1 The relevance of the past

Everything has a history, whether it is the universe or your heartbeat. The former is of real significance to the astronomer and the physicist; the latter in terms of its regularity is significant to the cardiologist. History is significant for a psychodynamic therapist, although probably in a rather different way than for the astronomer or the cardiologist or even for the professional historian.

You, the reader, have a history. I have a history. Psychodynamic therapy has a history. We need to know something of those histories to know who we are. And this book has a history, which is also relevant. Reflecting on its history may help demonstrate the way in which I find history is significant for my practice as a psychodynamic therapist.

To begin at the beginning . . .

Freud’s pioneering work is naturally open to criticism, but it is helpful to identify three ways in which he opened up possibilities for psychotherapy and counselling as we know it today. Firstly, he developed, through the promptings of some of his rather critical patients (see Jacobs 2003: 70) as well as his ability to think outside the box, a way of being that encouraged his patients simply to talk to him and through their stories and expressions to reveal their otherwise hidden feelings and fears. He recognized just how important his relationship was with his patients, and theirs with him. He also identified ways in which they sometimes repeated, in the very relationship they had with him, patterns that they displayed with or to others, both in their present circumstances and in their past. This he called transference. He realized that he too could react to patients, and this was eventually called counter-transference. Today therapists by and large know that it can be difficult to disentangle just who does what to whom in the therapeutic relationship. The client (or patient, although in this book I will stick largely with the former term) and therapist (a term I use to cover counsellors and psychotherapists) have an impact upon each other; but it is the therapist’s responsibility to monitor and hold the relationship as far as he or she is able to, allowing clients to take the session where they will.

Secondly, Freud tried to understand how we tick: what goes on within us, whether we are with others or on our own? What is it that we call the mind, the spirit, the psyche, the soul, the self? He made several attempts to analyse the mind, of which the most familiar terms are the divisions between conscious
and unconscious and between ego, id and super-ego. Whatever scheme we adopt – and psychoanalysis has several – perhaps what is most relevant is that we relate not only to other people – parents, siblings, family, friends, teachers, colleagues; and to objects – pets, places, artefacts; but that we have a network of relationships within ourselves too. We exist not only in a world external to us, but we are peopled within by a host of past and present relationships, living memories, internalized as the jargon puts it. Guntrip put it this way: ‘Freud...accurately represents the human psyche as the kind of entity that carries on its own internal development by differentiating itself into a number of *dramatis personae*...The one person functions actually as a group of persons’ (1961: 138). These inner figures (or objects, as psychoanalysis calls them) at different times and in differing tones ‘speak’ within us, and influence the way we think, react and behave. We are made of different experiences, of various relationships and of numerous ways of processing them that have left their mark; many are positive, but inevitably some less benign.

This leads to the third contribution Freud made to the development of therapy: he was particularly struck by the way in which childhood laid down patterns that are seen in the adult self and in adult relationships. And here we start to engage with the history of this book. I wish to show how a therapist’s view of history can expand from using information from the client’s history to try and comprehend the present, to drawing upon the images and language of psychoanalytic developmental theories that may suggest greater possibilities for understanding.

**Stages of life**

There are many aspects to psychoanalysis but the one that is most commonly known about is Freud’s emphasis on sex. Or should we say ‘sexuality’? It is all rather confusing, as some psychoanalytic terms can be. We encounter more such terms below when thinking about Melanie Klein’s developmental theories. Freud certainly thought that children demonstrated sexual feelings and interests at a time when they were thought to be innocent of such proclivities. Yet, what Freud was also interested in was the way pleasurable and unpleasurable feelings were associated with different stages of infancy. Sex as it is more usually understood is part of a third stage of development – the phallic or genital stage; but the two earlier stages, oral and anal, also involve pleasurable, even erotic, feelings. The oral stage is mainly concerned with feeding, where an infant’s mouth is perhaps the most sensitive part of the body. Everything goes into the mouth, as if it is through the mouth that an infant senses the taste, shape and quality of an object, whether that object is a nipple, a teat, milk, more solid food, a rattle, a stone, etc. But this seemingly narrow way of looking at pleasure and sexuality is only the start. Freud and those who have followed him have taken this starting point to consider how the whole experience of
feeding and being fed affects a mother and baby and their relationship. So the pleasure from the nursing relationship can be contrasted with the pain of going hungry, or the pain of not receiving attention quickly enough for all manner of other needs (more of this in Chapter 2). Similarly the anal stage is not just about the pleasure of evacuation of urine and faeces, or the trials and tribulations involved in toilet training. The phallic stage, surrounded with controversy of course because of the gender bias towards men and boys in Freud’s theories, and the whole issue of the Oedipus complex, appears to be much more about sex. But Freud may well have been right to suggest that oral and anal pleasure is also involved in what he saw as the foreplay leading to genital sex.

It was this basic scheme that influenced me when I was writing the first edition of *The Presenting Past* (1985). There were, however, other dimensions that were part of my thinking.

Firstly, in a brief paper Freud (1908a/1959: 167–176) wondered whether there were character traits that might be associated with what he called ‘anal erotism’. He refers to love of money, connecting faeces with gold; to obstinacy as an anal trait; and to what we call ‘mooning’ as a sign of defiance and scorn. His follower Wilhelm Reich extended this idea to ‘character analysis’ (Reich 1949) describing more fully the defensive nature of the oral, anal and phallic character. These ideas have had great influence upon later psychoanalytic thinking, although the direction that Reich took, into an intense concentration on sexual fulfilment for mental health, has not found favour.

Secondly, the Danish born analyst Erik Erikson (1965) put forward an expanded scheme for psychological development. Instead of Freud’s three stages in infancy Erikson proposed eight ages. Instead of Freud’s psychosexual stages, Erikson proposed psychosocial stages. Table 1.1 shows the difference between the two models, adding two further stages beyond infancy that are part of Freud’s model.

