion foregrounds the drive to

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[29] López-Corvo (2003) explains that the L and H link can be seen as analogous to Freud's love and aggressive instincts but K goes beyond Klein's assertion of a drive to knowledge.

knowledge as supremely relevant to the development of the person (López-Corvo, 2003). The word knowledge for Bion designates the capacity to know rather than denoting an awareness about something already known. Thus, the positive K link (+K) represents an individual's capacity to know something about one's "propensity to contain" (López-Corvo, 2003 p.157). For Bion, knowledge is fundamentally an assertion of relationship because an individual can only know in relation to something. Knowledge requires an object of awareness and a capacity to communicate this awareness. Sustaining a +K link depends on a commensal type relationship between container, contained and mental growth (+K) where each benefit from each other. This enables growth in a person's thinking apparatus, in K and increases the possibilities that a person can learn from experience. An individual is able to integrate new knowledge and remain free of rigidities. Therefore K is always unsaturated because one's level of knowledge is always changing as is necessary for mental growth and evolution.

Thus, a positive container-contained dynamic, linked through +K, occurs in an emotional environment that is conducive to growth. If there is a negative atmosphere however, the devolution of thought occurs. There are varying degrees to which thought can devolve. Some thoughts cannot be contained because the container is damaged and not able to hold the contents of a thought. Symington and Symington (1996) explain that a damaged container may not be able to bear painful emotions such as pain, guilt and regret. These are instances where there is a potential contained (thought, pre-conception) but there is not a container-contained so emotional experience does not shift or ease. When there is damage or fragmentation in the container, there is at least some capacity for container and contained to interact in thinking (Symington and Symington, 1996). But envy can also attack the connection between container and contained, creating a negative link which Bion calls "minus K" (-K) (Transformations, 1965, p. 115). –K is fundamentally destructive and therefore cannot occur within a commensal type relationship between container-contained. A –K link disallows primitive impressions to be transformed into thoughts, creating a reversal in thought, confusion and

nameless terror in a person (López-Corvo, 2003). It is thus antithetical to a person's search for the truth about his experience and himself.

One of the ways in which –K emerges is through a reversal of the α-function. On the one hand, an absent α-function can be harmful to one's health as β-elements are not transformed into α-elements and experience is felt primitively and concretely; thought does not develop. However, Bion (Learning from Experience, 1962) spoke not only of an absent α-function but of a reversal of the α-function. Sandler (1997) conceptualises this reversal as an "anti α-function" (p. 43) which he describes as an active, negative process whereby α-elements are transformed, regressively, into β-elements (1997). Linking this active anti α-function with projective identification, Sandler suggests it is used more often than not as a way to evade painful depressive position experience. Sandler (1997) adds that this function is more widespread than we realise and creates collective distortions in reality. In explaining the way in which α-elements can be transformed into β-elements, Sandler distinguishes between psychical and material reality. On the one hand, a fact may be unreal in terms of material reality but may be true in terms of psychical reality or a person's lived and felt emotional experience (Sandler, 1997). On the other hand, a thing may be described in terms of material reality and seem real but be used in a way to dissemble the truth of one's psychical reality. Sandler's (1997) concern is with the latter; that people can live in the material reality of things and eschew that which is not easily apprehended - psychic reality. In Sandler's construal of this anti α-function, he observes that people can employ concrete material facts in order to evade truthful aspects of psychical reality and escape contact with "real emotions" (1997, p. 45). Often anti α-function is used to avoid the psychic reality of depressive functioning. Psychologically, a person returns to a primitive usage of projective identification, regressively transforming meaningful experience into meaningless sense data.

Sandler (1997) suggests that there is something primitive but not necessarily pathological about the anti α-function. On the one hand, humans tend towards mental growth and from the beginning of our lives we are given the task of

processing raw "sensuous" data into "psychic data" (Sandler, 1997, p. 46). As Bion puts it "if the capacity for toleration of frustration is sufficient the 'no – breast' inside becomes a thought and an apparatus for 'thinking' develops" (cited in Sandler, 1997, p. 46). But using Bion, Sandler postulates that there is a universal tendency that functions in the reverse to turn psychic reality back into material reality, opposing the development of thinking. This relates to the notion mentioned earlier that for Bion the central tension in the human being is between thought and its evasion. This reversal of α -function exists within each person and its presence is not necessarily an indication that α-functioning is disturbed (Sandler, 1997). Rather, Sandler (1997) is pointing to the onerous burden on the human mind to contain immaterial abstractions in a psychic space. Therefore this natural tendency arises, which is part of a human's more primitive functioning, to create rigid organisations in the mind. Anti α-function operates to avoid frustration and produces a state of mind where a person is dominated by the pleasure principle. It allows a person to live with lies, concreteness and a type of rationality that allows his beliefs to pass for "truth and reality" (Sandler,1997, p. 47).

In the unfolding of α and anti α–functions, it is interesting to note the inter-connectedness of emotions and thinking in Bion's thought. Klein's notion that affects need to be felt and integrated is not dismissed but rather deepened as Bion posits the necessity to think about feelings in greater degrees of abstraction. This again serves to suggest that mental growth in Bion's model is not to be equated with rationality. In fact, the evasion of feelings blocks the unfolding of thought. Anti α-alpha function and the thoughts it produces are often close to, even approximating, depressive functioning. Yet, these types of thoughts deny a person the experience of painful truths and uncertainties, allowing for the prevailing of the pleasure principle (Sandler, 1997). A prevailing pleasure principle is linked to immediate gratification without delay. Thus when it prevails, the bearing of frustration over time is prevented and thought is disallowed. The anti α-function not only prevents a person from working through and attaining D but also hampers the oscillating movement between Ps and D, essential to mental growth and health for Bion. Bion's construal of thought and its links to mental health envision a person not

evading but rather entering more fully into, the feeling of things. In *Cogitations* (1991), where Bion refers to mental health as an unflinching contact with reality, he includes one's personality as part of the environmental reality that a person needs to confront. These notions will be explored more fully in the final section of this chapter.

4.5. The Capacity to Suffer

The most crucial decision on which mental growth depends is whether frustration is evaded or faced. Encountering a painful state of mind, does the individual immediately engage in one or more of the numerous defence mechanisms readily available for the purpose of getting rid of the awareness of the frustration, or is there an attempt to remain open to it, to tolerate it and to think about it? (Symington and Symington,1996, p.67).

Allowing the experience of feelings is not always easy. Crucially, it requires the human capacity to tolerate frustration and/or suffering. Frustration, explained by Symington and Symington as a "desire unmet" (1996, p. 69), makes a person experience a painful state of mind. This could include difficult feelings such as depression, boredom, hopelessness, envy and guilt. The actual experiencing of these feelings is akin to psychical reality (entering more fully into the feeling of things), which the psychotic part of the personality tries to avoid. Frustration can assume many forms. It can be innate or acquired through one's development (De Bianchedi, 1991). Frustrations include experiencing the absence of the object, the impossibility of fully apprehending the object and the deferral of absolute or definitive knowledge (De Bianchedi, 1991).

In Bion's terminology, frustration is caused when a pre-conception is met with a negative realization as absence (López-Corvo, 2003). β-elements, as the very beginnings of thought, are the first formulations of the experience of absence. The rudimentary forms of sense-impressions characteristic of β-elements are painful and appear to the person as concrete and bad internal objects (López-Corvo, 2003). In order to evade these experiences of

frustration, a person may act out in different ways, including through pathological projective identification (Symington and Symington, 1996; López-Corvo, 2003). As Symington and Symington (1996) explain, the psychotic part of an individual's personality does not like psychic reality and will therefore resist thought. Hence the acting out occurs. The acting out is an attempt to get rid of the unthinkable β-elements through evacuation. The β–elements remain untransformed, the individual's capacity to understand through α–function is disallowed and a person is opened up to psychotic experiences and the further impeding of thought (Symington and Symington, 1996).

An individual may refuse to bear the suffering fully but will also not elect for complete evasion of the suffering via projective identification or acting out. Rather, López-Corvo (2003) suggests that he may opt for a kind of omniscience where he holds onto perceived true and false ideas in a dictatorial way. The person may choose to live by certain extreme dictums of what is morally determined to be right or wrong as a defence against feeling both the absence of fulfilment or the utter realisation of a desire (López-Corvo, 2003). This option is a blocking of the thinking process and might even contain traces of anti α-function where a person holds onto an idea or a fact in reality in order to ward off the psychic truths of his feelings. Whichever path of evasion is chosen, the main problem caused, from a Bionian perspective, is that the development of thought is blocked (López-Corvo, 2003; Symington and Symington, 1996)

On the other hand, if a person chooses to tolerate the frustration, the unpleasant, undigested experience of β-elements are held in mind long enough for something to shift, so that α-function acts on it, transforms it into something mental and engenders the possibility of thought. Importantly, a particular experience of frustration does not need to be eternally endured. But the capacity to bear frustration for some period of time allows the α-function to act on the undigestible elements, modifying the feelings of frustration. The thinking process allows the frustration to be felt differently and more bearably (Symington and Symington, 1996). The growth of the personality depends on whether a person tolerates frustration over a period of time or evades it. If the

person bears the frustration, the absence can evolve into a thought which will modify the intensity of the frustration, making it tolerable. This thought, which is a conception mating with a realisation makes it possible not only to bear suffering but to learn and grow from experience (López-Corvo, 2003). Thus α-function is essential in that it transforms the persecutory ideation of the β-elements into something meaningful, assisting in the tolerating and modifying of frustration (Symington and Symington, 1996). Tolerance of frustration, as with Klein, allows for the formation of symbols and for real change and evolution in a person. The converse applies as well: for Bion mental growth cannot occur without this capacity to tolerate frustration (De Bianchedi, 1991).

Thought and frustration tolerance are connected from early infancy in the dynamic between container-contained. Thought begins with the experience of absence. Provided the absence is neither experienced as too overwhelming, nor satiated too quickly, the infant will tolerate the frustration and develop a thought in the absence of the object, thereby representing the object in its absence. As with an infant, so with an adult: If a person cannot tolerate frustration, he believes (phantasizes) that the world must be as he wants it to be (Sandler, 2005). In effect he denies the reality principle and is governed by Freud's pleasure and displeasure principle. The person may feel the pain but the person does not actually suffer the pain (Sandler, 2005). Rather he tries to evade it (Sandler, 2005; Bion, Attention and Interpretation, 1970). Moreover, the action the person takes to evade the suffering (be it projective identification, acting out, the emergence of a symptom) furthers the person's predicament and is deleterious to mental health (Sandler, 2005). It is important to realise that the capacity to bear suffering is not a rational decision. It can be excruciating for a person to feel that their desires are not fulfilled. As Sandler (2005) explains, the evasion of frustration and consequent acting out is not an indication and moral judgement that a person is driven by his desires. Rather, if a person is filled with innate paranoid or narcissistic traits, he can experience his desires as absolute necessities, rendering the foregoing of such wants an excruciating experience (Sandler, 2005). Perhaps this explains why the capacity to bear frustration and defer gratification is such a triumph of human development and why it is not ever

mastered to perfection. As Symington and Symington (1996) put it, "Both in analysis and in oneself it is possible to see the moment-by-moment choice as to whether to evade frustration or to tolerate it and on this depends our mental health" (p. 70).

4.6. Thought: What is it?

Progress is less impeded if we consider 'know' to refer to a relationship, and reality and truth to refer to qualities of mental phenomena necessary to sustain mental health (Bion, Cogitations, 1991).

Having accrued some of Bion's language through this chapter, we can come to a deeper understanding of Bionian thought. Bion's writing abounds with the language of mental growth and evolution, the capacity to think thoughts and so on. Indeed, it is this capacity to think and live a life of mental growth that is the crucial index measure of mental health from a Bionian perspective. But the question remains; what is thought for Bion? While the words "thought" or "mental growth", with their associations to mind and thinking, sound like a deviation from Klein's work around feelings, thinking for Bion is rooted in affect.

Mental growth is not about the mere acquisition of knowledge (Symington and Symington, 1996). Rather it involves a deeper understanding of oneself which then informs an understanding of others (De Bianchedi, 1991). For Bion, thought is required in order to engage reality, think about the self and also to think about one's own thinking processes (Symington and Symington, 1996). A person starts off in a state of "being-becoming" where he is unaware of aspects of his reality (De Bianchedi, 1991, p. 7). Gradually a person comes to know these aspects and is able to understand them in greater degrees of mental abstraction, without losing contact with the resonance of their emotional origins (De Bianchedi, 1991). In addition, thinking has a dynamic character to it and is linked to being ready for action (Symington and Symington, 1996).

Bion believed that thinking was not just about the content of thoughts but also about an apparatus that was capable of thinking about oneself (Symington and Symington, 1996). Bion distinguished between thoughts and a thinker. He believed that there are pre-existing thoughts (experienced at first as β-elements) waiting for the mechanism of thinking or the "thinker" (Symington and Symington, 1996, p. 82). These more latent thoughts could then be developed by thinking them. Thus there is both an apparatus used for thinking about thoughts and also an endless amount of thought elements waiting to be thought about.

According to Bion, as we think, using our thinking apparatus, we develop the capacity to think about things instead of experiencing the thing-in-itself as something concrete (Symington and Symington, 1996). This distinction between thoughts and a thinker is described in the originary example of the infant and the breast. An infant may desire a breast which is not present. If the infant cannot conjure up a thought, it will experience the absence of breast as a persecutory "no-thing". In Bion's understanding this "no-thing" is the presence of something unpleasant or a bad object. Yet this experience of something unpleasant is still a thought (Symington and Symington, 1996). However, at this point, there is a thought, without a thinker. The experience of the absence is a thought that is not yet thought about. In the absence of this thinking process, the experience of pain and the object perceived to be creating the pain are seen as one; the thought and the object remain a "thing-in-itself" (Symington and Symington, 1996, p. 82). This is the unassimilable β-element. This then needs to be expelled via projective identification. If this happens mental development is stymied. When we reject painful feelings and refuse to think, the development of thought is impeded (Symington and Symington, 1996). On the other hand, the experience of the absent breast as a "no-thing" has led to a thought which could potentially lead to mental development (Symington and Symington, 1996). If thought about, the thought could almost be seen as an antidote to the actual object (Symington and Symington, 1996). If the infant is able to think that the good breast is absent and that it has not changed into something malevolent, then thought is developing.

The collapse of thought with the thing-in-itself implies in Bionic terms a certain primitive morality where absence of the good object is seen as bad and presence of the good object is seen as good and where concrete equivalences are drawn in the sense of Hannah Segal's symbolic equation (1988). This primitive approach eliminates the possibility of the whole object relationship, as elucidated in the Klein chapter (p. 10). The way to shift from this primitive morality is through mental representation (Symington and Symington, 1996). Thus, the nature of the whole object relationship, a crucial indicator of mental health, relies on a certain capacity to think about things.

This capacity to think about things is a process of abstraction whereby the concrete experience is separated from the thought that symbolically represents it. As Symington and Symington put it, "the essential elements are recognised and drawn out of the experience" (1996, p. 84). In the language of alpha and beta, the α-function assists in separating out essentials from the matrix of β-elements. In this sense, the abstract thought that develops is not necessarily a lofty, philosophical idea (although it might be). Rather, it is grounded in β-elements which then become translated into things that can be named and understood. This process takes place in an emotional environment and inter-subjectively, in relationship to the internalised other.