Inevitably I do less than justice both to Freud or Erikson by simplifying their models. Freud’s model seems to be based solely on fulfilling the drive

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<thead>
<tr>
<th>Table 1.1</th>
<th>A comparison of stages of development: Freud and Erikson</th>
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<tr>
<td><strong>Freud’s stages:</strong></td>
<td><strong>aims</strong></td>
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<tr>
<td>Oral stage</td>
<td>feeding</td>
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<tr>
<td>Anal stage</td>
<td>muscular pleasure</td>
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<tr>
<td>Phallic phase</td>
<td>oedipal resolution</td>
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<td>Latency phase</td>
<td>learning</td>
</tr>
<tr>
<td>Adolescence</td>
<td>genital expression</td>
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<tr>
<td>(Adulthood)</td>
<td>love and work</td>
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to feed, to evacuate the bowels, to have sex or to give up the aspiration to become one’s parent’s partner. In truth his description of these stages is more extensive than that. And Erikson’s model has a number of caveats. For example, it is as important to learn whom or what to mistrust as well as to achieve a sense of basic trust. What is important here is to demonstrate that the various stages of growing up bring with them different tasks of a psychological and social significance.

The concept of stages of development is appealing; after all we tend to measure how well children are developing physically in stages, such as the first smile, sitting up, crawling, the first step, progress in speech, in coordination, and so on. There is no uniformity in such developments although there are markers and average times when each stage may be reached. That should be our first caution too when thinking in terms of psychological development. Nevertheless, there may be such identifiable stages in psychological as well as physical development. Similarly there are recognizable stages in certain psychological processes, such as mourning. There are studies of grief that can enrich a therapist’s sensitivity and expertise to where a grieving client may be in that process (for example Worden 1991; Lendrum and Syme 2004). Box 1.1, from Collick (1986), includes examples of typical statements that might be made in each stage (the Abraham quotation is my own addition):

<table>
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<th>Box 1.1 An example of the stages of bereavement</th>
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<tr>
<td>Shock: ‘I just went cold.’</td>
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<td>Numbness and unreality: ‘This isn’t me.’</td>
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<tr>
<td>Disbelief: ‘It can’t be true.’</td>
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<tr>
<td>Yarning: ‘Come back.’</td>
</tr>
<tr>
<td>Emptiness: ‘An aching void.’</td>
</tr>
<tr>
<td>Searching: ‘He must be somewhere.’</td>
</tr>
<tr>
<td>Anxiety: ‘Must I sell the house?’</td>
</tr>
<tr>
<td>Anger: ‘He had no right to leave me like this.’</td>
</tr>
<tr>
<td>Guilt: ‘If only…’</td>
</tr>
<tr>
<td>Remembering: ‘I’m afraid of forgetting.’</td>
</tr>
<tr>
<td>Depression: ‘I’m too tired to bother.’</td>
</tr>
<tr>
<td>Loss of identity and status: ‘Who am I?’</td>
</tr>
<tr>
<td>Stigma: ‘I’m an embarrassment to others.’</td>
</tr>
<tr>
<td>Sexual deprivation: ‘To have someone’s arms round me.’</td>
</tr>
<tr>
<td>Loss of faith: ‘Why?’</td>
</tr>
<tr>
<td>Loneliness: ‘I just dread weekends.’</td>
</tr>
<tr>
<td>Acceptance: ‘He’d have laughed about it.’</td>
</tr>
<tr>
<td>Healing: ‘My loved object is not gone, for now I carry it within myself and can never lose it’ (Abraham 1927: 436–437).</td>
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</tbody>
</table>
Useful though such a description is, it comes with a warning: the stages of grief do not necessarily follow a precise order. In other words the model provides some very helpful pointers to the way a person may be feeling, which is possibly related to a particular stage in the process. But people also differ in what they feel and when.

Similarly there are difficulties about models of development based upon stages. Looking back on the 1980s it is clear that there was a vogue for stage models, although they obviously had already been suggested by Freud and Erikson, and by Piaget (1950) in his model of intellectual functioning, with four stages, the final one of which (that of being able to think conceptually) beginning at around the age of 11. Using Piaget, but building further upon his scheme to examine the development of moral thinking, Kohlberg researched (1981) how we make moral judgements, research that was refined to take account of gender differences by his colleague Carol Gilligan (1982). Fowler (1981), using the stage theories of Piaget, Kohlberg and Erikson as the main resources for his own research, mapped out the development of stages of faith or belief, which I later used critically in my own study of the psychology of belief (Jacobs 1993), but revised thoroughly in the light of my developing thinking in my study of Illusion (2000).

I have found Erikson’s (1965) stage theory, the Eight Ages of Man, useful as a therapist in trying to locate where a client is psychologically, and how the presenting issues might be related to the different ages. Erikson’s model – as indeed other stage theories – suggest a path of development like climbing a staircase, or like building a tower of toy bricks, so that as one stage is successfully negotiated the child (and adult) passes on to the next stage, with the confidence that the previous achievements have given him or her. The different stages suggest tasks and attitudes – whether physical or intellectual, or aspects of emotional development – that a therapist might expect to find at different ages, and that generally can together be said to constitute adult maturity. A therapist might want to look at anything that might have hindered development when the client was younger. Older psychoanalytic models of what happens when people break down suggest that, where there is a crisis or a conflict for an individual, they will tend to regress back to a position where there is an opportunity to re-negotiate any earlier issues that were not favourably dealt with at that younger age. Another possibility is that people can become in some respects ‘fixed’ or stuck at a particular stage of development, and demonstrate, for example, a dependent, obsessional or competitive character, depending upon whether their developmental block is located in oral, anal or phallic stages (to use the Freudian psychosexual model). The model thus demonstrates two possible defences known in psychoanalytic terms as regression and fixation.

As far as it goes, such views of development in stage theories can be useful. They suggest, I believe correctly, that unfinished business and unresolved issues from the past often have a powerful effect on living in the present. By
implication satisfactory resolution of present issues in the therapeutic relationship can help the past (and indeed the future) to be faced, re-negotiated and in some respects even re-lived. As Malan writes, confirming the views of early analysts: ‘the experience of the old problems in the relation with the therapist – but with a new ending – is the most important single factor in therapy’ (1963: 208).