Thus thought is intimately linked to what Bion called "emotional experience" (Learning from Experience, 1962, p. 69). In talking about emotions, Bion positioned himself slightly differently from Freud and Klein, choosing to extend the term emotions to "emotional experience" (Sandler, 2005). While emotion is a dynamic influx linked to instinctual sources, the word "experience" links it to something else which could be internal or external (Sandler, 2005). Thinking at its origins depends both on this experience of emotions and on an inter-subjective link to another (be it internal or external). As Bion said, "an emotional experience cannot be conceived of in isolation from a relationship" (Learning from Experience, 1962, p. 42). Following from Freud, Bion expressed that no emotion could occur without a not-me, an object. For Bion, "emotional experience" is about a person being in touch with their psychic

reality and this can only happen in relationship. However, the relationship does not need to be concretised in the form of another human being. For Bion, all objects, animate and inanimate are in relationship with each other (Sandler, 2005). An emotional experience is an emotion with a link that allows it to be thought about within the space of psychic reality. It differs from an emotion which lacks this link to "not-me" and so is not yet in a state where it can be thought about (Sandler, 2005). Bion's term "emotional experience" assists us in grasping his link between emotion and thought. Emotions in and of themselves need to be thought about in order for growth to occur. Conversely, thought cannot take place without the origins of an emotional environment, which allows the thought that emerges to be resonant and vital, not detached and void of substance.

4.7. Thoughts and Thinking, Paranoid-Schizoid and Depressive Positions

Klein saw the arrival at and working through of the depressive position as the fulcrum of mental health, as I have argued in the previous chapter. However, Britton (1998) using Bion suggests that to remain in the depressive position can be tantamount to inertia in terms of mental growth and that it is essential for human development and for mental health to leave the security of the depressive position and embrace a new round of uncertainty and possible fragmentation.

For Bion, mental health does not end at the depressive position *per se*. In fact, as Britton (1998) puts it, "yesterday's depressive position becomes tomorrow's defensive organization" (p. 73). Rather, positive mental growth is something that evolves spirally (De Bianchedi, 1991). For Bion, part of mental health is an ability to tolerate movement between the depressive and paranoid-schizoid positions, in both directions (Britton, 1998). The movement from the paranoid-schizoid to the depressive position is well documented by Klein. Similarly, Bion suggested that a person must be able to tolerate the paranoid-schizoid state until a new pattern would emerge. This evolved state he called D and saw it as analogous to Klein's depressive position. However,

he did not want his Ps to be seen in the same way that Melanie Klein's paranoid-schizoid position was formulated. Therefore, in Bion's work the movements between the two poles of Ps and D and D and Ps need to be seen as cyclical aspects of life. Crucially, this movement is only tolerable through a person's capacities to think thoughts (Britton, 1998). In essence, mental health remains about the capacity to think thoughts and the underlying capacity or willingness to suffer frustration so that thoughts can develop. This enables, not a straightforward working through of the depressive position á la Klein, but rather a pendulum type movement between Ps and D and Ps again.

Hence, Bion posits the possibility of a healthy transition from D to Ps or a post-depressive, paranoid-schizoid state (Britton, 1998). In so doing, he articulates the possibility that something appearing as disturbed behaviour and primitive expression can still be an advance in a person's growth. Britton (1998) postulates two possibilities: He explains that D, once worked through can be a comfortable space for a person as it enables experiences of moral coherence, sanity and the capacity for triangular space and reflective thinking (1998). But in order to evolve as a person, he may need to contact unknown elements in himself which can be more easily accessed in states of fragmentation associated with Ps. Thus, a person's willingness to move from the comfortable, mentally secure space of D into a "post-depressive paranoid-schizoid state" can be a sign of mental health (Britton, 1998, p. 72). Thus, it seems that for the purposes of human development a person needs to be willing to face the possibility of disintegration (Britton, 1998). He explains that D produces a shape and gives the shape meaning through the process of containment. However, Ps can be seen as the psychic space where a selected fact, in the initial form of a sensuous β–element, emerges and crystallizes (Britton, 1998). In other words, the thoughts requiring a container can sometimes be found in the fragmented experiences of Ps. The other option would be a pathological regression where a person is in a normal post-depressive position (Ps) and moves to a quasi-depressive position. These possible psychic movements challenge our assumptions of D always being good and Ps being bad. Thus Britton proposes that there is a movement from

a depressive to a post-depressive paranoid-schizoid position that is essential for mental health.

Thus there is not simply a move from Ps to D to Ps to D as in the Kleinian model. Rather Ps to D leads to Ps (n+1). The (n+1) is indicative that this is actually a move forward whereby a person integrates new material from the Ps (n+1) space, both in terms of knowledge and psychic awareness. It thus offers the opportunity for a different quality of the D (n+1) which is to come. For Britton (1998), Ps, D and Ps (n+1) are actual states of mind while D (n+1) is a possibility which rests on faith. Faith here does not refer to a religious sensibility. Rather, it refers to the individual's trust in the possibility of shifting from the uncertain and uncomfortable state of Ps to something beyond Ps, even though D (n+1) is not apprehended or tangibly experienced. When a person arrives at D (n+1), it becomes the new D (n) of the day. In the words of Bion, D (n+1) is a preconception and when realised it becomes a new conception, D (n).

Ps (n+1) is a "post-depressive position" and it requires a person to be willing to embrace psychic discomfort and narcissistic loss (Britton, 1998, p. 75). It can produce panic and fears of chaos. Britton is positing that once a person has arrived and worked through D (n) there is an inevitability that the person will be shifted by life events or something internal to Ps (n+1). This is part of development. At this point however, a person can regress to a quasi psychic retreat whereby they evade the uncertainty that has come upon them and regress further. Manic and melancholic defences can be employed in this regressed depressive state (and the use of the anti α-function) while a person could regress to a Ps (path) and become more properly paranoid (Britton, 1998). Alternatively, in embracing the Ps (n+1) they move to a new as yet "unimaginable" resolution which incorporates new facts, the possibility of D (n+1) (Britton, 1998, p. 79).

This is helpful clinically and in an understanding of mental health. It demonstrates that something can appear pathological but actually be a transition and therefore an indication of a willingness to grow and develop and

not become stuck in the depressive position. It makes us examine the move from Ps to D in a more nuanced way. Instead of seeing a shift from Ps to D as linear, á la Klein, there is a constant move between Ps and D and both are required for thought and mental growth. Importantly, this deepens the sense of what is required for mental growth in Bion's thinking. Mental growth sees development as an evolution, whereby a person moves from depressive position functioning into post-depressive states that can enrich the depressive potential to come. Optimally in states of mental health, a person evolves like a spiral, visiting a place that is familiar yet different. In the words of T.S. Eliot, "We shall not cease from exploration/And the end of all our exploring/Will be to arrive where we started/And know the place for the first time" (Four Quartets, 1963).

4.8. Conclusion

From Freudian impulses to Kleinian affects, Bion's work deepens our understandings of mental health as the capacities for thinking, thought and frustration tolerance are seen as essential to the growth and evolution of a person. His conceptualising of thought is always rooted in the emotional experience. Indeed, thought allows a person to process and tolerate painful emotional experiences, transforming them through processes of abstraction. Thought is also inter-subjective. Whether thought occurs in the interaction between two people or whether it occurs internally there is the requirement of a dynamic between self and other, between container and contained. Thus, mental growth is always relational. Moreover, thought is not about finding definitives or absolute truths. As has been described, the processes of thinking require a willingness to move from coherence to uncertainty again and again in order to enrich one's knowing about oneself and one's environment, and in order to face "reality" (Bion, Cogitations, 1991, p. 192). The mentally healthy person for Bion needs to think about things in a way that is rooted deeply in emotional experience, without the "memory" or assumption that they know this place and without the "desire" to escape and be elsewhere (Bion, Attention and Interpretation, 1970, p. 45).

5. WINNICOTT: BEYOND AND IN-BETWEEN FREUD AND KLEIN

5.1. Introduction

Ogden comments that Winnicott's theoretical explications of the "alive" subject constitute a "quiet revolution in analytic thinking" (1992, p. 624). Indeed, in Winnicott's writing while there are references to Freudian thought, and clear traces of Kleinian influence, his articulations of the psyche and mental health shift our understandings yet again. While Bion points to thinking as an inter-subjective experience, Winnicott's entire conception of the healthy subject is constituted along inter-subjective lines, which are at first between infant and mother and later become internalised. Winnicott highlights the importance of an early, primal dependence of the infant on its mother and of the quality of this early environment as essential to the acquisition of mental health (Rudnytsky, 1989). In this chapter I will argue that mental health for Winnicott is about the ability to exist in what he calls a "third space", that is neither purely subjective, nor entirely objective. While subjectivity and objectivity are also acknowledged as necessary for mental health, it is the capacity to reside in this space in-between which constitutes mental health for Winnicott. However, there are many capacities that need to be developed in an individual before he can reside in such a space. Specifically, the processes that occur around early dependence are fundamental precursors to the later negotiating of the "third space".

Winnicott wrote a seminal paper, "The Concept of a Healthy Individual" (CHI, 1967) where he discusses in his own terms what it means to be mentally healthy. In this paper he refers to health as something that extends beyond the absence of the symptom and that is not necessarily a state of comfort. He adds that at one time, perhaps, psychoanalysts did think about mental health in terms of the absence of a psychoneurotic disorder but that there has become a need for more subtle criteria (Winnicott, CHI, 1967). He writes that,

> … we are not contented with the idea of health as a simple absence of psychoneurotic disorder – that is, of disturbances relative to the progression of id-positions towards full genitality, and the organization of defence in respect of anxiety in interpersonal relationships – we can say in this context that health is not ease (CHI, 1967, p. 27).

In the above quotation, Winnicott comments that it is insufficient to apprehend mental health solely in terms of the movement of id-positions. In addition, he suggests that an evaluation of mental health requires the input of ego psychology but to evaluate the ego one needs to return to early, pre-genital development when the infant is still experiencing its most primitive needs (CHI, 1967). The quote also points to Winnicott's refusal to regard health as equivalent to a state of ease. There are a number of criteria that Winnicott enumerates in his description of mental health. He explains that healthy people feel fears, experience conflicts, suffer from doubts and frustrations as well as enjoying all the positive features of living (CHI, 1967). He writes that a person needs to feel that he is living his own life, that he can take responsibility for his actions and can accept blame where appropriate (CHI, 1967). In his language more specifically, mental health is indicated when a person has moved from dependence to independence or autonomy (CHI, 1967). A further expression that he suggests is about mental health as a state of being. From being emerges the possibilities of doing (CHI, 1967). Unlike the psychiatric view of mental health where functioning is regarded as important, Winnicott unequivocally places internal states of being above external ways of functioning (CHI, 1967). From his writing it is clear that Winnicott seeks something beyond Freud's developmental stages as an indicator of mental health. He approximates these notions of something beyond by suggesting that a person needs to feel a sense of aliveness, of existing and being. These are of course very broad terms, open to a range of interpretations. We therefore need to consider what constitutes this "space beyond" and explore what feeling a sense of aliveness and being means for Winnicott.

If, for Freud, healthy development reaches its apotheosis in a person's adjustment to and acceptance of the reality principle in a successful negotiation of the Oedipus complex, and for Klein, mental health is about developing a sense of internal reality as negotiated through affects and the working through of the depressive position, Winnicott articulates an additional, third space of psychological habitation which is necessary for mental health (CHI, 1967).

In this third space a person can engage with transitional phenomena (Winnicott, CHI, 1967). Occupying a position of liminality, the third space exists in-between self and other, between phantasy and reality, where continuity (of subjectivity) and contiguity (with the other) intersect (Hopkins, 1997). Originating in infancy, the third space represents a developmental shift where the infant is starting to "weave other-than-me objects into the personal pattern" (TOTP, 1971, p. 3). Transitional phenomena are those objects which the infant encounters as it starts to move away from the primary object of the breast. Initial transitional phenomena include the infant's thumb, a part of a sheet or blanket and even mouthing and the beginnings of sound. In the course of development an infant selects a particular object from the wider range of transitional phenomena in its environment. This object provides comfort and wards off anxiety and becomes known as the "transitional object" (TOTP, 1971, p. 4). The significance of the third space and transitional phenomena are explored in more detail in this chapter.

For Winnicott this third space is as essential to mental health as an acceptance of external reality and an ability to manage internal reality (Hopkins, 1997). In order to inhabit this space, an individual needs to have acquired certain capacities from the facilitating environment at a very early stage of development (Winnicott, PED, 1945). Indeed, if for Klein mental health is about working through the depressive position, Winnicott is concerned with capacities that develop at a pre-depressive level of

development[30] (PED, 1945). His primary concern is with this pre-verbal dimension of human experience where the infant is utterly dependent (Hopkins, 1997).

5.2. The Role of the Environment in the Development of Mental Health

Winnicott stresses the "primacy of dependence (Rudnytsky, 1989, p. 338) more than any other psychoanalytic thinker, in both human development and the analytic encounter. While he acknowledges the tension between nature and nurture in an individual, Winnicott prioritises the role played by nurture, suggesting that mental health is predicated on a particular quality of inter-subjective experience: the existence of a facilitative and unimpinging environment (SIA, 1968). His emphasis on the pre-verbal dimension of human experience leads him to regard mental health as a developmental and inter-subjective concern (SIA, 1968). Mental health is dependent on what happens in earliest infancy and is informed by the quality of environmental care provided, at first by the mother (SIA, 1968). Something occurs in the development of the individual in these early months of life which is essential to the unfolding of the mental health of a person. A person's "inherited tendencies" (CHI, 1967, p. 28) can only emerge if, as an infant, the individual is held and handled well and this holding needs to extend through from infancy to care of the child in the family. This early experience is what establishes the potential blueprint for a person achieving a sense of self, of existing and of autonomy as described above.

In this early phase of development the facilitation of an individual's development according to inherited tendencies, is paramount to mental health. This uninterrupted flow of development, "continuity of being" is the only way that an infant can move from dependence to independence (Winnicott, MPS, 1949, p. 247; SIA, 1968). Winnicott stipulates that this early

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[30] Winnicott concurred with Klein's notion of the depressive position. He referred to the psychological state of the depressive position as having acquired a capacity for concern (Rudnytsky, 1989).

environment needs to be "perfect"[31] (MPS, 1949, p. 245). In his words, "the perfect environment is one which *actively adapts* to the needs of the newly formed psyche-soma, that which we as observers know to be the infant from the start" (MPS, 1949, p. 245). At first, this need is absolute (Winnicott, 1949, MPS). This requires a devoted mother who makes all adaptations to meet the needs of the child. She is able to do this because she imagines the child's needs by identifying with the child through her narcissism, imagination and memories (MPS, 1949). If this environmental provision is absent, the child will not develop according to its natural tendencies (Winnicott, SIA, 1968). Such is the symbiotic relationship between infant and mother that Winnicott suggests that initially the unity of self includes the mother. The infant is so inter-subjectively intertwined with the mother at this early stage that it does not distinguish between "me" and "not-me". Indeed, for Winnicott, an infant does not exist without its mother.