However, such developmental models are open to criticism in that ‘the term stage, used simply to describe observations, as is often done in everyday language, has no scientific or explanatory value’ (Mussen et al. 1969: 23). Stages do not explain behaviour; although they do have some value in the sense of making distinctions clearer. Stages are generally distinct periods of development, where certain aspects of behaviour, thought or expression (that often occur together and are therefore clustered) are obviously present in a way that was not evident earlier. Although stage theory has descriptive value it is essentially artificial, a construct of the theorist rather than an endemic feature in human nature. Such theories have their weaknesses in practice too, particularly the tendency that I return to below, to label people and put people into boxes, depending upon whether or not they appear to have successfully negotiated the sequence of stages expected of them by age or life position.

Measuring development by stage or age is something of which many parents are aware as they observe their children’s growth; for some this is natural concern to see their child take new steps; for others it becomes an ambitious anxiety that frequently has a deleterious effect upon the child, who always feels the obligation to achieve. Therapists may have learnt not to be so anxious, but their model may create anxiety in the client.

Stage theories propose a linear model, as if development goes in a straight line, and imply that once a particular stage has been negotiated satisfactorily the basic tasks have been accomplished; so, using Erikson’s Eight Ages, after the first stage the model implies that when satisfactorily negotiated, the basic strengths of trust have been acquired once and for all. To be fair to Erikson this was not what he was suggesting: ‘The assumption that at each stage a goodness is achieved which is impervious to new inner conflicts and to changing conditions is, I believe, a projection on child development of that success ideology which can so dangerously pervade our private and public daydreams’ (1965: 265). Those who read about the model, and see its uses, without reading this footnote, might think otherwise; that trust, once established in infancy, is solidly there for the rest of life. This is plainly not so. Trust, the issue that Erikson identifies as central to the first age, appears in different forms throughout life, and changes its object at different stages. The blind trust of the baby is not helpful in the second age, where increased mobility means learning not to trust situations and objects that are potentially dangerous – fires, stairs, etc. Parents of the second-stage child themselves have to learn a new kind of trust that is careful but not overcautious. This in turn represents a type of trust
that could be said to be part of Erikson’s sixth age of generativity (which includes parenthood). The basic strengths or ‘virtues’ (Erikson’s term) that form the major part of each stage continue to develop throughout life, in the new circumstances that constantly present themselves.

I was aware of some of these difficulties when I wrote the first edition, and suggested that one way of overcoming this particular weakness in a linear model was to envisage a cyclical model instead, so that personal development might be seen as more like climbing a spiral staircase rather than a straight set of steps. In effect we might then say that each of the eight ‘treads’ that make up a 360° rise of the staircase represent the eight issues identified by Erikson (of trust, autonomy, initiative, industry, identity, intimacy, generativity and integrity); and that each 360° rise represents a different phase of life. Taking the ‘virtues’ that Erikson had proposed as helpful constructs we therefore can see that each one has potential relevance as an ‘issue’ at any stage of life.

My hesitation about adopting stage theory can be seen in three ways in the first edition of this book (Jacobs 1985). Firstly, I had set out the chapters as ‘Themes and Variations’ – a musical image that expressed how I thought there was repetition of what I had called ‘OS’, ‘AS’ and ‘GS’ themes in latency, adolescence and adult life. Using the abbreviations OS, AS and GS was an attempt to distance the reader from too close an identification with Freud’s oral, anal and genital stages, although I found myself hoist by my own petard when students of the book kept quoting OS, AS and GS in their essays as if they were concepts carved in stone! Because I was not clear myself at that time, it was difficult for the reader to take what I was tentatively seeing as metaphorical concepts without turning them into hard-and-fast facts.

Secondly, I introduced an idea in the chapter on adolescence that was on the edge of recognizing the inter-penetration of Erikson’s ‘virtues’ at each age. Adolescence can be seen as a watershed in Erikson’s model, especially if we follow the division of adolescence into three periods – early, middle and late – as suggested by Laufer (1974) and others. Figure 1.1 shows how each of these successive substages in turn take up themes from the first three ages, and point forward to the three stages of adult life that Erikson identifies.

Thus, early adolescence, with sexual development pushed more obviously into consciousness by physical changes at puberty, picks up the themes of sexuality from the third age. At the same time this set of issues points forward, preparing the sexual identity of a young person for the sixth age of intimacy. Middle adolescence could be described as being particularly concerned with issues of independence from parental influence, and moving towards autonomy and self-direction. Dynamic issues of the second age are thereby picked up with considerable force – battles of will are even harder, with physical strength and determination making young people formidable fighters for themselves. This middle period of adolescence is also the time when there is the desire
THE PRESENTING PAST

oral muscular- anal locomotor genital latency adolescence early adulthood mid-adulthood late adulthood

integrity vs despair

generativity vs stagnation

intimacy vs isolation

identity vs role confusion

industry vs inferiority

initiative vs guilt

sexual identity

independence

autonomy vs shame and doubt

trust vs mistrust

sense of meaning

Figure 1.1 Erikson's model adapted: adolescence as a watershed

for economic independence, by moving into the area of work, whether in paid employment or in the self-motivated attitudes to work required for study through further and higher education. Looking forward, this period of middle adolescence lays the foundation for middle adulthood (Erikson’s seventh age) where generativity is singled out as a major task, as a parent and/or as a worker. The late period of adolescence, where there may be interest in the state of society and the world, and experimentation to find a sense of belief and
THE RELEVANCE OF THE PAST

purpose (including one’s own identity), has obvious links with the first age, where Erikson has identified issues of trust and the emergence of the rudimentary ‘self’. Yet, this later period of adolescence also prefigures the final stage of the Eight Ages, that of ego integrity, where confidence in a person’s overall handling of his or her life is a necessary step towards the acceptance of death. This is why it can be said that each period of adolescence looks backwards and forwards, like a true watershed.