With good development, the child sees mother as not-me as well as all other objects as not-me with some permeability between me and not-me so that "me" can take in or introject elements of not-me (Winnicott, SIA, 1968). Thus a sense of self, the "I Am" starts to emerge; this signals the beginnings of separate ego development (Winnicott, SIA, 1968, p. 56). For this sense of self to emerge the infant needs to allow a loss of the merged unit. As the infant develops, its need for an environment that caters to its needs becomes tempered. It becomes important for the mother simply to be "good enough" (Winnicott, MPS, 1949, p. 245). Winnicott (MPS, 1949) describes the "good enough" mother as the ordinary mother who will at times fail to meet the needs of her child. At this stage, the infant's mental activity and understanding accommodates the mother's failures (MPS, 1949). Thus the initial blueprint for mental health is not personal to the individual (MPS, 1949). A person can only become an integrated totality if "a perfect environment" is provided for "the

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[31] Winnicott uses the term "perfect" to describe the ideal early maternal environment. The notion that anything can be perfect, including a mother or a maternal environment is of course questionable. He has been criticised for imposing impossibly high expectations on the mother (Gallop, 1987). However, the point remains that in early development when an infant is utterly vulnerable and dependent, care needs to be taken to create an environment that shapes itself as much as possible, to the needs of the infant.

core of the self" (MPS, 1949, p. 246). Initially, the environment is supposed to do this but later this holding environment becomes internalised so that the person is able to care for himself (MPS, 1949). In the early months of an infant's life, the infant is utterly dependent on the mother in order to achieve three crucial steps in development: integration, personalisation and realisation.

5.2.1. Integration

Klein indentifies integration, and particularly the integration of so-called negative feelings and impulses into the personality as a criterion for mental health and suggests this occurs during the depressive position. For Winnicott integration is set in motion earlier, as the infant is born, and involves an initial coming together of the ego (PED, 1945). This is essential as in this early phase the infant feels as if it is scattered, in bits (at times in its own body at times in its mother's body) and unintegrated. Integration allows for a sense of self, the "I am" ((Winnicott, SIA, 1968, p.56) to emerge and for the ego to develop so that eventually the individual is able to function in the world. Thus integration is about gathering the infant into a basic unit that holds together and does not feel as if it is in bits (PED, 1945). At first a mother is required to gather one's bits together and later an individual develops a capacity to self integrate (Winnicott, PED, 1945). Initially, integration is assisted by very physical actions; an infant needs to be held, bathed, rocked, handled and even named (Winnicott, PED, 1945).[32] This process allows the infant to feel, gradually, that he is a whole being and that he is not inhabiting now his own body and now his mother's body but is localized in time and space, in his own body (Winnicott, PED, 1945).

Integration seems to be a primary criterion of mental health for Winnicott. Without a basic sense of one's self existing in time and space, it is impossible to inhabit more liminal spaces such as the third space. In addition, Winnicott

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[32] This contrasts interestingly with Bion's notion of containment which is less physical and more about a thinking capacity that is engendered between mother and infant. For Winnicott, a sense of self is at first facilitated by something more fundamental and concrete than thought; actual touch and correct handling.

writes that a healthy individual needs to have capacities for integration and also for disintegration where appropriate (CHI, 1967). He distinguishes between healthy and pathological forms of disintegration. Healthy disintegration or the ability to rest, relax and dream is what allows a person to express his creativity (Winnicott, CHI, 1967). A capacity for disintegration is what affords a person the possibility of actually being alive. However, it seems that healthy disintegration cannot occur without having acquired a primary sense of integratedness. On the other hand in pathology, disintegration or a person's experience that he is falling into bits, can lead to psychosis or a person can live a split-off, schizoid existence, constructing pathological defences in order to ward off disintegration (CHI, 1967). Rigid defences against disintegration can divest a person of his creative impulses and prevent creative living (Winnicott, CHI, 1967). Here Winnicott (CHI, 1967) is pointing to the fine line between psychopathology and health. Disintegration in pathology can be a sign of psychosis while in a relatively healthy person (integrated) it can allow a person the experiences of creativity. In contrast, sometimes sanity has a symptomatic quality to it because it is charged with fear and the denial of madness (CHI, 1967). Mental health requires that a person handle the innate tendencies of a human being to become disintegrated (CHI, 1967).[33] To feel real, people need to be willing to be in touch with their capacities to feel unreal and possessed. As Winnicott writes, "Health is not associated with *denial* of anything" (CHI, 1967, p. 35).

Over time, the attainment of integration gives an individual the sense of existing within parameters of boundaries and space; the person needs to have a sense that he has both an inside and an outside and that things come from outside (Winnicott, PED, 1945). In acquiring a sense of inside and outside, the infant attains a sense that he can be enriched by what he incorporates and also has a sense he can get rid of something when he has got what he wants from it (Winnicott, PED, 1945). He also sees mother as someone with an inside. From this description it seems that healthy

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[33] Winnicott distinguishes between unintegration and disintegration in infancy. The former is a normal part of the development where the infant feels itself to be in bits before its ego coheres. The latter is a terrifying experience where the infant feels itself to be dropped by the mother figuratively or physically (PED, 1945).

integration can lead to the capacities for healthy forms of projective
identification and object relations with the progression of development.

5.2.2. Personalisation

As important as integration is the attainment of personalisation (Winnicott,
CHI, 1967). Personalisation refers to an integration of psyche and soma and
its accomplishment implies that one feels as if one's full person is in one's
body (Winnicott, CHI, 1967). Winnicott (MPS, 1949) defines psyche as the
"imaginative elaboration of somatic parts, feelings and functions, that is, of
physical aliveness" (p. 244). His description of the psyche as an elaboration of
soma reveals how he regards the mind as inextricable from the body.
Winnicott also stresses that while we know that a healthy brain is essential for
the unfolding of imaginative functioning, a healthy person does not feel as if
the psyche resides in the brain or in any one particular place (MPS, 1949, p.
244).

The grounding of psyche and soma and the task of personalisation is
facilitated by two things; instinctual experience and the processes of body
care brought on by the facilitating environment. Both holding and handling are
essential to the development of personalisation and facilitate a degree of
harmony and integration between psyche and soma (CHI, 1967; Ulanov,
2001). Holding is described by Winnicott (CHI, 1967) as the initial carrying of
the infant while in-utero which then extends to the entire spectrum of
"adaptive care" (p. 27) necessary to the infant, including handling. Holding
refers both literally to holding the child and figuratively to holding the child in
mind. It is essentially about creating a caring environment that holds the child.
Handling on the other hand is subsidiary to holding and refers to the physical
details of early infant care; being bathed, fed, rocked and kept warm (Ulanov,
2002). Holding, both physically and figuratively, allows a person to move from
non-integration to integration and back again while handling allows a person
to acquire a sense of skin that envelops an inside that is separate from
outside (TFS, 1960; Ulanov, 2001). The psyche comes to be housed in the

body of the individual (Ulanov, 2001). Simply put, a good psychological environment early on is actually a physical one. [34]

It is through these early processes that a person acquires a sense of "continuity of being" or "going on being" (MPS, 1949, p. 247; Ulanov, 2001, p. 44). Continuity of being allows an individual to realize that he who sleeps is the same as he who is awake and that he who is satiated by the breast is the same person who wants to scream and destroy the breast. Thus, it enables an individual gradually to acknowledge his split off parts as he realizes that he who loves is the same person as he who hates and so on. [35] This is linked in early, primitive development to an infant's sense that he can display his ruthlessness because he feels that his mother will survive his aggressive and retaliatory attacks (PED, 1945). The infant's early, acquired sense that it is safe to be ruthless with mother allows the infant to not dissociate his ruthlessness. This becomes a necessary precursor for the infant being able to integrate his ruthlessness more consciously at a further stage of development when he forms a capacity for concern. Personalisation, with its associated qualities of psychosomatic aliveness also enables children and adolescents (and we might add adults) to experience enjoyment (CHI, 1967).

Gradually, psyche and soma develop so that they are in a dynamic of mutual inter-relatedness (Winnicott, MPS, 1949). If all progresses well, the inter-relatedness becomes inextricability; a person's body, with an inside and outside is "felt by the individual to form the core for the imaginative self" (MPS, 1949, p. 244). Indeed, challenging the dichotomy between mind and body, he avers that aliveness is about a sense of inhabiting a body (MPS, 1949). For Winnicott the development of psychological capacities such as imaginative functioning are dependent on psyche-soma integration and aliveness: imagination begins through elaborating on somatic experience (MPS, 1949).

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[34] It is interesting to note that in early stages of development, the infant does not experience a distinction between the developing body and psyche (Winnicott, MPS, 1949). Therefore the actual physical holding of an infant is fundamental to its psychic growth and development.
[35] This notion of integrating split-off parts is Kleinian. Winnicott's contribution is that the early environmental care and attainment of integration and personalisation are essential to these later integrative capacities; he foregrounds psyche-soma integration as essential to other forms of integration (Winnicott, SIA, 1968).

Later mental and psychological developments need to be informed by this physiological functioning (Winnicott, MPS, 1949).

If personalisation is an indicator of mental health, depersonalisation can assume the form of a person living as if they inhabit their minds only and not their bodies. In an extreme form, this mind-body split can assume the form of schizophrenia (CHI, 1967). In less extreme forms, a split between psyche and soma is an indicator for Winnicott that a person is living what he terms a "false-self" existence (MPS, 1949, p. 249; CHI, 1967, p. 33). This contrasts with a person being in touch with his true self which gives him a sense of his own authenticity (Winnicott, TFS, 1960; Rodman, 1987, p. xxix). Winnicott draws an analogy between his expositions of the true and false self and Freud's division of the self into a central aspect that is powered by the instincts and another part that is externally focused and operates in the world (TFS, 1960).

For Winnicott, the true self starts as a theoretical potential and from it there emerges the spontaneous gesture and personal idea. The gesture can manifest as any form of communication that comes from the infant, for example crying because it is cold or mouthing for food. In infancy, the gesture is physical, what Winnicott calls part of a "sensori-motor grouping" (TFS, 1960, p. 145). The "good-enough mother" needs to meet this infantile gesture and make sense of it (TFS, 1960, p. 145). In this interaction the mother who is ever-present and sensitive to the infant's needs, facilitates what Winnicott calls an "experience" which meets the infant's current wishes (PED, 1945, p. 152). From the infant's point of view, this utter adaptation to its needs (at first manifested through the mother's ever available breast) creates a sense of its own omnipotence as it feels it can wish for something and the thing can present itself. Thus, Winnicott calls this experience an "illusion" (PED, 1945, p. 152). However, while there is a quality of hallucination and illusion to the experience, the hallucination is also borne out in reality by the actual sensate experience (at first of the breast). The actuality of the experience means that the infant experiences his "illusion" as a thing belonging to external reality (PED, 1945). When the mother presents what the infant wishes for, infant and

mother "live an experience together" whereby the infant feels that he hallucinated the nipple (PED, 1945, p.152).

If the mother is not good enough, she substitutes the infant's gesture with her own. This sets up a compliance in the infant and is the earliest aetiology of the false self. The true self can only emerge if the mother meets the spontaneous gesture or "sensory hallucination" (TFS, 1960,p. 145). In doing this repeatedly, the mother strengthens the infant's weak ego and the true self acquires its life. While the infant's gestures are physical, as an individual develops, the gesture encompasses all forms of communication and desire that stem from the true self. The gesture and idea come as an expression of originality, from deep within a person, giving a person a sense of their creativity and realness (TFS, 1960, p. 148).

Through this process, the infant begins to believe in external reality which at this point seems magical because of the mother's adaptation to the infant's needs. However, in being allowed his omnipotence, the infant is gradually able to relinquish it and in time the spontaneity of the true self is able to join up with the reality of the world (TFS, 1960). The infant comes to enjoy the illusion of omnipotence and to recognise the illusory element of his experience. For Winnicott this is the beginning of play, imagination and the apprehension of symbolic development. In addition to experiencing the spontaneous gesture, the emergence of the true self is coterminous with a full psychosomatic existence. It constitutes what Winnicott calls a "psychosomatic indwelling" (Winnicott, CHI, 1967, p. 29).

If an individual feels that it is unsafe to reveal his authenticity and spontaneity, the true self goes into hiding. In this case, the false self is used as a defence to protect and hide the true self from being exploited and annihilated. Living with a false self defence implies a compliant but inauthentic existence (Winnicott, TFS, 1960). For Winnicott the false self exists in a split off mind (Winnicott, CHI, 1967). Indeed, a salient aspect of the false self is depersonalisation, the mind has a sense of being localised in a false locality, not in the body but simply in the brain (MPS, 1949; TFS, 1960). This is why

often an individual who lives by his false self regards his mind as the habitat of his being. The false self defence always carries a splitting or dissociation between intellectual activity and psychosomatic existence (TFS, 1960).

In terms of mental health, a person can have a highly functioning false self in the world, yet live with a sense that he does not really exist. The false self may be very successful but it will lack "creative originality" (Winnicott, TFS, 1960, p. 152). There are various manifestations of false self existence and not all of them are pathological. On the pathological spectrum, a person may behave to himself and others as if his false self is his real person (TFS, 1960). Less extreme is a person who lives with a false self while his true self is afforded a secret life (TFS, 1960). As a person moves towards health he may try find the conditions where the true self can come into its own. If the conditions cannot be found then the false self will perpetuate the defence.

In mental health, a person's life is informed by the true self (without being overwhelmed by it) while the individual harnesses the false self in order to function in accordance with the norms of society (without using it as a defence) (Winnicott, TFS, 1960). Thus there is an interaction between the two as societal functioning cannot be managed by the true self alone (TFS, 1960). This is because the true self has a very private aspect to it; it contains the deepest wishes and desires of a person which are not always appropriate to the reality of a given moment. The true self needs the false self as it is more easily able to adapt to reality and compromise. The false self negotiates with the world, finds ways in which the true self can express itself, connecting to things which feel real and worthwhile (TFS, 1960). In health a person's existence is powered by the true self. A person has a sense of being alive in his body tissues and a sense of being in touch with his bodily functions including his heartbeat and breath (TFS, 1960). At the same time, the false self with its mediating and executive functions, will allow for this crucial sense of aliveness to be realized in the world in appropriate ways. The false self contains the ego functions necessary to the realization of the true self in the world.

Provided the true self is not inhibited, it develops complexity over time, develops a trust in its own existence and is able to tolerate breaks in continuity of true self living (TFS, 1960). Thus it can handle false self experiences where it must comply but it does not feel as if its self is being annihilated in these instances (TFS, 1960). A healthy compliance develops and a person can adapt to his environment but this can only happen if there is a priori sense of a true self that has been made possible by the mother. "There is a compliant aspect to the True Self in healthy living, an ability of the infant to comply and not to be exposed" (Winnicott, TFS, 1960, p. 149). Thus compromise becomes an achievement and a way of measuring mental health (Winnicott, TFS, 1960). However, when an individual is presented with choices concerning crucial matters and deep values, the true self will override the false self.

Interestingly, coming to inhabit the space in-between the false and true self, between compliance on the one hand and creative living on the other, serves as a precursor for a person's capacity to use symbols (Winnicott, TFS, 1960). For Winnicott (TFS, 1960), the capacity to use symbols requires an ability to inhabit a space between dream and reality, between utter illusion on the one hand and grounded reality on the other. An individual who can exist in the in-between, compromise space of the true and false self existence acquires a deeper capacity to inhabit in-between spaces, allowing for an engagement with symbols. Conversely, a deep split between the true and false self disallows this in-between existence and results in a poor capacity to use symbols and a poverty of cultural living.

Depersonalisation and false self defences are more likely to occur with intelligent babies and mothers who are more likely to make impingements on the child because the child's intelligence will accommodate the mother's impingements (MPS, 1949). An impingement is any disturbance that occurs environmentally that interrupts the "continuity of being" of the infant (MPS, 1949, p. 247). On the one hand, the baby may appear to tolerate the frustration because it is intelligent (Winnicott, MPS, 1949). Therefore the infant may bear the impingement instead of reacting by crying. This

perpetuates the mother's committing of further impingements as the infant does not communicate that it is disturbed. But this intelligence can result in the infant denying the actuality of its psychological or physical disappointment. The failure of the mother can produce an overdevelopment of mental functioning and create a tension between mind on the one hand and psyche-soma on the other (Winnicott, MPS, 1949). In these instances, the psyche of the individual gets "seduced away into the mind from the intimate relationship which the psyche originally had with the soma. The result is a mind-psyche which is pathological" (MPS, 1949, p. 247). A false self ensues. Thus mental health requires a degree of intimacy between psyche and soma which an over-active and over-compensating mind can undermine. A healthy false self-true self interaction depends on the early attainment of personalisation.

If mental health is about a quality of authenticity linked to psychosomatic aliveness, its attainment requires a forgoing of the split-off intellectual capacity in order to locate the true self of a person (SIA, 1968).[36] Winnicott refers to a patient who came to therapy because her entire life felt false. She had developed mental functioning which she falsely located in her head (MPS, 1949). Winnicott (MPS, 1949) describes how in the analytic process, this patient had to be willing to relinquish her mind and return to a purely physiological state where all she was doing was breathing. This allowed her for the first time to claim her psyche as "an entity of her own" (Winnicott, MPS, 1949, p. 252) a body and also the beginnings of fantasy, informed by her physiological functions.

Winnicott (MPS, 1949) cites Scott who says when a person inhabits the mind as a defence, the person loses connections between the superficial and deeper aspects of the self, loses a sense of the boundaries and solidity of his

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[36] Winnicott does not seek to disparage the intellect. But in his emphasising the importance of psyche-somatic integration, he warns that the intellect can be exploited in order to perpetuate a split between psyche and soma (SIA, 1968).

own body and loses a sense of the body's memories, perceptions and images. Indeed, if Klein is interested in the shifting of affects as an indicator of mental health, Winnicott's theory around personalisation seems to predicate psyche-soma integration as essential to the experience of any full feeling or experience of existence. He writes that "the true self, a continuity of being, is in health based on psyche-soma growth" (MPS, 1949, p. 254).

5.2.3. Realisation

Freud foregrounds the importance of adjusting to the reality principle as necessary to mental health, but Winnicott highlights integration and personalisation as essential precursors to developing a primary relation to reality (Winnicott, PED, 1945). Adjustment to reality, called "realisation" in Winnicott's terms, is considered essential for emotional development (Winnicott, PED, 1945, p. 149). For Winnicott, adaptation to reality is a lifelong task that is never fully exhausted (PED, 1945). The beginnings of adjusting to reality take place through the inter-subjective, primary and fundamental interaction between mother and child. This inter-subjective interaction occurs at a vital confluence of the illusory and the real. It requires the mother to adapt to the infant's needs, creating the illusion for the child that it can hallucinate the object it desires into being. This process, where mother and infant "live an experience together" (PED, 1945, p.152) is described in more detail on p. 10. There, its importance is highlighted because the mother's active responding to the infant's gestures affirms and cultivates the true self of the child. However, the mother's adaptation to the infant's needs is also requisite for the development of realization. As the mother responds to the child's needs, the child is able to inhabit a space between hallucination and lived reality; what it hallucinates is experienced in the tactile, sensate world in the form of what mother presents. Thus, the infant gradually acclimatises to the reality principle and relinquishes omnipotence. This space requires that the infant grapple with a sense of its subjective experience as opposed to objective reality. As such this early dynamic informs the development of future object relationships (Winnicott, CHI, 1967).

The capacity for object relations, made possible by this early experience between infant and mother, continues to be an indication of health throughout adult life (Winnicott, CHI, 1967). Drawing on Klein, Winnicott points to the importance of both internal and external object relating and of having a balance between the two. He writes that object relations reach their full embodiment in meaningful interpersonal relationships but that they also exist in creative relating to internal objects (Winnicott, CHI, 1967). Winnicott explains that it is the richness of external and internal object-relating that assists a person in achieving a sense of being and existing. He writes that while a healthy person's inner world connects to the outer world, there is a space in the inner world that is separate from external reality and contains an aliveness of its own. He also comments that introjections and projective identifications take place all the time in object-relationships. Differing from Klein somewhat, Winnicott sees projective identification as both inevitable and also as a way of being connected to external objects in the world (provided the projective identification has a particular quality to it) (CHI, 1967). This connection to others through projective identification is what enables experiences of loss and death to be felt more keenly by healthy people (CHI, 1967). Reflecting sagely on the emotional hazards that accompany meaningful object relationships, Winnicott comments, "health must be allowed to carry its own risks" (CHI, 1967, p. 31).

While reality is associated with an individual's relationship to the external world, a person's adjustment to reality facilitates the evolution of the inner object relationship and ultimately enables a relationship to fantasy life and imagination (PED, 1945). Always concerned with the inter-subjective relationship, Winnicott suggests that the subjective experience of one's imaginative life can only be fully lived when a person has a sense of an objective reality (PED, 1945). A sound relationship between inner and outer is crucial. For Winnicott, something about the experience of illusion and the unfolding of imagination is integral to the psyche and mental health of an individual. He seems to be responding directly to Freud's assertion of the libidinally-driven child when he suggests that a child's interests in bubbles, breath, clouds, rainbows and fluff are reflective of this interest in illusion and

are not equivalent to libidinal drives or instincts (Winnicott, PED, 1945). Indeed, he comments that animal instincts and functions are part of being human but beyond our instinctual development, there is the capacity for cultural experience (Winnicott, CHI, 1967). Moreover for Winnicott, cultural experience is not about instinctual discharge as described in Freudian sublimation (Winnicott, LCE, 1967). Many of Winnicott's notions reveal an indebtedness to Freud and Klein. However, as mentioned in the introduction, in his discussion of cultural experience, he postulates a space requisite for mental health that extends beyond Freudian sublimation and beyond Klein's depressive position (Rudnytsky, 1989).

In his seeking a space beyond Freud and Klein, Winnicott indicates that psychoanalysis has been concerned, historically, with neurotic illness, addressing ego defences against anxieties that arise from instinctual life (Winnicott, LCE, 1967). Because of this association between psychoanalysis and neurosis, psychoanalysts have come to claim that mental health is about less rigid ego defences (Winnicott, LCE, 1967). This has been explored in detail in the Freud chapter. However, Winnicott comments that while psychoanalysts may have apprehended the importance of the absence of illness, "we have yet to tackle the question of what life is about" (Winnicott, LCE, 1967, p. 369). He continues, "It is of first importance for us to acknowledge openly that absence of psychoneurotic illness may be health but it is not life" (Winnicott, 1967, LCE, p. 369). He suggests that instinctual life is only one aspect of a person's experience and can become a seduction unless an individual has the capacity for experience in the realm of transitional phenomena (LCE, 1967). For Winnicott, something about the capacity to live in the transitional space is akin to life, living and being real for an individual.

5.3. Transitional Spaces, A Space "Beyond" in Mental Health

As mentioned, this chapter explores what it signifies for Winnicott that a person should be able to experience a sense of "being" and "feeling real" in order to be mentally healthy (CHI, 1967, p. 22). This notion of feeling real is predicated on a sense of ego-integration, psychosomatic aliveness and an

adaptation to reality. But it extends to other aspects which are informed by these aforementioned developmental milestones. In his exposition on mental health, Winnicott highlights three capacities as crucial to mental health. He refers to the importance of external life, including interpersonal relationships (CHI, 1967). He also acknowledges that a person needs to be able to experience an inner life (CHI, 1967). In acknowledging the importance of external and inner reality he recognises the influences of Freud and Klein on his thinking.[37] However, Winnicott's unique contribution and metaphor to his understanding of mental health and what it constitutes to be alive is about a third space, in between the inner and the outer. This third space, called the "potential space" (LCE, 1967, p. 372) or transitional space keeps inner and outer reality separate yet interrelated (TOTP, 1971). For children it is the space of play, while for adults it is the sphere of cultural experience (CHI, 1967, p. 35), called the "cultural space". This space encompasses an appreciation of the arts, the myths of history, of philosophy, mathematics, group management and religion (Winnicott, LCE, 1967; CHI, 1967). This realm of cultural space is neither fully internal as it is not simply dream, nor is it purely external as it is informed by dream and image making (CHI, 1967). A person needs the capacities to inhabit the realm of this in-between space (in addition to external and internal reality) if he is to be regarded as mentally healthy.

While the word "capacity" has been used throughout this research to refer to different aspects of mental health, it is Winnicott who emphasizes the word "capacity" in his expositions on the development of the individual (Hopkins, 1997, p.488). The word capacity, derives from the Latin *capere* which means to hold or contain and it is related to the adjective *capax* which means "roomy or capacious" (Hopkins, 1997, p. 488). It also implies the words "capable" and "capability", suggesting an ability to do things (Hopkins, 1997, p. 488). Capacity is both about the ability to hold something and also about the ability to do something (Hopkins, 1997, p. 488). For Winnicott the notions of

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[37] In fact, Hopkins (1997) suggests that Winnicott moved away from Freud in this regard. He shifted from Freud's dichotomy between fantasy and reality to Klein's dichotomy between inner and external reality.

capacity, capaciousness and space are very intertwined. A mentally healthy person needs to be able to hold and live in inner space, external space and transitional/cultural space.

How does the capacity to inhabit transitional space, this intermediate area of cultural experience, unfold? This area of cultural experience starts as the potential space between mother and child and is informed by the experiences of integration, personalisation and realisation described above (CHI, 1967). From the beginnings of life, the infant will have intense experiences with things that are experienced both as extensions of himself and as separate from him and beyond his omnipotent control (Winnicott, LCE, 1967). In Winnicott's language, the infant will hover between the subjective object and the object objectively perceived (Winnicott, LCE, 1967; TOTP, 1971). In this dialectical tension between me and not-me, between continuity of self and contiguity of the other, a potential space arises.

In this potential space, the infant will start to play with any objects that are readily available such as a piece of wool or blanket (Winnicott, TOTP, 1971). The objects founds in this space in-between are called "transitional phenomena" and if the child forms an attachment to one such object and it forms a function of helping the child ward off depressive anxiety, it is called a "transitional object" (TOTP, 1971, p. 4). This has been described in the **Introduction** to this chapter on p. 3. The infant relates to transitional phenomena in transitional space differently from earlier objects. Instead of having a sense of omnipotent control the infant starts to have a sense of control by manipulation (TOTP, 1971). The transitional object is not an internal object because it is real but it is equally not a purely external object at least from the point of view of the infant (TOTP, 1971). The infant assumes a deeply subjective relationship to the object, it assumes rights over this object and has an unusual cathexis to the object (TOTP, 1971). Yet, unlike the internal object, the transitional object is never under magical control and is not purely outside control like the external object. However, there is interplay among the three because an individual can only engage with transitional objects when the internal object is internalised, and is felt to be good and not

persecutory (TOTP, 1971). This internalisation can only occur because of the behaviour of the external object. Winnicott, more than Klein, emphasizes a causal relationship between the type of early maternal care provided and the quality of the infant's introjected objects. It is thus the external, facilitating environment that determines whether the infant's introjected objects will be good or persecutory, which in turn informs the possibility of inhabiting transitional space.

The processes involved in transitional phenomena signify that a person is starting to weave objects that are "other-than-me" into its pattern, resulting ultimately in affectionate types of object relationships (Winnicott, 1971, TOTP, p. 3). Thus, these objects are never lost, nor repressed (TOTP, 1971). Rather in health, the cathexis of these objects spreads and becomes more diffuse permeating the entire range of space between inner and outer reality.

This space, formed between infant and mother, both joins and separates as the mother gives the child an experience of trust and reliability. Unlike inner reality and the environment which Winnicott regards as constants, this space is variable in that it relies on an interaction (LCE, 1967). Winnicott unequivocally states that an adult's capacity for cultural experience is engendered only through the infant's early experience of dependence on the mother (LCE, 1967). Through dependence a certain confidence is sown. The early instantiation of confidence and reliability are essential to the child as they lead to a further capacity which enables experience in the transitional space; the capacity "for belief" [38] (Hopkins, 1997, p. 489). Confidence and reliability develop as a child senses that it is creating the objects around it and that these objects will survive the destructive urges of the child (Hopkins, 1997). They will not disappear, nor retaliate (Hopkins, 1997). With time, there is a sense of object-constancy and a sense of trust that accumulates which cultivates this "capacity for belief" (Hopkins, 1997, p. 489). This requires a certain depth, an interior space where the child has a sense that certain things are worth believing in (Hopkins, 1997). Belief involves the capacity to trust in

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[38] Belief is not about a religious affiliation although the object of belief might end up being affiliated with a religion. The capacity precedes the object (Hopkins, 1997).

something. Moreover, according to Winnicott, belief allows a person to hold onto paradoxes, more complex truths and less certainty. The ability to accept paradox and release a need for certainty is regarded as a positive outgrowth of a healthy human being. Thus, the capacity for belief is not about certainty and dogmatic truths. Rather, the capacity for belief which emerges out of the confidence and trust formed in the early relationship allows a person to inhabit a realm that is betwixt and between, neither fully internal, nor fully external, a realm of paradox, uncertainty and symbol formation.

The concepts of transitional space and cultural experience led Winnicott to re-examine Freud's concept of illusion. While Freud saw illusion as something that was devoid of content, Winnicott sees illusion as something necessary to the infant which then forms the basis of art, religion and cultural experience in adult life (Winnicott, TOTP, 1971). Winnicott is interested in what lies underneath illusion, giving it substance (Winnicott, TOTP, 1971). He writes that illusion should be regarded as essential to human existence and not viewed merely as something to be outgrown (TOTP, 1971). Yet, he warns that illusion can be taken to the extreme when a person forces others to share an illusion that is not their own (Winnicott, TOTP, 1971). With an individual's capacity for illusion instilled, he is more able to manage the disappointment of disillusionment which is first ushered in during the depressive position at the time of weaning (Winnicott, TOTP, 1971).

Winnicott links his notions of cultural space and the importance of illusion to the depressive position. He suggests that the very ability to work through the depressive position and fully accept uncertainty and paradox is determined by one's capacities for illusion and disillusionment. In the depressive position, a person attempts to relate inner and outer reality. This effort is worked on throughout life in the realm of this third space (TOTP, 1971). Thus throughout life, we engage in this realm of illusion, this third space through the arts, religion, imaginative living and creative scientific work (Winnicott, TOTP, 1971). It is not possible to attain depressive position functioning without a capacity to inhere in this third space. Winnicott's notion of the third space and his evaluations of illusion, belief, paradox and creativity expand the definition

of mental health as it becomes important to inhabit transitional realms in order to be fully alive. This state of mental health is dependent on a particular, early quality of care that instantiates a capacity for belief and a tolerance of paradox and uncertainty.

5.4. Conclusion

In this chapter, Winnicott's understanding of mental health has been explored in the context of his wider theoretical framework. While he works from certain core assumptions that are of Freudian and Kleinian origin, his views on mental health have an iconoclastic feel to them. Indeed, Winnicott wrote, "Freud's flight to sanity could be something we psychoanalysts are trying to recover from" (cited in Hopkins, 1997, p. 493).

His elucidation of a third space necessary for mental health that starts as play and becomes an area of cultural experience is a unique phenomenological and psychological contribution. Phenomenologically, the positing of a potential space between external and internal reality is a unique psychoanalytic assertion. Psychologically, the ways in which Winnicott points to the necessity of inhabiting this space as an indicator of mental health is also significant. Hopkins (1997) suggests that his cultural space is one more example of the Winnicottian dialectic between separateness and union which he expounds upon in early development between infant and mother and which later becomes an intra-subjective concern.