The third pointer to a different way of relating stage models to therapy was a brief mention in the first edition in the way I treated latency (Jacobs 1985). Freud suggests that in the latency period (approximately 6 to 12 years) developmental drives and aims diminish in intensity (particularly oedipal issues, which should have been sufficiently resolved), and re-emerge forcefully again at puberty. It is clear to any casual observer that children of this age do not cease being interested in sex: they use plenty of their own terms associated with genitalia and toilets in their jokes. The intensity of certain emotions may be less strong than they are during adolescence, but it is difficult to see a child in the latency stage as other than continuing to experience the feelings and concerns of previous stages. This is to be expected if each age does indeed involve the issues that Erikson identifies as significant for personal development.

Furthermore, although the stress culturally in the latency stage is on learning, learning is not confined to those particular years. Learning takes place before the latency period, and afterwards: in adolescence, in training, in adult education, including learning counselling and therapy through seminars, reading and supervision. In the light of this observation I found Hartung (1979) helpful, with his suggestion in an article on learning psychotherapy, where he builds upon the Erikson model: that in order to be able to learn, adults need to be able to enter a ‘latency mode’, like children in the latency age.

The concept of a ‘latency mode’ is important. The term does not only apply to children in school, although children need to enter this latency mode in order to learn. When they are not overstimulated by dependency needs (which might be seen as oral issues) those who learn can feed their growing appetite for understanding and information. Not too troubled by the need for perfection (often linked to anal issues) they can find fulfilment in the satisfactory completion of tasks, and in being able to make, do or understand things well. Relaxed about cooperation and not being unduly competitive (oedipal issues), learning presents opportunities to relate to and identify with others. In a latency mode, children and adults can learn to experiment with objects as well as with friendships and social groupings; to tolerate the frustration of results taking time; to ask questions, and look for proof of observations and explanations; and to alternate between passively receiving instruction and actively investigating. But if children or adults are too stimulated at the same time as they are learning by other emotional issues then it becomes very much more difficult for them to learn, and so maximize
the opportunities presented by the teacher. Hartung (1979) illustrates how this can happen over issues of dependency, authority and rivalry, drawing upon the first three stages of the Erikson model.

The difficulties that can interfere with the latency mode apply to children and adults alike. The child who is able to control bowels and bladder is free to engage in a whole range of activities at school; whereas the child who is still soiling is likely to be so concerned with problems of staying clean and dry, that there will be less time at school available for concentration upon all the learning activities on offer. An adult in a learning environment who is too concerned about perfection may find it difficult to complete written work. A child who is concerned about the arguments between parents at home may find it very difficult to concentrate upon tasks at school. Similarly, an adult who is going through a crisis in a personal relationship may find it difficult to learn in a re-training situation. If there is continued overstimulation of other issues, attitudes to learning as well as the learning itself may be influenced detrimentally. Although some children and adults sometimes use their work to defend against worries, most people, of any age, find it hard to concentrate when there are more pressing issues on their minds.

Latency then becomes a way of being that can apply at any age. The idea of a ‘mode’, such as a ‘latency mode’, is a valuable way of looking at and using the Erikson Ages. Just as we have to enter into a latency mode to learn, so other aspects of relating to other people and other objects in the external world, as well as relating to ourselves, involve us in other ‘modes’: it might be possible therefore to speak of an attachment mode, or an autonomous mode, a mode of intimacy or creativity, even a letting go mode – each one of which may involve different qualities and strengths, and different ways of relating, and which is informed by the more traditional stage models.

Looking at this same point from a contrasting perspective, learning involves all the other aspects in Erikson’s model. A colleague once described latency as a ‘mini-cycle of development’, which supports the cyclical view of development I have already suggested. Her role was one of training teachers, and using Erikson’s ‘virtues’ as related to each age she described the task of the teacher (a key figure in the latency stage) as building up in a child a sense of hope so that learning can take place, and the willpower to see the task through, especially in the early stages when the task seems too difficult. The teacher needs to point towards a direction for learning that indicates its purpose, and to build on an appropriate method so that the child gains competence. This will lead to independence in learning, and a stage of ego integrity that generates reliability (fidelity), and love of learning and its potential for life, a caring attitude and wisdom (Hunter 1983, personal communication).

Modes rather than models might be a better way of using stage theories. In the first edition of this book I was not ready to let go altogether of a chronological sequence. I was still in a mid-way position, between ‘stages’
and ‘themes’, not altogether sure about completing the move to themes. In subsequent editions I took that decisive step, to use the ideas that flow from stage models as metaphors that might help me understand myself and my clients more. I want to stress to the reader how valuable it is to suspend disbelief when thinking about psychoanalytic propositions, and to use what essentially are ideas, not necessarily related to factual evidence, as one would poetic language, always capable of pointing to people’s experience.

Using the idea of ‘modes’ or ‘themes’ as distinct from ‘stages’ to examine human development is in fact to link in with other traditions of psychoanalytic theory, in which the apparently clear steps of a stage model had similarly been replaced by concepts such as that of ‘positions’ in the theory put forward by Melanie Klein. Julia Segal observes that Melanie Klein, long before me, found Freud’s concept of stages of development too limiting. Although she concurred with Freud that children’s interest is focused upon oral, anal and genital concerns, ‘there was constant movement from one to the other and back again’ (Segal 1992: 33). The similarities to my cyclical version of the Erikson model are immediately obvious. Klein (1975) describes two particular sets of attitudes that react to and act upon these concerns, which she calls the ‘paranoid-schizoid position’ and the ‘depressive position’. Klein does not believe we are ever free of these positions: adults as well as young children oscillate between them time and again throughout their life – indeed they do so in the course of any normal day.

I explain these positions more fully in Chapter 2, but at this point I refer to them to illustrate the way Klein suggests continuity of developmental concepts through all stages of life. She uses the term ‘paranoid-schizoid position’ as a way of describing the early state of mind in the newborn infant and in the first few months of life. Here good experiences and bad experiences are not yet understood as emanating from the same nurturing object (mother, or more precisely the mother’s breast). Instead, there is in phantasy (this particular spelling of a very important concept is Klein’s) the perception of an ideal breast, that provides food and comfort when it is needed; and a bad breast, that withdraws, or is unavailable to the baby when it is most wanted, and so is endowed by the child with an attacking quality. This attacking quality is reinforced, Klein believes, by the projection onto the breast of the child’s rage at being frustrated. Thus, the child feels persecuted by this bad breast, putting the young infant temporarily into a paranoid state, largely of its own making.

We have to be careful, in any study of children, not to attribute to them adult states of mind without real evidence. Such phantasies as Klein supposes are virtually incapable of proof, and can only be surmised from other evidence. The term ‘paranoid’ as used by Klein can refer to the infant’s state of mind; or to the person with paranoid schizophrenia who believes that everyone is against him and that the world is a hostile and dangerous place; or to the persecutory feelings that we can experience when we wake on a Monday morning (or any
morning?) and think, ‘Do I have to get up? I don’t feel like facing “out there” – I’d sooner stay here where I am, cosy and warm’. These are, of course, different states in their intensity and their degree of permanence, but they are all related to the early experience of the infant as Klein describes it. Similarly the term ‘schizoid’ applies to experiences throughout life. In infancy it refers to the way in which the breast that is perceived as persecutory is split off from the breast that is perceived to be beneficent. Schizoid feelings can range from the infant who needs to protect the vulnerable self from attack; to the adult person who is totally cut off from others, since others are perceived as dangerous because of their hate or even because of their love; through to the state of mind that says, ‘Just leave me alone for a while. I need some space to myself’.

Klein’s term ‘depressive position’ is first used of the child’s growing perception that early good and bad experiences come from the same source. It has little to do with depression as it is normally understood – it is another of those confusing psychoanalytic terms. It describes how a child begins to integrate experience, able to contain loving and hating feelings, without fear that the hating feelings will destroy the loving feelings. I explore this concept more fully in Chapter 2, and at this point wish to stress that the ‘depressive position’ similarly is one that we experience throughout life, as we work through phases of paranoid-schizoid experience, and phases of more constructive and integrated experience. Julia Segal sums it up: ‘Under the pressure of frustration of various kinds, the attacks of the paranoid-schizoid position continue throughout life, though mitigated more and more by a sense of love and reality which can no longer be denied . . . Klein saw the conflict between love and hatred as the motive force for much of what happens in life’ (Segal 1992: 39–40).

Although she disagreed over many aspects of Klein’s theories and practice, there is a similar sense of the continuity of a theme in Anna Freud’s ‘developmental lines’ (1973: 59–82), where aggression is seen in various forms in the different stages: biting in the oral stage, sadism in the anal stage, domination in the phallic stage. While Anna Freud’s ‘developmental lines’ are more obviously linked to a stage model, she makes important distinctions that merit further consideration. For example, she makes it clear that the various developmental lines progress at different speeds. She also writes: ‘The interactions between progression and regression . . . [and] . . . the disharmonies, imbalances, intricacies of development, in short the variations of normality, become innumerable’ (A. Freud 1973: 94, original italics). Her position, if closer to her father’s than Klein’s, nevertheless lends some support to a more fluid use of stage theory in working with children and adults.

A further example of the continuity throughout life can be seen in attachment theory. Again this is more fully explained in Chapter 2. Here it is important to note that modes of attachment are relevant not just to infancy – indeed this is one of the important differences between the terms ‘attachment’ and ‘dependency’. Whereas dependence may be necessary from
time to time, in a kind of regression to the security of infancy, attachment is a concept that has much positive value to it. Attachment issues remain throughout life. The title of the book *Attachment Across the Life Cycle* (Parkes et al. 1991) illustrates this perfectly.

There may be something to be said for even more ‘positions’ that we find ourselves in, for good or ill, in pleasure or pain, than the two positions Klein proposes. Modes, themes, positions, developmental lines: in a sense it does not matter what we call them since the value lies more in the different dimensions and perspectives they foster in the therapist’s attempts to comprehend what a client is describing and experiencing or has experienced in the past.

I suggest that three major themes embrace virtually every presenting issue in one way or another. They are, as the following chapters illustrate, the theme of trust and attachment, linked originally in my mind to Freud’s oral stage but now greatly extended to embrace trust and attachment modes, character traits, etc.; the theme of authority and autonomy, linked originally to the anal stage and extended now to include authoritative, autonomous, assertive and accepting modes; and the theme of cooperation and competition, linked originally to the phallic/genital/oedipal stage, but now including appropriate competitive, collaborative, belonging and sharing modes. My discussion of these themes is not exhaustive, but it is suggestive of how fruitful they can be.

**The themes in practice**

There is no getting away in all the theories I have discussed from the importance of the foundations laid or not laid down in infancy and childhood. We are formed through a variety of experiences, then and later, some remembered, some forgotten, some even misinterpreted, some of which make us who we are now, some of which have left little apparent mark. The relationship between the past and the present is complex. Not only may a person be influenced in the present by memories of the past, but memories of the past may be influenced by present experience.

It is sometimes thought that psychoanalysis or psychodynamic counselling and therapy is principally interested in the past, and involves digging around in a person’s history for the events that have led to what troubles that person now. There is some truth in this picture, but only some. This book aims to demonstrate how awareness of the past informs the present, and helps therapist and client understand ways of being, acting and thinking. Psychodynamic therapy is more about the present than the past, but works on the premise that in understanding something of the past, and its influence upon the present, the path towards change or acceptance becomes clearer, if not necessarily easier to negotiate. Change may be hoped for, but sometimes acceptance is all that is possible.
As I have shown from my own history of writing this book, the therapist always has the possibility of her or his imagination, and not just of his or her thinking, being informed by theories of development. Those theories, some of which have been referred to, others of which will be spelled out in more detail in later chapters, do not provide answers as such, but they do provide ways of entering further into a client’s experience. Let us take the following example.

Chris knew he had been born prematurely by Caesarean section shortly before his mother’s death. After a short period with his father, he was moved to his father’s parents’ home, where, he had been told, he spent the first two years of his life.

When his father married again, Chris (who had apparently seen little of his father in the intervening years) was moved back to his father’s new family, where the rest of his childhood was relatively untroubled, although his relationship with his father was always strained.