Indeed, Winnicott's notion of cultural space is predicated on attainments acquired in early development. Winnicott supported Klein's ideas on the depressive position, and her notion of the manic defence as defences against the depressive position (Aguayo, 2002). However, he criticised the absence of environmental emphasis in her work and her lack of focus on the role of the mother in the development of the child (Aguayo, 2002). Hence Winnicott focuses on a pre-depressive position which exists with the mother in tandem (Aguayo, 2002). It seems that in describing mental health, Winnicott seeks a space beyond Freudian sublimation of instincts and beyond Klein's

depressive position where he feels a person can be and feel real and fully alive. This leads him to explore pre-depressive functioning and also the role of transitional space in mental health.

Winnicott's ideas on mental health, on early dependence and the role of the environment as well as his positing of a third space in between internal and external reality enrich our understanding of what it signifies to be mentally healthy. We shall consider further their overlap with and diversions from Freud, Klein and Bion in the next chapter.

5.5. Key for Winnicottian Texts

CHI: The Concept of a Healthy Individual

LCE: The Location of Cultural experience

MPS: Mind and its Relation to Psyche-Soma

PED: Primitive Emotional Development

SIA: Sum I AM

TFS: True and False Self

TOTP: Transitional Objects and Transitional Phenomena

6. DISCUSSION

6.1. Introduction

In this thesis I have explicated four key psychoanalytic theorists' views on mental health. In the process, I have returned to the theoretical models of each theorist and searched for the underlying metaphors around which their ideas on mental health seem to turn. While it is not possible to reduce their ideas on mental health to a single metaphor, certain key notions have risen to the fore as central to mental health for each theorist. In what follows I briefly review the dominant conceptualisations of mental health used by each theorist. Next, I consider significant differences and similarities among these theorists and I attempt to consider implicit differences which could be reflective of differing philosophical underpinnings. Finally, I consider a meta-theoretical perspective on the nature of each thinker's use of metaphor as an expression of mental health.

My central argument in this chapter is that the different views on mental health among the different thinkers reflect different underlying perspectives on the world. If we, as psychoanalysts and psychoanalytically-oriented therapists, subscribe to one or another approach, we unwittingly impose particular worldviews on our patients as well. Therefore it is important for therapists and analysts to take greater cognisance of the philosophical underpinnings of theorists instead of seeing each theory as a universal truth. This will allow us to be more aware of our own implicit assumptions and to consider our aims and values with each patient more carefully.

6.2. Summary of Central Metaphors

For Freud, mental health turns on his structural theory. The ego needs to be able to relate to the id and the superego. Additionally, mental health requires that neither the superego nor the id is too overwhelming. This in turn allows a person to manage the central conflicts between the life and death drives as well as the pleasure and reality principles and to live with a degree of

uncertainty and ambivalence that is not avoided through evasions such as religion, addictions or other forms of mental illness.

For Klein the focus shifts away from Freud's structural theory and the theory of instincts.[39] Freud's assertion of the life and death drives becomes for Klein a central conflict in a person between feelings of love and hate (Stein, 1990). For Klein, mental health is about managing the vicissitudes of these feelings of love and hate and their different manifestations (including idealisation, denigration, envy, admiration, aggression etc) through the paranoid-schizoid and, more importantly, the depressive position. Working through the depressive position becomes a hallmark of mental health for Klein as it is an indicator that a person can tolerate mature levels of feelings or affect, including depressive anxiety. This is what enables a person to love in a complex, alloyed Kleinian sense.

Bion, working with and advancing from Klein, develops his own language around mental health which includes two crucial factors; a person's capacity to think about his feelings and his ability to tolerate the frustration that precedes and results in thought. Bion articulates this ability to think as a function in the psyche, expressed through the container-contained. His notion of thinking is not about intellectualised abstraction; it is feeling-toned and requires that a person enter into his feelings and not detach from them, so that he can modify and symbolise them at increasingly abstract levels.

Finally, Winnicott's unique contribution to an understanding of mental health is about a third space that exists between external and internal reality. This space emerges inter-subjectively, at first between an infant and its mother and later becomes the space of play, cultural life and symbol formation. For Winnicott a person needs to be able to inhabit this transitional or liminal space in order to be fully alive and vital. An ability to inhabit this space indicates that a person can tolerate paradox and uncertainty.

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[39] Klein never explicitly rejects the instincts, but her thought reflects a shift in focus from instincts to affects as has been discussed in previous chapters.

6.3. General Differences

Paying close attention to the language of each theorist, it is interesting to note that Freud refers to a "structure" as central to mental health (his structural theory), while Klein speaks of "position" as important (paranoid-schizoid and depressive), Bion identifies a "function" in the psyche (alpha function, container-contained) and Winnicott points to the importance of inhabiting a "space" (transitional/cultural). Are these simply linguistic idiosyncrasies or does the language of each theorist point to something about their views on mental health that is important? This shall be considered in the chapter. In addition, the theorists differ in terms of the different developmental stages that are vital in determining the outcome of mental health. While Freud's formation of the superego around the time of Oedipus (three to five years of age) is central in his formulation of mental health, for Klein, the potential for mental health is imprinted much earlier, during the depressive position when a child is pre-verbal and still an infant.[40] For Winnicott and Bion, the potential for mental health is instilled even earlier at a time of pre-depressive functioning. In addition, the instantiation of mental health varies for each thinker. Winnicott and Bion point to the inter-subjective factors required for a person to be mentally healthy. For Freud and Klein inter-subjectivity and the importance of the environment is not denied but is equally not foregrounded.

For all four theorists, mental health is couched in the original language of their specific theory. As these thinkers forge new ground, aligning themselves with their predecessors yet also distinguishing themselves from them, their ideas on mental health shift somewhat. In terms of what is common to all the theorists, it is interesting to note that external functioning is not any of their priorities when it comes to apprehending what it means to be mentally healthy. In addition, the mere absence of symptoms does not suffice. There is also an interesting focus for each theorist on the importance of bearing anxiety, frustration or paradox. For Freud the bearing of anxiety is an important indicator of mental health and he questions the validity of turning to

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[40] Baudry (1994) writes that the Freudians believed that anything preverbal was not knowable and there was no point in saying anything about it.

religion in order to ward off this fundamental human experience. For Klein, the ability to experience and tolerate depressive anxiety is an indicator of mental health while for Bion, the bearing of frustration is essential to the development of thought. Winnicott points to the importance of tolerating paradox and uncertainty. In addition, each theorist refers to the capacity to love as an indicator that mental health has been attained.

6.4. Specific Differences and Dialogues Among the Thinkers

As Stein (1990) has noted, Klein does not explicitly deviate from Freud in her writing. In fact, she often reveals an attempt to highlight similarities between herself and Freud and to employ his language, even when she intends different meanings (Stein, 1990).[41] This attempt at pointing to the similarities and playing down the differences has sometimes been perpetuated in the different schools of thought. Baudry (1994) points out that in the early Freud-Klein controversies, the Kleinians sought to show that their paradigm flowed from Freud's thought. They also took Freud's texts and quoted them, sometimes out of context, in order to demonstrate that Kleinian ideas were implicit in his writings (Baudry, 1994). However, for the purposes of understanding mental health, there are some important differences between Freud's and Klein's thought. In this section, I explore the tension between "drives" and "affects" as well as between "structure" and "positions" in Freud's and Klein's work respectively.

Throughout the development of Freud's work, he remained concerned with managing instincts while Klein's work shifted to managing anxiety as a way of tolerating higher and different forms of feeling/affect. She continued to use the word drive, but Greenberg and Mitchell (1983) argue that for Klein the drives were not purely internal states to be regulated internally but were "directional psychological phenomena, constituting complex emotions" (p. 138). Stein (1990) points to libido and aggression, so central to Freud's thought as the

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[41] Baudry (1994) has pointed to a phenomenon in psychoanalytic thinking where some key terminologies are loose in definition and are applied and used in variable ways by different thinkers.

elaboration of the life and death instincts as a case in point. For Freud, these are quiescent and pervasive forces in a person, while for Klein, these same terms become more personal, directional emotions and a person has more agency in the task of integrating them.

In other words, Freud's conceptualising of internal forces in relationship with each other transform for Klein into emotions that are directed towards a wider variety of internal and external objects. Thus, for Freud, mental health is about managing an internal tripartite structure, while for Klein, emotions become directed towards a myriad of internal and external objects - the quality of which all matter for mental health. Greenberg and Mitchell (1983) suggest that for Klein, libido and aggression are "inherently oriented toward the outside world, as personal, structured passions" (p. 143). In a Freudian model, when evaluating mental health, an analyst may be interested in the drives as expressed through the structural dynamics of the psyche. In a Kleinian model, this is less important than the emotional valencies directed towards one's objects. This distinction between internal drives and object-directed drives that have an emotional valency reflects a shift from a focus on instinctual energy to an evaluation of mental health based on the quality of emotional relationship between oneself and one's objects. As the language of drives is still present in Klein's writing, it is important to draw out this distinction and for therapists to take more cognisance of it.

The difference in metaphor between Freud's notion of "structure" and Klein's articulation of "positions" reflects an additional important underlying tension in their thought. Stein (1990) concedes that Klein's theory did not make room for a mental apparatus within the psyche and Yorke (1994) argues that mental health within a Kleinian framework lacks a model like Freud's tripartite structure of the mind. He explains that while Klein points to the importance of managing persecutory and depressive anxiety, she does not emphasise enough how this anxiety needs to be managed through the ego (Yorke, 1994). Freud conceived of the ego as a mental apparatus that had to manage various incursions from the id, ego and the external world. Hence, the modification of the ego becomes so central in a Freudian paradigm in the

attainment of mental health. On the other hand, Klein's view of the ego referred more to the self and did not play such an important function in the development of her theory.[42] The articulation of a notion like "structure" in the psyche, allows for modifications and growth of the structure. Freud's use of the term opens up the possibility for psychic change and the attainment of mental health; it leads to the possibility of the personality being transformed. The word "structure" is not to be regarded simply as a linguistic expression. Rather, it informs how treatment is planned and goals are established for a patient in an analysis.

Where "structure" is central to Freud, "positions" are important for Klein. Thus for Klein, mental health is about managing anxiety situated within the persecutory and depressive positions, and there is no reference to modification of personality structures within the psyche. Some argue that Klein's positions are represented as crude dichotomies formed in infancy and that they do not accommodate for interplay among different parts of the personality at different levels of mental development (Yorke, 1994). In situating the human being in one of two psychological positions, Klein's theory can miss the complexity of the human being, reducing everything to crude dichotomies of infancy (Yorke, 1994). Klein's focus on positions can end up reducing the possibilities of mental health to a horizontal movement, swaying between one and another position in an endless cycle. Freud's structural model has a more linear sense to it of a person's ability to shift and grow through life. Yet Klein's foregrounding of affects in relation to objects modifies Freud's model which is in danger of curbing a human being as a cluster of drives which need to come under the reality principle. Therapists would do well to consider how to integrate the notion of "structure" with "positions" as the exclusion of either paradigm can limit what we conceive of as achievable for our patients.

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[42] Prior to 1923, Freud used the word ego to refer to the self and at other times to the executive function of the mind. Yorke (1994) argues that while Kleinian technique has shifted in the last fifty years, Kleinian concepts have remained reified and untouched by Klein's followers. However Yorke suggests that shifts in technique necessarily imply a shift in theory. For example, Kleinians have come to implicitly acknowledge that there are not just different psychological functions but ego functions in a Freudian sense.

Where Freud and Klein are similar is in their assertion that tolerating ambivalence is an indication of mental health. Both thinkers suggest that an acceptance of the limits of the self and reality and the acknowledgement of the inevitability of good and evil within a person and one's objects is essential to becoming a mature and mentally healthy individual. Thus a central philosophical underpinning is shared: Both assume that it is part of human fate to live lives filled with frustration and limitations (Strenger, 1997). Moreover, there is an assumption that there exists an inevitable mismatch between inner and outer reality which fuels the suffering that we are ultimately meant to accept. This is reflected strongly in Klein's notion that a person's opus in life is achieved in working through the depressive position with its resultant acceptance of ambivalence. For Freud it is expressed in *Civilisation and its Discontents* (1930) where he elaborates on the importance of bearing the suffering of life.

Bion, an object-relations theorist who was influenced by Klein and Freud, developed conceptions of mental health that differ from them. He articulates mental health in related terms of a person's capacity for thought as well as frustration tolerance. More than Klein, Bion explicitly rejected Freud's structural model, suggesting he did not find it useful (Symington and Symington, 1996). Yet he compensated for this by developing other notions, such as the container-contained, in order to express how thinking develops in the psyche.

While the concept of tolerating suffering appears to be shared by both Freud and Bion, the underlying assumptions of each thinker vary greatly (Symington and Symington, 1996). Freud avers that the pleasure principle has an overriding influence on human motivation and behaviour: a person forgoes a particular pleasure in the hope of experiencing greater pleasure at a later date (Symington and Symington, 1996). The irreconcilable clash between the pleasure and reality principles consigns people to inevitable suffering. Yet pleasure remains the primary driver; sublimation as a notion of deferred and transformed pleasure remains central to Freud's thought until the end. Bion,

on the other hand, suggests that people are not only motivated by higher or lower experiences of pleasure. A qualitatively different factor motivates people; a desire for the "emergence of truth" and "emotional growth" (Symington and Symington, 1996, p. 6). However, these prime motivators often require the concomitant acceptance of suffering (Symington and Symington, 1996). This subtle difference implies that Bion does not hierachise pleasure as a driving factor in a person, nor does he seek the elimination of suffering.

Moreover, Freud's notion that a person be able to tolerate suffering is not exactly equivalent to Bion's notion of frustration tolerance. That a person should tolerate suffering is part of Freud's articulation of the reality principle, where internal and external reality clash, suffering is inevitable and a person needs to tolerate it. Bion's notion of forbearance has an added dimension to it; it is accompanied by the possibility of emotional growth. There is a sense in Bion's thought that being able to tolerate frustration and suffering produces thought and leads to the development and even enrichment of the human being. The underlying premise of Bion's notion of suffering has an implicit transformative quality to it and is linked to hope.

Bion was closer to the Klein school than any other. He used her thoughts on projective identification, splitting, the death instinct and the paranoid-schizoid positions (Symington and Symington, 1996). Like Klein, he was concerned with inner reality and objects. There are also some similarities in their approaches to mental health. For Klein, a person needs to be able to tolerate the vicissitudes of affect in order to work through the depressive position and thus develop capacities for mental health. For Bion, the capacity to think about one's feelings and confront the truth about oneself also implies an ability to experience feelings such as regret, sadness and guilt. As these difficult feelings emerge, Bion suggests that truth (most simply explained as an individual's awareness of his given emotional state) emerges and with it the emergence of hope (López-Corvo, 2003; Symington and Symington, 1996). While there appears to be an alignment in terms of their viewpoints on affects, it can be argued that Bion develops Klein's work further. If Klein refers

to the importance of transforming affects from the paranoid-schizoid to the depressive positions, Bion develops an understanding of the underlying processes whereby feelings emerge and are transformed. In his work around the container-container and the alpha-function, Bion develops a greater understanding of what is requisite for affective shifts to take place in a person. While it is possible to see Bion's work as a development and evolution of Klein's thinking, there are also fundamental differences in their underlying assumptions which in turn inform variances in their approaches to mental health.