In his adult life Chris found himself attracted emotionally and physically to women a good deal older than himself. His own sense of this was that he was continually searching for his mother (and grandmother). We can imagine that there was a double loss in his early life: of his mother to whom he had been deeply attached by the umbilical cord; and then by the process of attachment to his grandmother, from whom he was taken away when he was 2 years old. In therapy Chris did not remember these early losses, but he was able to return in his imagination, prompted by his therapist to how that must have been for him. He decided to visit places associated with his mother. In the relationship with his therapist any breaks (for holidays) and the termination of the therapy, which itself had to be premature, were more difficult for him than for some clients. Linking the past as he had been told it, the past which he could imagine, his present relationships to older women and his relationship to his therapist provided some clarity for Chris in understanding how his feelings related to attachment and separation could be so strong.

In this instance there was some known history, added to which the therapist’s understanding of the importance of attachment and separation helped provide a focus for the therapy. In the next example very little history was known, but imaginative exploration of images that flowed from developmental theory helped provide possible clues to Diane’s reactions. This is a more complex example of how imaginative understanding of the past through psychoanalytic theory can enhance the therapist’s perception.
Diane presented two issues at the start of her first session of therapy. The first was that she was binge-eating, and then making herself sick. The second was that her husband had left her, and she was unable to get him to say anything about his future intentions. He was unwilling to pronounce the relationship between them over and finished, but neither would he return to her. 

She did not say much about her childhood and adolescence, nor did the therapist ask any particular questions that might help him see whether the past could throw light upon the present. It was too early for that. Diane talked very fully about how she was reacting and feeling in her current situation; and the more she said, the more the therapist was able to connect up her words with one of the presenting symptoms—her problem with food. Eating is clearly connected with ‘feeding’ and therefore perhaps with themes that are typical of the oral stage of development. He began to play with the language and images of the oral stage to see if this might throw light upon the way Diane felt and acted. 

Diane told the therapist, for instance, that she desperately wanted her husband to come back so that she could have a baby to love: it would be sufficient for him to return long enough for her to become pregnant. She didn’t appear to want a baby in order to tie her husband to their relationship. She also described their relationship when they were living together as one where she mothered him so much, and did everything for him, that he had begun to feel hemmed in and dependent upon her. 

As the session went on, the therapist began to experience Diane as very demanding. It was not that she was asking a lot of him in any obvious way: she talked very freely, and that should have made it easier for him. But she spoke at such speed and length that it was often impossible for the therapist to get a word in edgeways, and it was difficult to bring the session to a close. At the end, when she had left the room, the therapist felt quite drained; and this happened at the end of subsequent sessions, convincing him that this was something to do with Diane’s impact upon him, and not his own tiredness. It was unwise in these early sessions to make explicit his counter-transference (feeling drained), but he used his awareness of it to consider the possibility that Diane needed to feed off his presence and his time, perhaps trying to build herself up in a way that no amount of physical eating could achieve. 

What he did wonder explicitly was whether Diane might need to give so much love because she needed love so much: ‘You seem to put your unloved self into your husband, or into the baby you so much want, and try to love your self through that. I think you may feel empty inside, now your husband has gone away, and when you have
no baby to feed and look after, and perhaps you are trying to fill that void by eating’.

Diane reacted to this interpretation with real understanding: it clearly made some sense to her. This was reflected in the sessions that followed, in that she talked about herself differently. She started to make what were now quite appropriate demands upon her husband: she asked him where she stood, and made him take a share in sorting out their money problems. They both began to accept responsibility for some of the domestic issues that had arisen since their separation. She began to make legitimate demands for herself, rather than to act them out through oblique, obscure, unsatisfying and potentially damaging means. Her eating steadily came under control, and she talked of beginning to feel a sense of her self once more. It was as yet a shadowy self, but she felt she had ‘more substance’. In fact, Diane said, whereas before she had lived from point to point through each day – breakfast to lunch, lunch to tea, supper to bed – she was now able to look and plan further ahead. Whereas before ‘my arms and legs seemed all over the place and not to belong to me now I am beginning to come together’.

What is of real interest here is not her history (since the therapist knows very little of it) but that it was possible to reflect upon the phrases Diane used, the feelings she evoked and the images that came to the therapist’s mind. This example shows how the ‘oral stage’ in a Freud/Erikson stage model can be used as a metaphor to consider what we might call a psychodynamic picture of this client. The therapist did not know (and even if the therapy had been longer he may never have known) whether Diane was starved, or felt starved of love during her infancy. It did not matter, except as a question of intellectual interest, whether she had been or not. What helped the therapist, and consequently the client, were the associations he had to Diane, to her presenting issues, and to her language, that linked with his knowledge of issues generally around feeding, emptiness, making demands, boundaries, the fragmented self, etc. He was able to reflect back to her aspects of how she might feel, which she could accept, and which provided her with a different experience of herself. Perhaps she felt understood on a deeper level and not just at the level of presenting problems. If there had been some confirmatory knowledge from Diane’s past, which supported the impressions he was receiving, the therapist might have wanted to add a tentative explanation to his interpretation of her emptiness. He had noted, for example, the short time span of her day and her living from meal to meal (three to four hours, reminiscent of early feeding patterns); and the image of her body being ‘all over the place’ was for him so like a baby’s flailing limbs.
In this example, the oral, attachment and young infant imagery is the most obvious metaphor to follow, although it is also possible to look at Diane and her issues from the imagery of another ‘stage’, or, as I prefer to call it, of another ‘theme’. The trust and attachment theme I begin to describe in Chapter 2 can be matched by a theme around autonomy – images and associations that link to a stage of development, where key features are about order and control. It was obvious that Diane liked to organize her husband, and that he was a more disorganized person who needed to break free from her oppressive control. She described how she needed to keep people happy, by saying what she felt they wanted to hear; so she was unable to be assertive and autonomous enough to be her own person. She dressed very smartly, even when she said she would prefer to wear casual clothes. It was as if she had to look perfect for any casual visitor who might come unannounced. Her rapid speech in the session might have been interpreted as a way of keeping the therapist in his place, and controlling how much he was permitted to say. In this respect there was some confirmatory evidence of what could be called anal stage material from Diane’s descriptions of her parents: her mother was very controlled and could not show her feelings, particularly when she felt others might criticize her for them; and her father appeared to have been a strict disciplinarian – a severe authority figure. The therapist might therefore have chosen to make his opening interpretation around this ‘control’ theme. He preferred to use the oral imagery as being where Diane was currently, having shifted from being controlled and controlling when she had been living with her husband, to a mode of being in which she was not in control of her eating, and unable to make appropriate demands.