Symington and Symington (1996) suggest that Bion's notion of "O" separates him further from both Freud and Klein. "O" is the ultimate, unknowable reality that takes place in an analytic session, in artistic creation or in a state of "illumination" (López –Corvo, 2003 p. 197; Symington and Symington, 1996). The paradox of "O" is that it can be touched on through experience but it can never be fully known (López -Corvo, 2003). Moreover, for a person to develop an ongoing capacity for thought and therefore to be mentally healthy, an individual must be open to "O" in life and in the analytic session (Eigen, 1981)

Bion's view of "O" is described as having metaphysical and religious allusions (Symington and Symington, 1996). Indeed, Eigen (1981) describes the openness to "O" as a position of faith where a person suspends the desire to know and surrenders to the inevitability of not fully knowing. This faith accumulates as a person suffers the disruptions and difficulties that psychic life is prone to (Eigen, 1981). In his description of "O" Bion, unlike Freud, acknowledges a "religious" position which does not rest on the desire to escape suffering but indeed is constituted through enduring suffering. His acknowledgement that a human being can experience metaphysical possibilities in mental health is a significant shift away from Freud and Klein. In contrast, Klein and Freud regard religious sentiments, at best, as a crutch to help the mentally weak deal with suffering. "O" with its premise of unknowable reality, challenges fixed and more constricted ideas of the human being. In asserting that the starting point of the human is "O", Bion creates the ontological possibility that human beings have desires beyond those of

physical needs (Symington and Symington, 1996). This is distinguishable from Freud who regards the starting point of the human being as that of fundamental physical drivers; undifferentiated and indistinguishable impulses (Symington and Symington, 1996). It is also discernible from Klein who conceives of the human being as determined by internal forces such as greed and envy (Symington and Symington, 1996). [43]

In his model of the human being and mental health, Bion makes room for possibilities that extend beyond the pleasure principle, the id, ego and superego, and even beyond the depressive position as is discussed in the Bion chapter. The postulation of "O" is a significant indication that Bion's thought is not underpinned by the same values of determinism as Freud and Klein. Being open to "O" and living with a faith in that which cannot be known is distinguishable from Freud's focus on ego-mastery and from Klein's delineation of processes whereby ego and objects can be known through introjection and internalisation (Eigen, 1981).

Bion's metaphor of the container-contained seems similar to Winnicott's notion of a holding environment. Yet, Symington and Symington (1996) expound in great detail on the differences between the concepts. The container is an imaginary concept. It is used to describe the thinking apparatus that develops between mother and child and gradually becomes internalised, but its actual function is abstract and not concrete (Symington and Symington, 1996). A container is an "internal" phenomenon. In contrast, Winnicott's holding environment is concrete and external; it requires the physical holding and handling of the infant by the mother (Symington and Symington, 1996). Leading from this, the holding environment is both non-sensuous and sensuous. The mother needs to hold the child figuratively but also literally. [44] The container, however, is non-sensuous. The container-contained dynamic is active but it can promote growth or destructiveness,

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[43] Although I have argued that Klein's theory is primarily about affects, it is important to note that these affects are seen as innate to a person, and in fact, to be the expression of basic body contents and drives (Strenger, 1997).

[44] It is important to acknowledge that Winnicott's notion of the holding environment does include that the child be held figuratively in the mother's mind. His writing on the holding environment is not reducible to a purely sensuous experience.

while Winnicott's holding environment by definition is meant to be positive and promoting of growth (Symington and Symington, 1996).

Yet, I wish to ask whether these concepts are as separate and differentiated as Symington and Symington suggest. In spite of the significant theoretical differences, each concept is understood to be vital in the attainment of health within the respective frameworks of Bion and Winnicott. The container is what makes thought possible, the fundamental prerequisite for mental health in a Bionian framework. For Winnicott, a holding environment allows for a sense of self to develop that is eventually distinguished from the mother, enabling a person to live in transitional space. Thus the container-contained leads to thinking capacities while the holding environment leads to the inhabiting of the third space that is cultural life. It enables the capacities for experiencing psychosomatic aliveness, symbol formation and object-relationships. Importantly, some of the capacities acquired through a holding environment are thinking abilities. Therefore, while the container-contained and the holding environment may function differently, they seem to yield similar outcomes. I would argue that Bion's container leads to the more narrow capacity of thought whereas Winnicott's holding environment leads to a breadth of capacities one of which is the capacity for thought. Where thinkers wish to discern between the container-contained and the holding environment, there seem to be important overlaps between these concepts, even while they remain irreducible.

There also appear to be similarities in some of the underlying premises between Bion and Winnicott in their approaches to mental health. Both Bion and Winnicott understand mental health to depend, at some point in its development, on an inter-subjective experience. They also hold a less pessimistic view of human nature than Freud and Klein. In the Winnicott chapter I wrote about his assertion that the capacity for belief is essential to mental health as it enables an individual to experience transitionality. Eigen (1981) suggests that Bion's concept of "O", while not reducible to Winnicott's notion of transitional space, is an expression in his language of the importance of faith and belief. Both Bion and Winnicott situate these

analogous notions as central to mental health. In Eigen's (1981) words, both "O" and transitional space are central to developing full "human-consciousness" and "self-other awareness" (p. 413).

Moving on to Winnicott more specifically, it can be argued that Winnicott's notions of mental health separate him most starkly from Freud and Klein. In fact, his less deterministic views of human nature have had him referred to as the "arch romanticist of psychoanalysis" (Strenger, 1997, p. 213). For Winnicott a human being is motivated by a desire to feel "alive" and this innate sense of "aliveness" relies on the external environment to be perpetuated (Strenger, 1997). Mental health in a Winnicottian sense is linked to the realising of one's true self, of one's spontaneous gesture. However, because we are born into utter dependence, this potential can only be realised through a suitable environment. In contrast, for Klein an individual's nature is pre-determined and the effect of the environment on the individual does not mitigate some fundamental assumptions about human nature: Klein's view of human nature sees the human being as an individual filled with greed, envy and aggression co-existing with loving and reparative strivings and she downplays the role of the environment in early development.[45] Indeed, Padel (1991) observes that for both Freud and Klein, the infant is born a separate individual and its task becomes one of forming a psychical relationship with the mother, while for Winnicott the infant is born as a unit with the mother and its task becomes about separation.[46]

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[45] Padel (1991) points to the interesting divergences in Winnicott's and Klein's thinking as it unfolded historically: Winnicott's paper "Primitive Emotional Development" was published in 1945 where he enumerates the importance of the mother's holding and handling of the child in the early pre-depressive phase where integration, personalisation and realisation are essential. On the other hand, Klein's seminal paper "Notes on Some Schizoid Mechanisms" (1946) emerged one year later where she insists on the fundamentally paranoid-schizoid state of the early infant's experience, irrespective of environmental provisions.

[46] It is interesting to note that Klein's view of the infant as an aggressive, egocentric being was in accordance with cultural norms of her times (Strenger, 1997). The commonly held views of her times were that infants' should not be overindulged or spoilt, that it was good to let an infant cry (Strenger, 1997). In contrast, Winnicott's theory around the infant emerged around the forties and fifties when Dr Spock brought out his revolutionary book on the infant, arguing that infant's could not modulate their own frustrations. It became inadvisable to frustrate the needs of the infant.

Winnicott's notion of the "true self" jars with a Kleinian paradigm. Her view that the human being moves from the paranoid-schizoid to the depressive positions has been critiqued for allowing little more for the individual than the integration of envy and aggression and the subsequent experience of sadness and guilt. In contrast, Winnicott acknowledges the importance of working through the depressive position as being a hallmark of health, but he also foregrounds experiences beyond the Klein's depressive position (Padel, 1991). Life is not simply about repairing perceived damage done, it is also about creativity. Creativity for Winnicott is what constitutes "aliveness" (1971, p. 79). Winnicott does not view creativity narrowly as the production of a work of art but rather sees it as something that is potentially present in any healthy human being. It is constituted by a particular approach to life, by looking "in a healthy way at anything" (1971, p. 80). Creativity pertains to that in a person which is real, personal, original and hidden; therefore it comes from being in touch with one's true self (Winnicott, p. 81). Winnicott even enumerates the manic defence (and the liveliness it involves) as an experience that can constitute aliveness and potential creativity (Padel, 1991)

If his view of the individual's potential differs from Freud and Klein, Winnicott's metaphor of the cultural space separates him further from Klein and Freud's demarcations. He conceives of creativity as much more than a defence or a sublimation (Eigen, 1981). For Winnicott, creativity is itself a primary term of human experiencing and this is why he is the only thinker to predicate a cultural space as essential to mental health. For Winnicott, in contrast to Freud and Klein, creativity permeates psychic life and is involved in the very birth of self and other, a process more fundamental than substitute strivings (Strenger, 1997).

Strenger (1997) says that Winnicott's development of the transitional space was a direct response to Klein's fatalistic view of the world. The intermediary space is precisely one which negotiates the boundaries of me and not-me. Life and subjectivity are constituted in the interstices of relationship between self and object, self and environment instead of being defined by innate, pre-determined forces. Therefore, the difference between Klein's choice of the

word "positions" and Winnicott's articulation of "space" becomes significant. The former alludes to something fixed and narrow, pre-determined, if you like, while the latter is suggestive of something expansive and capacious. The metaphors reflect the underlying viewpoints of each theorist towards the relative potential of the individual.

What seems to be emerging from this thesis is that "metaphor matters". Indeed, the shifting language of each theorist refers to variations, not just of language, but of the philosophical underpinnings which inform his/her worldview. The differing metaphors of each thinker reflect basic underlying premises in relation to the world, human nature and the interaction between internal and external reality in relation to an understanding of mental health. Psychoanalytically-oriented therapists and psychoanalysts need to examine deeply, not just our patients' metaphors, but the metaphors of the writers who guide our work. This can help us consider our own premises in relation to our theoretical predecessors. In turn, this can assist us to become more aware of the implicit assumptions that guide our work as therapists, determining the treatment and goal outcomes for our patients. Moreover, the end-goal that drives our work, the meaning and significance of mental health should be the first point of inquiry.

6.5. A Meta-Theoretical Perspective on the Metaphors of Mental Health

Thus far I have considered the metaphors of mental health for Freud, Klein, Bion and Winnicott at the level of content. I have considered some of the philosophical underpinnings implicit in these metaphors and discussed where these thinkers differ from each other and also where they converge. I now wish to shift this discussion from content to process; to consider the very act of articulating an idea on mental health through language. I wish to argue that something about the enunciation of each of these theorists' ideas on mental health through language points to an additional insight about mental health which can only be apprehended at a meta-level or the level of process. To begin this discussion I turn to the work of Julia Kristeva.

In her book *Maladies of the Soul* (1995)*,* Kristeva makes an interesting comment about the role of psychoanalysis in the late twentieth century. Starting with the assertion that modern life is permeated with a hollowness beneath the veneer of spectacle and consumption, she suggests that psychoanalysis is the one space where people can still locate a psychic life for themselves. This is because psychoanalysis is one of the few remaining spaces that respects the value of psychic life and facilitates the "eroticization of language" (1995, p. 36). Erotic speech for Kristeva is the significatory end of a particular dynamic, with the other end being instinctual drives. The importance of erotic speech becomes clearer when Kristeva suggests that many modern psychopathologies are plagued by a common malady; the inability to represent. This deficiency might come across to the analyst through the experience of a psychic mutism or a communication from the patient that he/she feels "empty or artificial" (p. 9). This inability to represent the psyche results in a deficiency in sensory, sexual and intellectual life. Thus, she suggests that analysis can provide "an eroticization of language" which can help relieve symptoms and can give patients a greater capacity for signification (1995, p. 44). She clarifies that this in no way is about seeking the normalization of the patient.

Hence she suggests that in the future psychoanalysis is going to be one of the few remaining endeavours that "will allow change and surprise, that is, will allow life" (1995, p. 44). Elaborating on her argument, Kristeva reminds the reader that the primary method of treatment in psychoanalysis is the linguistic mechanism. The speech of both the patient and the analyst incorporates different series of representations which are primarily psychic in origin, and are not reduced to biological systems. Thus the task of the psychoanalyst becomes to "restore psychic life and to enable the speaking being to live life to its fullest" (1995, p. 9). For Kristeva, modern psychic maladies are at heart about a difficulty to represent the psyche. This disjunction between psyche and speech creates a hollowness found not just in society but also in the utterances and articulations of people. We speak but there is no eros to our language. This can end up destroying the psychic life of the individual. Therefore the task of psychoanalysis is to revitalise grammar and rhetoric and

to enrich the style of patients who wish to converse within the analytic framework. In being able to articulate his/her own psychic life, an individual's capacity for intimacy becomes possible (Kristeva, 1995).

I cite Kristeva at length at this point in the chapter in order to consider the ways in which theories of mental health are expressed through metaphors that shift from thinker to thinker. In the process of creating new metaphors that embrace but also move beyond the language of the theorists who come before them, each psychoanalyst in this project seeks to articulate his/her erotic language. By erotic language I refer to a language that connects to and represents his/her own psychic life and that reaches out to the other- the object. That each thinker carves a new language for him/herself is not incidental. Rather, it is part of the project of psychoanalysis itself; that each individual can draw from his/her psychic life an enunciation, an utterance that is representative of the psyche, is capable of intimacy and is therefore erotic.

At this level of consideration, the differences between the thinkers assume an altered significance. It is not that one is right and the other is wrong. All are expressions of an attempt to represent mental health; mental health that is not reducible to normality but that is defined by its idiosyncratic nature and also by its vitality. The individual nature of each thinker's metaphors has been expounded upon throughout this research. The vitality of their language is conveyed by the fact that we remain reading their theories today but perhaps more-so by the fact that they each ventured to craft a distinctive theory at all. Each thinker had the courage to seek their own articulation of things, even as they felt beholden to their predecessors. Kristeva points to the weight that Freud bears on his followers. She writes that he "staked out a path that all innovators must respect if they lay claims to psychoanalysis" (1995, p. 36). In this statement she points to the weight of psychoanalytic tradition which each thinker needs to bear as they consider for themselves the vicissitudes of the psyche, of pathology and, indeed, of mental health. Therefore, while each theory may have its lack and its imperfection, the very act of writing the theory models an analytic perspective on mental health; the willingness to explore psychic life and to express that through language.

Each thinker wrote in relation to their analytic predecessors, in relation to their own life experience, in response to the zeitgeist of their times and in relation to their own psyche. In this sense their writing reflects many of the features of mental health we have spoken about; the ego's ability to bring desire under the reality principle, a capacity for ambivalence which is an indication of depressive functioning, an ability to think about themselves and their patients and an inhabiting of cultural space. Could it be that the aliveness of a person, as expressed through idiosyncratic language is an indication of psychic life and therefore of mental health? If so, we have come a far distance from notions of normalcy, functioning and the eradication of the symptom.

7. CONTEMPORARY PSYCHOANALYTIC THOUGHT ON MENTAL HEALTH: MENTAL HEALTH AS ACTS OF READING AND INTERPRETATION

This thesis has considered perspectives on mental health from the points of view of four psychoanalytic thinkers who lived and wrote in the first half of the twentieth century. In this section I consider attitudes towards mental health articulated by contemporary psychoanalytic thinkers. Firstly I enumerate some key writings that deal with the subjects of "mental health" and "psychic change". Using the work of Cooper (1992), I show that there are broadly three approaches to mental health as encapsulated by what are called the "reconstructionists", the "developmentalists" and the "anti-curists". In the course of the discussion I show that, regardless of approach, contemporary thinkers tend to refer back to the language of mental health articulated by Freud, Klein, Bion and Winnicott. Finally, I suggest that if the early psychoanalysts can be depicted as writers and creators of metaphor, contemporary thinkers in the field are readers and interpreters of inherited concepts and metaphors on mental health.