What about a third theme, the one that might be linked to the psychoanalytic oedipal stage of development? Were there rivalry or sexual issues here? Diane’s husband left her in the first instance because he had a relationship with another woman. There was a three-person situation, typical of problems related to that theme. But for the therapist that was almost the sole identifying issue around that theme. With some clients, the material brought to therapy can be understood in two or three different ways, as if looking through different lenses at the presenting material. But to avoid confusion in the therapist and for the client, it helps to listen carefully for the predominating theme in each session, and to address one’s thinking and explicit interpretation to one set of issues at a time.

The past is most obvious where a client recounts her or his history, which includes not only what has happened to her or him, and to members of her or his family, but also what the client has been told or even imagines has happened. Yet, possibilities about the past can also be imagined, and tested out through interpretations, from the way a client presents, in the difficulties the client has currently and in the relationship between the therapist and the client. The past can be re-lived in the present. The relationship between client
and therapist, as Sarno describes it in relation to Freud’s early case histories, is ‘a living laboratory’ (1990: 32); or perhaps more aptly a ‘stage’ upon which is re-enacted, with the therapist, aspects of the story of a person’s life.

Psychodynamic theory includes a concept known as ‘the triangle of insight’, in which past and present relationships outside therapy and within therapy, and in the external world and internal world, can be linked. The triangle of insight (see Figure 1.2) describes both a way of thinking about the client that can lead to linking the client’s experience of past relationships with significant people, including the way they have been internalized so that they ‘live on’ inside the person, with the client’s current relationships to others outside the consulting room, and to the therapist. Making links between a client’s current relationships and the relationship with the therapist is of course not uncommon in other therapeutic orientations. It is perhaps the attempt to integrate the three points of the triangle that distinguishes the emphasis in psychodynamic work from other orientations.

Some example of linking are as follows.

1. Between the two points of the triangle ‘out there’ and ‘in here’: ‘You’ve been saying today that you get very anxious when things in your room are out of place: I feel you are anxious here too, especially when I can’t make things neat and tidy for you’.

2. Between what a person describes in his or her current situation, and a past event or relationship: ‘You’ve been saying today that you get very anxious when things in your room are out of place: that reminds me of something you’ve said before, that your father was very fussy when anything got untidy at home when you were a child. It’s as if he’s still there, in your room, or inside you, commenting on how untidy it looks’.
3 Between the client’s reported past and the present situation with the counsellor – known in psychodynamic theory as ‘transference’: for example, ‘You say your mother always went around tidying everything up after you as a child. I wonder whether you’re also saying that you wish I could put everything in order for you here and give you a neat answer’.

4 Referring to all three points of the triangle: ‘You are clearly feeling that your life’s a mess – it feels impossible to put any order on it. I think this is made worse because your father always insisted that you have everything ordered when you were a child, and your mother would make sure it was, to protect you from his rage. I’m wondering therefore whether you’re feeling really frustrated with me, because I don’t seem to be helping you to get everything sorted out?’

When such links can be made, whether it is between two or three points on the triangle of insight, this often brings relief, not least at being understood at a deeper level. But insight is not normally enough. Although much emphasis has been put in the past on the mutative interpretation in psychoanalysis (for example Strachey 1934), there is today much greater recognition of the centrality of the relationship between therapist and client, as providing a place where old patterns of relating are re-experienced, and new ways of relating are tested out (Meissner 1991). The therapeutic relationship provides what Winnicott (1965b: 85) constantly calls in relation to mothering a facilitating environment. Although this obviously refers to good parenting, therapy inevitably mirrors in some respects parenting that was not ideal: like the absent or preoccupied mother, a therapist is not always on tap; like the parent who inadvertently fails to give enough reassurance, the therapist fails to provide enough ordered answers. Like the controlling parent, a therapist sets limits on the time and availability of sessions; and like the parent in the oedipal triangle, he or she is not available to become the partner with whom the client might wish for an intimate relationship. Negative experiences from the past – frustrations, rejections and disappointments – will often be re-lived in the therapy relationship itself, providing the potentiality for the therapeutic experience to evoke and in the end contain, good and bad feelings, dangerous fantasies, disturbing thoughts, as well as the fondness and freedom of a maturing sense of relatedness.

Some cautionary notes

The relationship between the present and the past is a fascinating one, but it needs to be handled with some caution if the three major themes in this book are to be used wisely and sensitively in therapy.
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1 There is seldom a single explanation that explains why a person should be feeling the way he or she does now. To suggest that psychodynamic theory seeks to uncover a single trauma is a caricature of a much more careful and painstaking approach. That type of detection may appeal to the amateur sleuth, but is scarcely sufficient in seeking to understand the complexities of human nature. Freud warned against thinking there were obvious clues (1916/1963: 27). It is a literal rather than a metaphorical use of history.

2 As individuals we construct our personal history in much the same way as a nation or a people construct their national or cultural history, in order to support our way of seeing things. As Lechte suggests, history ‘is always written from the perspective of the present’ (Lechte 1994: 111). A person’s history will change, sometimes subtly, sometimes with dramatic new revelations, as the person changes; and, in therapy, as the therapeutic relationship passes through its different phases. Sometimes there are new memories; but all the time there are possibilities of new interpretations, and fresh ways of constructing experiences. We are, in health, constantly interpreting and re-interpreting ourselves, our past and the present. It is a rigid view that is less healthy.