Cooper (1992) suggests that there are three different approaches to mental health within the psychoanalytic paradigm. The first model follows a traditional Freudian paradigm, articulating mental health in terms of a surgical metaphor, as a requisite repair to damaged psychological structures (Cooper, 1992). Here, says Cooper (1992), the central metaphor is "reconstruction" (p. 246) whereby distorted affect and object-relational structures are reshaped and repaired. This is in line with Freud's ideas on mental health which I have argued centre around his structural theory and the need for modification. The "reconstruction" model informs a different approach to psychoanalytic technique: the analyst is active in trying to get the patient to understand his maladaptive behaviours through interpretation and insight (Arlow and Brenner, 1990; Cooper, 1992). This is done, largely, through careful attention to the transference which is examined but not manipulated.

Cooper's articulation of the "reconstruction" approach is reflected in Arlow and Brenner's model of psychic change and conflict. Arlow and Brenner (1990) construe mental health and pathology in terms of conflict and compromise formation. Grounded heavily in Freud's structural model, these thinkers suggest that mental functioning is determined by an interaction of various forces in the mind. Health occurs when a person is able to make "normal" (Arlow and Brenner, 1990, p. 679) compromise formations as opposed to creating symptoms out of their conflicts. Included within this process is the importance of a person having a growing awareness of the nature of their conflicts (Arlow and Brenner, 1990).

Arlow and Brenner's views are supported by thinkers like Steiner (1996). Steiner suggests that the theory of mental conflict remains at the heart of psychoanalysis and that mental health requires the ability to negotiate one's conflicts. He explains that when a conflict cannot be negotiated, symptoms develop and maladaptive defence mechanisms are employed. The aim of analysis is to help an individual resolve conflict in healthier ways, through insight (Arlow and Brenner 1990; Steiner, 1996). Insight assists a person to understand their conflicts instead of acting out on them. However, this is not equivalent to Bion's sense of thinking instead of acting. Rather, control over impulses remains part of the aim (Arlow and Brenner, 1990). In Arlow and Brenner's (1990) words, "the range of the patient's awareness is broadened, irrational anxieties are diminished, and the tendency toward resorting automatically to stereotyped responses in the face of perceived danger situations gradually diminishes. The range of the ego's control is expanded" (p. 680). Many of Freud's ideas are found in the above quotation. There is a focus on the lessening of anxiety, less of a tendency to act out on impulses and, crucially, the ego is strengthened. Arlow, Brenner and Steiner reflect Freud's approach to mental health within their own contemporary frameworks.

Steiner (1996) says the resolution of conflicts inherited from Freud is greatly enriched by Klein's notions of projective identification. He refers to Klein's development of the notion that ego and objects are split into good and bad and he links this to her development of the psychological mechanism of

projective identification where the split off fragments of a person are disowned and attributed to someone else in phantasy. When this occurs, a person denies separateness between self and object, depletes his own personal resources and experiences the object in a perceptually distorted way. Thus the aim of psychoanalysis becomes to regain those parts of the personality that have been lost because of the mechanisms of projective identification. For Steiner (1996), projective identification is reversed if a person is able to face psychic reality, withdraw projections and mourn the loss that results from this "confrontation" (p. 1076). As Steiner (1996) puts it, projective identification obscures the reality between self and object and this reality is necessary for insight. Yet, it can only happen when projections are relinquished. Projective identification and regaining parts of the personality do not negate the overarching aim espoused by the conflict model. Regardless, insight remains the central goal of the process and projective identification becomes a tool to understand how an individual is blocking insight from taking place (Steiner, 1996). While Steiner relies on Freud and Klein in his articulation of mental health, his use of Klein differs from Caper's application of Klein which will be discussed further in this chapter. Klein may inform their thought, but they each assume a slightly different attitude to mental health.

Arlow, Brenner and Steiner seem to advocate a "reconstructionist" angle to mental health, whether they are informed by Freudian or Kleinian theory. However at the end of Steiner's discussion, he emphasises that analysis should not aim to solve a patient's conflict but should aim to develop the individual's mental assets to the point that he can resolve these conflicts in his own, unique way (Steiner, 1996). Compromise formation remains an index measure of mental health, however Steiner acknowledges that analysis can assist this process but not complete it. Rather, he suggests an individual needs to be equipped to resolve his own conflicts. This attitude, found throughout psychoanalytic writing, reflects a cautious attitude in terms of what can and should be achieved in an analysis.

The second approach is termed the "growth" model (Cooper, 1992, p. 246). The "growth" model assesses mental health in terms of whether a patient is

able to resume his/her normal pattern of growth prior to its being thwarted (Cooper, 1992). Referring to Kohut, Cooper (1992) explains that this approach claims that in an environment of benign objects, a person will grow according to their potential. In this model, it is the environment (benign or harmful) which thwarts the natural growth and unfolding of a person. Thus mental health occurs when a person can resume their natural growth pattern and fulfil their potential. This model is described by Arlow and Brenner (1990) as the "developmentalist" approach (p. 684). However they trace it back to Winnicott where he avers that mental health will occur if environmental provision is appropriate allowing a person to fulfil his/her innate potential. Called "developmentalist", this approach holds that symptoms have a specific developmental (as opposed to constitutional) aetiology. This attitude informs the psychoanalytic technique of those who hold by the "growth" or "developmentalist" model: there is an aim to create in the therapeutic situation an improved version of the mother-child relationship that failed the patient in the first few years of life (Arlow and Brenner, 1990). Moreover, the analyst will be aware of how his counter-transference could obstruct natural, healthy processes and will try to create a therapeutic environment that can facilitate growth (Cooper, 1992).

As mentioned, Cooper attributes the "growth" model to Kohut. In his paper, "Introspection, Empathy and the Semi-Circle of Mental Health", Kohut (1982) elaborates on what he regards as mental health from a self psychology perspective. Critiquing some of the central tenets of traditional psychoanalysis, Kohut says that psychoanalysis can fall into the trap of becoming a re-education based on predetermined goals. These goals are unacknowledged and unquestioned and the patient is led toward them through the transference. Kohut says that hierarchised in this re-education model are the values of knowledge and independence. Yet he warns that these can lead a patient away from his own "nuclear programme and destiny" (1982, p. 399). Kohut is concerned that these values have led analysts away

from understanding the needs of the innermost self.[47] For Kohut, given the right environment, a child will become a cohesive, harmonious self with the right balance of assertiveness and affection. He also rejects the Freudian assertion that humans are consigned to intergenerational and familial strife as articulated by the Oedipus complex. Rather, he suggests that given the right environmental conditions, a natural, deep familial bond can form.

For Kohut, the core of the self is inherently positive; it is constituted by the functions of introspection and empathy. Other aspects of the self such as hatred and aggression are reactive and brought on by environmental wounding. For Kohut, as with Winnicott, it is flaws in the early environment that cause pathology. A person is not caught in a great inner battle between *Eros* and *Thanatos* but rather struggles because of interferences with innate growth potential that occurred in early childhood. Human beings thus have a need for a normal "self-growth-promoting-milieu" (Kohut, 1982, p. 405). Mental health in an individual cannot be defined apart from one's environment.

According to Kohut, mental health is about experiencing a repaired self and a sense of self-esteem; this can occur through shifts in environment starting with the therapeutic situation. In therapy the aim is to restore the self, to elevate self-esteem and to allow for the evolution of a new self (Arlow and Brenner, 1990, p. 680). In the unfolding of Kohut's argument, he turns to the myth of Odysseus in order to attest to the possibility of natural and inherent intergenerational bonding. He cites an instance where Odysseus saved his son's life through an action which resulted in his being sent off to war. Kohut draws on the myth in order to attest to the inherent empathy in individuals which extends towards their children. He then offers a re-interpretation of the Oedipus myth in order to challenge Freud's assertion of a-priori inter-generational strife. He points to the (often ignored) fact that Oedipus was a rejected child and suggests that it was environmental factors which led to the

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[47] Kohut (1982) takes issue with the drive concept in psychology which he regards as an imposition from biology and with notions such as "autonomy", "identity", and "adaptation" which he sees as imports from social psychology (p. 401).

subsequent patricide, not an inherent, universal feeling of aggression or jealousy directed from the son towards the father.

Kohut's central articulations around mental health have to do with a certain type of self which at its core is innately good and has the capacity for introspection and empathy. In his writing he challenges Freudian notions of biological determinism, ineradicable internal conflict and the absolute truth of the Oedipus Complex. Kohut's writing seems to suggest that given the right conditions, cure is possible and amounts to a return to an original goodness. His argument relies on an explicit re-reading of Freudian theory around the Oedipus Complex.

Cooper refers to the third approach to mental health as the "anti-cure group" (1992, p. 245). This group claims that psychoanalysis should not be about cure per se. Rather, the goal of psychoanalysis should be to "foster curiosity" about one's mental life, expand the area available for psychological scrutiny and increase one's degree of individual autonomy (Cooper, 1992, p. 245). Cooper adds that this approach can ironically be at odds with what our patients regard as success. He explains that our patients want to feel relief and might choose symptomatic relief over the deeper work of psychoanalysis. Mitchell (1993) comments that this approach to mental health has become stronger in the late twentieth century. He argues that mental health in a psychoanalytic paradigm is no longer about coming to terms with unacceptable impulses. Rather, it is about helping individuals to live a richer, subjective life. Similarly, Cooper (1992) points to how, previously, the process of working through and the role of the superego were considered essential for psychic change and now this has shifted.

Robert Caper's writing contains strong strains of this anti-cure approach. Tracing Caper's writing on mental health reveals an interesting development between 1992 where his language seems informed by Kleinian thought, and 2001 where his metaphors reflect Bion's influence more strongly. In 1992 Caper writes that the goal of psychoanalysis should be nothing more than the integrating of different parts of the personality. He says that this notion goes

back to Freud's (1933) idea "where id was, there shall ego be" (p. 80); but he believes Freud was referring to split off impulses or affects while Caper is referring to split off parts of the personality. Caper (1992) warns that the goals of analysis should not be more elaborate than this or the analyst will fall into the trap of seeing himself as a "magical healer" (p. 285). He cites an instance where Kohut alleviated his patient's symptoms while perpetuating his patient's splits because he allowed the role of "magical healer" to be projected onto him. Caper (1992) warns strongly that it is important to realise that mental health is not about getting rid of unconscious parts of the self which emerge. Rather, the goals are more curtailed: a person needs to accept his unconscious parts, mourn the attendant loss of the idealised self and face depressive anxieties. Acceptance of all that one is, rather than impressive exorcisms of unwanted aspects, seems to be the cautious understanding of what analysis can achieve and what mental health is. For Caper (1992), there is very little reference to eliminating symptoms other than to warn analysts that the quick cure of a symptom could simply be the perpetuating of a split between patient and analyst. Rather, he emphasises that mental health is about the patient recovering himself.

Caper's cautious writing about mental health and psychoanalysis in 1992 has a depressive position tone; he points to the limitations of what can be achieved. Implied in Caper's approach is that the analytically-oriented therapist needs to be vigilant about not imposing his values about cure onto the patient or simply accepting the patient's views on what he perceives as normal functioning, including his values about cure. As he puts it, "Success in analysis is measured by the degree of integration, not by the degree to which the patient approximates a standard of normality" (Caper, 1992, p. 289). While he and Steiner refer to Klein and the notion of integration, Steiner's approach has a more structural, "reconstructionist" flavour to it while Caper's application of Klein's concepts is more cautious as to what can be achieved.

In 2001 Caper revisits the question of what can be achieved through psychoanalysis. Instead of a focus on integration, he suggests that the goal of psychoanalysis and by inference what is to be regarded as mental health is

an individual's capacity for "psychological development" (2001, p. 99). "Psychological development" seems very broad but Caper explains that it takes place through four shifts in an individual, each one being requisite for mental health. The first is the creation in the individual of a new relationship or attitude to his/her own mind. This altered relationship to one's mind entails than an individual perceive events in his mind as mental and not concrete. Such a shift renders the mind less frightening to the patient and, paradoxically, allows him to react to his mind as something that is not predictable or knowable. While Bion has written extensively about approaching the patient without memory or desire and without imposing past experiences, Caper (2001) says that in mental health this is also the task of the patient in relation to his/her mind. Instead of trying to predict or control the mind, an individual needs to realise that his mind and thoughts can only be acknowledged and thought about.

A shift in attitude to one's mind is crucial and leads to the next change required of an individual for "psychological development": an individual may long for control over his mind but mental health is about realising and accepting that the mind cannot be controlled. Thus a person needs to forego his/her omniscience and desire to control the mind and recognise a central tenet of psychoanalysis; there is an unconscious and therefore we do not control our thoughts. Thus the analyst's task may be to show that what the patient perceives as sanity (a controllable and predictable mind) is actually insanity, while sanity is what the patient previously may have regarded as madness. Like the lines in Emily Dickinson's poem "Much madness is divinest sense/To a discerning eye;/Much sense the starkest madness" (1959, p. 122) Caper points to a notion of mental health that is distanced from a sanitised conception of "normalcy".

The third shift required in a person is that an individual be able to feel in general and to feel like oneself in particular (Caper, 2001). Here there are echoes of Klein and Winnicott, in the sense that a person needs to be able to feel affect and also to feel in touch with something akin to a true self. Feeling one's feelings can be experienced as destabilising and thus, can sometimes

come at the cost of feeling utterly secure. Therefore Caper (2001) expands on his concept of feeling by saying a person needs to be able to bear experience instead of gaining an utter feeling of security. The fourth shift he enumerates is that the ego, that part of the personality which can "think, feel and form judgments" (2001, p. 114) needs to be strengthened. The ego, in turn, will mitigate the "archaic superego" which is that part of the personality which impedes thinking and learning (Caper, 2001, p. 114).

In sum, Caper refers to four criteria by which mental health can be attained: that a person is able to experience his mental life as abstract, that a person is open to surprise (including in his mind) and does not hold onto omniscience, that a person can feel and think about what he feels, and that a person's ego is strengthened. He concludes that these are four angles on the same thing but they only point towards rather than "define what that thing is" (2001, p. 115). Caper's four criteria contain echoes of his primary influences. His focus on shifting one's attitude to one's mind has a strong Bionian feel to it, while his emphasis on relinquishing omniscience and strengthening the ego hark back to Freud's notions that the ego should be both flexible and strong. His referring to the importance of experiencing feelings has a Kleinian feel to it and his earlier writing on integrating different aspects of the personality also seems strongly Kleinian.

Caper (2001) points to the limitations of analysis and challenges the notion that analysts can perform miraculous cures for their patients. Perhaps, he plays down what can be achieved in an analysis because he is concerned that analysts may impose their value systems onto their patients in the name of cure. He warns that analysts, like their patients, can fall into the trap of seeking stability, normalcy and cure. This can be detrimental for the patient as the analyst may unconsciously be trying to tame the mind of the patient in order to fit the analyst's needs. Rather, the analyst needs to help the patient develop a capacity to be in contact with and tolerate his own mind which will in turn allow the person to develop independently. For Caper the analytic encounter has the potential to confer on a person a sense of independence so that the person is free to use the experience of analysis as he/she wishes.

Yet in spite of his cautious tone, what Caper articulates as achievable is significant for any individual. That a person can integrate split off parts of his personality, can think about himself, his feelings and thoughts, that he can forego his omniscience and that his ego can be strengthened above the archaic superego are all inner, psychological attainments which can enable a person to live his life. Indeed, that Caper shifts in his own writing from 1992 to 2001 is a reflection of these very capacities evolving in the author, to think about his own thoughts and assumptions, to relinquish a sense of omniscience and embrace change.

Ogden (1992) also works with the conceptual and linguistic inheritance of prior theorists (Freud, Klein and Winnicott) but he acknowledges that he is an interpreter of their work. His interpretations yield interesting nuances in how he perceives the psychoanalytic subject and mental health within a psychoanalytic paradigm. Centrally for Ogden, mental health is about being able to live in the interstices of existence, relinquishing rigidity and stasis. Although he does not articulate it explicitly, his concern with the non-static subject is suggestive of an approach to mental health that veers away from cure.

Ogden (1992) looks to Klein's writings in order to support his approach, specifically her articulation of the paranoid-schizoid and depressive positions. However, he adds an additional position called the "autistic-contiguous position" (1992, p. 614). In this position a person experiences life in a more sensuous way as first experienced between the infant and the environmental mother, prior to the sense of a separate existence. Thus Ogden says that mental health is about being able to occupy a "dialectical tension" (1992, p. 613) among these three positions. A person hovers among these positions because neither one can be apprehended or experienced in pure form.

Ogden's focus on a person's capacity to hover among these positions differs from a traditional Kleinian notion where a person moves linearly from the paranoid-schizoid to the depressive position. Ogden (1992) writes that in

psychoanalytic thought there is a focus on positions or structures existing diachronically (within linear time). However, he emphasises that positions also exist synchronically (simultaneously). For Ogden the synchronic aspect of these positions is vital. For mental health to occur, a person does not need to have arrived at the depressive position but can inhere in all three positions simultaneously. For Ogden (1992), this confers on a person a richness of existence. Thus for Ogden mental health seems to be about a subject that is de-centred, shifting, complex and constituted by states of liminality as opposed to fixed and linear positions. In his focus on the individual being constituted dialectically, Ogden affirms that the human being is displaced from his sense as leader of his own development. For Ogden, the paranoid-schizoid and depressive positions are not hierarchised. Furthermore, what he calls the de-integrating aspects of the paranoid-schizoid positions, such as splitting of objects and ego, should not be pathologised. Rather, they form one pole of the dialectic with its other end being the integrating aspects of the depressive position, as the split objects and ego move towards integration and wholeness. Without the pole of de-integration, the depressive position is in danger of becoming stale and fixed. Thus he writes, "The negating, de-integrative effects of the paranoid-schizoid position continually generate the potential for new psychological possibilities (i.e the possibility for psychic change) (Ogden, 1992, p. 616).

This dialectic extends into the inter-subjective space between the analysand and the analyst. For Ogden (1992), the individual comes to exist as an analytic subject in what he calls the "dynamic inter-subjectivity of the analytic process: the subject of psychoanalysis takes place in the interpretive space between analyst and analysand" (p. 619). In mental health, this inter-subjective process becomes internalised so that a person can end an analysis but continue his/her life in space that is constituted through dialectics, through a continuous "internal dialogue" (p. 619) that takes place within his own personality. For Ogden (1992), a healthy person is able to exist in an eternal dialectic between self and Other or object.

Ogden (1992) also refers to Winnicott to reinforce his claim that a healthy individual is de-centred. He refers to four of Winnicott's concepts, which he suggests are dialectical in nature. The first is the tension between separation and union that takes place between the mother and the infant. The second is the dialectic of recognition and negation by the infant of the mother in the mirroring phase. In this phase, the recognition and negation that takes place involve different aspects of the infant's self. As it looks into the mother's face, it discovers a sense of both "I" and "me" (p. 621). Ogden (1992) describes this as recognition and negation; the infant looks as its mother and through a recognition of what is relatively the same, it finds its "I". Yet, it also sees something that is not quite "I", experiencing a sense of relative difference or negation, allowing for the discovery of "me" (Ogden, 1992, p. 621). This engenders a sense in the infant of the "observing subject" and the "subject-as-object" (Ogden, 1992, p. 621).

Winnicott's third concept is the tension between creation and discovery of the object in transitional object relatedness and the fourth is the dialectic of the "creative destruction" of the mother during "object usage" (1992, p. 620). Ogden suggests that for Winnicott, a person always needs to be decentred and to be constituted through inter-subjectivity, through interactions with the Other. Also important for Ogden's notion of the decentred subject is the important role played by the unconscious in a person. That is, in psychoanalysis, neither consciousness nor the unconscious is privileged. Because consciousness is always undone by the unconscious, in mental health a person is never static but is always "becoming" (1992, p. 624). This is in line with Caper's notion that in mental health an individual needs to acknowledge the primacy of the unconscious and the fundamental uncontrollability of the mind.

Ogden's articulations of a person existing in a decentred way, in a dialectical tension between autistic-contiguous, paranoid-schizoid and depressive positions, between part and whole objects and between self and Other differ from Arlow and Brenner's conception (1964) that a person should develop linearly along diachronic lines with any pathology being regarded as a

regression to a temporal fixation point. His ideas also differ from Kohut's approach that there is an essential goodness or essence to a unified, coherent self. Rather, Ogden emphasises the values of decentredness as opposed to unitary coherence, flexibility as opposed to stasis, and seems more concerned with the individual's process of becoming rather than with a sense of actual arrival. This leads me to suggest that his approach to mental health is also part of the "anti-cure group" in that he refuses fixed goals for an individual in his articulation of mental health.

De Bianchedi (1991) writes an interesting article on psychic change, which she equates with the goals of a therapy or with the criteria enlisted for cure to happen. It is interesting that De Bianchedi chooses Freud, Klein, Bion and Meltzer in her exploring the meanings of psychic change. As with the other contemporary writers mentioned in this section, she remains indebted to the theorists preceding her and engages with their metaphors in order to wrest out her own. De Bianchedi concludes that for herself, mental health is about "mental growth" (1991, p. 9). Mental growth is both about thinking about one's emotional experiences and also involves a "becoming" (1991, p. 10) which is achieved through actual events in a person's life. Mental growth evolves into an intuitive understanding of oneself and others. This for De Bianchedi is the psychoanalytic understanding of mental health; the self needs to increase its knowledge about itself and through this the tendency to mental growth is increased. Her approach is similar to that of Caper and Ogden and is suggestive that perhaps there is an increase in challenging notions of absolute cure within a psychoanalytic paradigm.

7.1. Conclusion: The Act of Reading as an Act of Mental Health

In her writing on mental health, De Bianchedi (1991) makes a reflexive remark about the processes of reading and writing within the psychoanalytic paradigm. She says that as psychoanalytic thinkers and practitioners we also need to have a capacity for mental growth: we need to be willing to relinquish the known interpretations of theories, and approach the known texts anew in order to discover fresh connections and innovative meanings. Indeed, there is

a very interesting link to be made between our relationship to theory and our relationship to our patients; the one cannot be fixed and staid while the other remains alive and innovative. De Bianchedi thus points to an interesting connection between the vitality and ongoing processes of theory and the maintenance of these processes with our patients.

De Bianchedi, Ogden, Brenner, Steiner, Caper and even Kohut are indebted to their theoretical precedessors in their own formulations of the psychoanalytic subject and mental health. Arlow and Brenner (1990) explicitly acknowledge a debt to Freud, while Steiner's referring to compromise formations and personality integration harks back to Freud and Klein. Their approach challenges Mitchell and Cooper's claim that an emphasis on impulse control and structural change is obsolete among contemporary psychoanalytic thinkers. Kohut articulates his own theory (although it bears strong similarities to Winnicott's) but he does so through engaging in argument with Freudian theory. Indeed, while Kohut challenges the "father" of psychoanalysis, he does this through the act of reading. He attempts to inscribe another myth within the psychoanalytic corpus and to re-read the myth of Oedipus. Caper's work shows strong influences of Klein and Bion and Ogden acknowledges a debt to Freud, Klein and Winnicott. De Bianchedi explicitly traces her thoughts back to Freud, Klein, Bion and Meltzer. It is interesting to observe that while all of these thinkers engage with the theory that precedes them, they differ in the ways they read and interpret their predecessors' work. Therefore each of them engages rigorously with a textual inheritance but translates it in a creative way. In other words, it is their approach to reading that allows them to become writers and conceptualisers of theory.

In the **Discussion** I argued that at a particular level, mental health is about developing the ability to articulate one's own metaphors as is reflected through the writing of Freud, Klein, Bion and Winnicott. Among contemporary thinkers, a different pattern emerges, their articulations are uniquely slanted but they are influenced strongly by pre-existing ideas. However what becomes important is not that they "write" their own metaphors but that they read,

engage and interpret in a way that reflects a capacity for mental openness and growth.

This brings me back to the beginning of this research. Cooper (1992) comments that in psychoanalytic writing there tends to be a focus on clinical information and linking theory to clinical work, while there is a lack of pure conceptual theory. While this research is conceptual in nature, it is concerned with raising awareness among psychoanalysts and psychoanalytically-oriented therapists about our underlying assumptions to do with mental health. One of the techniques that is focused on in clinical research is the technique of listening to our patients; how do we listen, what do we listen for, what is "active" listening, how to listen without memory or desire and so on. However, as practitioners we carry the weight of theory with us into our consulting rooms. Therefore, I wish to suggest that if listening is important with our patients, reading and writing are important in our relationship to our own theory. As psychoanalytically oriented practitioners we need, for our professional mental health, to maintain an open, readerly approach to our psychoanalytic literature and to be willing to venture forth new metaphors where appropriate, balancing the tension between the weight of the past and the lightness of originality. This integration of listening well to our patients, reading our texts well and exploring their underlying assumptions and writing our own thoughts in our own formulated and articulated metaphors ensures that psychoanalytically oriented approaches will be able to sustain an aliveness and a freshness that constitutes our own mental health. In this way, our concepts will not become reified, as their aliveness will be felt, as it were, "all the way down", in our consulting rooms and also in our reading groups and our conferences.

8. CONCLUSION

This research has traced the articulations of mental health as integrated in the theories of four psychoanalytic thinkers, Freud, Klein, Bion and Winnicott. In returning to these theorist's writings and contemplating their explicit and sometimes implicit assumptions around mental health, it has emerged that there are significant differences among these theorists though they are all broadly "psychoanalytic". It has also emerged that there are striking similarities. Freud's approach to mental health is guided by his structural theory, his articulation of the life and death drives, his thoughts on love, and his work on tolerating anxiety through advanced forms of sublimation. The richness of Freud's writing has allowed later theorists to pick up and focus on different areas of his work so that differing psychoanalytic models and approaches to mental health have evolved who all attribute a link back to Freud. However, his structural approach to mental health is carried through in the compromise formation model of Arlow and Brenner and thus finds its own voice among contemporary thinkers.

Klein's writing on mental health is inextricably linked with her notion of the paranoid-schizoid and depressive positions and with the ability to feel affects as an individual moves from one position to another, gradually tolerating higher, more mature affects. Her writing also refers to the importance of the capacity to love, although her notion of love contains a complex amalgam of love and hate developed and evolved from Freud's notions of the life and death drives. Her development of the ideas of positions, integration and whole object-relations are all taken up and developed by contemporary thinkers into conceptions of mental health.

Bion's thought evolves from Klein but he develops a particular aspect and focus. Bion's central articulation of mental health is about the capacity to think

about one's feelings. This requires the capacity to tolerate frustration. For Bion, there is no such thing as cure, but rather a continuous evolution as a person develops and fine-tunes his/her capacities to think about himself. Crucially, this capacity is developed inter-subjectively through the mother-child relationship. The way in which Bion works with Klein's ideas informs contemporary thought as reflected in this thesis through the work of Caper and De Bianchedi.

Winnicott develops his own understanding of what it means to be mentally healthy. For Winnicott, mental health is constituted inter-subjectively and requires that a person be able to inhabit the third space, also known as transitional or cultural space. For Winnicott the capacity to inhere in between pure subjectivity and pure objectivity, in this in-between space is what makes a person feel fully alive and extends beyond the goal of eliminating symptoms. Winnicott's notions of in-betweenness and liminality are carried through in contemporary thought, in this thesis most notably, through the work of Ogden.

As this has been a consideration of the metaphors around mental health from a theoretical perspective, I have considered similarities and differences among the thinkers and shown that "metaphors matter" as they reflect underlying assumptions among the different theorists, which in turn inform technique and approach to one's patients. I have also shown that, while it is important to be aware of one's assumptions around mental health, all four conceptualisations of mental health reflect Kristeva's notion of the ability to articulate one's own original metaphors. In other words, the creative grappling and idiosyncratic presentation of all four thinkers reflects a process of writing and articulation of metaphors that is itself "mentally healthy".

In a brief consideration of contemporary approaches to mental health, I have observed that not much writing has been dedicated to this subject in recent years. However, the work that has been considered tends to rely on the weight of early psychoanalytic thinkers. Contemporary theorists are tasked with becoming careful readers and interpreters of theory. From the process of reading, however, innovative angles and focus-points emerge. Therefore it

seems that there is a strong "anti-cure" approach emerging among psychoanalytic thinkers and this needs to be thought about and considered further. As with writing, so with reading. I have suggested that the willingness to re-visit, re-read and re-interpret our psychoanalytic legacies will constitute an aliveness, a vibrancy and indeed a degree of mental health which can reverberate through to our patients and psychoanalytic community.

8.1. Limitations

Firstly, this study has focused on Freud and three object-relations theorists to the exclusion of many other approaches which fall under a psychoanalytic rubric. I have not considered the French psychoanalytic approach to mental health and Kohut's self psychology has only been briefly explored. For the nature and scope of this Research Report, it was important to curtail my study in this way.

Secondly, my study has limited its discussion to a theoretical analysis of differences and similarities among the different psychoanalytic thinkers with a focus on a theoretical and literary-theoretical approach. This study does not consider the historical and socio-cultural influences that may have contributed towards shifts in understandings of mental health. Related to this is a consideration of the culturally contextualised nature of mental health, which may vary from society to society. This is something that remains to be addressed in a further study.

Thirdly, this work has relied on my interpretation and reading of primary psychoanalytic texts. As such the findings of this thesis, including the central metaphors and concepts I have extracted from each thinker remain subjective. While I have attempted to find secondary readings to support my findings, it is possible that other readers of these texts might come up with slightly different approaches or angles. In addition, I have been aware throughout my study that in an effort to extract essential concepts, I might be in danger of reducing the complexity, nuance and richness of these thinkers and their theories.

8.2. Possibilities for Future Research

The nature and scope of the Research Report compelled me to reduce a vast topic to four thinkers and a theoretical discussion. I think there are myriad avenues for further research. There are opportunities to explore other psychoanalytic thinkers and their approaches towards mental health. There are also opportunities to formulate the discussion from different angles including a historical and socio-cultural understanding of shifts in mental health. There are also important comparative opportunities that research of this nature opens up; to consider the psychoanalytic paradigm towards mental health in comparison to psychiatric and other psychotherapeutic approaches. Moreover, I hope that this research might open up the possibility to examine other concepts which underlie our work. This thesis has considered the term "mental health" but other such terms including "pathology", "analysis", "treatment" and so on might benefit from similar investigation and contemplation.

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