3 Psychoanalysis, like history, is not an exact science, however much Freud may have wished it to be, although he recognized that a life science lacked the precision of the material sciences (Freud 1925a/1993: 242). In his third edition Rayner explains that his book Human Development ‘is not a gospel, it is limited in its data and vision. Think of it as asking pertinent questions, let yourself argue with it, think for yourself’ (1986: 10–11). This writer would echo those words. Learn from this and other texts by all means, but as Freud and many other analytic writer have, learn from your clients. Like great art and literature, psychodynamic theory becomes relevant when it speaks to our experience: ‘I have felt that’; ‘I know that fantasy myself’; ‘That helps me understand myself’. Psychodynamic ideas similarly are approximations and pointers, which should leave space for the individual client and the individual therapist to make their own. Even the language used in the theory should not be taken literally. Just as metaphor and simile are common features of everyday speech, so they are constantly present in the therapeutic dialogue in phrases such as: ‘It feels like . . .’, ‘It is as if . . .’. Images are there to be played with, not translated into hardened psychological concepts.

4 This is particularly necessary when working with difference. Caution is necessary in reading any study of human development and character that fails to recognize potential differences due to gender, sexuality, culture and race. Many of the studies of human development
(especially of psychosocial stages) have been by male scholars, using norms that may legitimately apply to men, but do not necessarily apply to women. Historical context and societal forces influence the way in which normality and abnormality are understood. Erikson shows the differences in child-rearing in two North American Indian tribes, the Sioux and the Yurok (1965: 127–141, 169–180), closely linked to the economic and environmental conditions of each native society. The examples in this book come for the most part from my own practice, limited inevitably by the contexts in which I have worked. The theories that have made sense to me and that I discuss in subsequent chapters relate to that experience. Where the practitioner is working in different settings, with different client groups, there are a number of good texts related to therapy, that will supplement any limitations in my experience: Lago (2006) and Ryde (2009) on race and culture; Chodorow (2011) on gender and sexuality and Davies and Neal (2000) on working with gay, lesbian and transsexual clients. Religious differences can also be significant cross-culturally, and where therapists and clients have opposing belief systems. My own book on Illusion (2000) examines different modes of belief. Black’s book on religion and psychoanalysis (2006) provides a contemporary perspective including chapters on Judaism, Buddhism and Vedanta. There is some literature on Islam and psychotherapy (Chaleby and Racy 1999; Akhtar 2008).

5 There is a particular bias in Western therapy in its individualistic stance. Individual history needs to be seen as much as it is possible from the client’s narrative, in the context of family history, and indeed of cultural history, whether at a local or a national level. This wider view is represented in systemic and family therapy (for example Dallos and Draper 2005).

6 While avoiding individualism, as a therapist I also wish to validate the uniqueness of each client’s personal history and present circumstances. This is, of course, not incompatible with seeing the client in context. But even when we have taken into account the relativity of psychological knowledge, have recognized the influence of gender and cultural variations, owned our own bias, and accepted the political and social context in which as therapists we function, it is important to look at how we apply theories of personal development to individual clients. There is a danger, in a text such as this, which sets out ways of identifying major psychodynamic themes, of promoting a type of ‘pathology-spotting’, or labelling of clients, which fails to do justice to the individual. I discuss this in much greater detail in my chapter on ‘Naming and Labelling’ in Our Desire of Unrest (Jacobs 2009), where I argue for the importance of naming accurately.
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at the right time, rather than peppering the client with learnt interpretations.

The themes that I explore in the following chapters are not intended as means of labelling or of diagnosing clients. My aim is rather to provide a way of looking at, and understanding, the therapeutic relationship as it concentrates upon a person’s inner world, with its different emotions, experiences and influences. As long as the themes and the terms used within them do not become simple catchphrases, but represent a way into the complex network of presenting problems and past issues, they can also provide a range of possible clues to look out for in the material with which the therapist is presented.

The different use of the concepts of labelling and naming is illustrated by a client who had seen me for quite a long time. Freda opened one session by asking, ‘What’s wrong with me? Am I a manic depressive? Am I neurotic? Do I have an anxiety-state?’ I was rather concerned how best to answer this, wondering what kind of answer she wanted from me. I decided to reply honestly (and partly because I was not sure I really knew the answer!) that I was not normally interested in attaching such labels to people. To my relief Freda replied that if I did, she would want a category all to herself! The reason was obvious: she came from a large family, in which she was the very middle child. Time and again she had talked of situations both in her family and in present relationships where she felt that she did not matter. She saw herself as always left out of invitations to parties, she felt people ignored her, and she recalled how her parents had teased her when she showed early signs of intellectual promise, which marked her out from their other children. She desperately wanted recognition, and yet she also felt guilty when she got it. She wanted to be treated as a unique individual. And she was prepared, had I labelled her, to insist on that too in any ‘diagnosis’.

Even ‘naming’ employs metaphors: all language is a means of trying to bridge the gap between inner experience and outer reality. It is also important to recognize that therapists and clients use words, as indeed a writer uses words, because it is probably the most convenient means of expression. Nevertheless, what therapists, clients and writers identify and name is still only an approximation to inner experience. Since psychodynamic theory is full of metaphor, there is a point with clients when it becomes essential to make it clear that what they and we speak and name may be better than a label, and may carry more force and feeling than a label, but that it is still only a fallible
and one-dimensional expression of the inner world. As the analyst Bion once wrote, psychoanalysis is ‘a stripe on a tiger’ (Eigen 1998: 16–17).

Psychodynamic theory meets our desire for greater knowledge as therapists, and aids the exploration and description of the inner and outer worlds of human relationships. Much as this knowledge may prove valuable it has limitations, not only because of what is not known, but because even what appears to be known is embedded in societal, cultural and gender assumptions, which must always cast some doubt upon the permanence or objectivity of these and other theoretical concepts.

Seen as metaphors, sometimes even as symbols, which can enhance the art and skill of the therapist, psychodynamic concepts and language have much to offer therapists and clients, although it will usually need to be translated into more commonplace language for most clients. Developmental models and themes provide many clues to possibilities that ultimately only the client can confirm or deny. If the themes inherent in the course of personal development are to have any value, it will not simply be because they promote knowledge, but because they can be integrated with that intuition and sensitivity that therapists have acquired in their training. Combining the knowledge of the theorist, the insight of the artist and the humanity of the therapist is a delicate skill. Theory only serves therapists and counsellors well if it serves the client well. It is primarily clients who make theory, and not theory that makes therapy.