

Filling the psychic gap: understanding psychosomatic problems in a multi-cultural clinic

NARENDRA KEVAL

Summary *This paper describes an analytic approach I used some years ago when working in a multi-cultural clinic to understand psychosomatic difficulties in an Asian Muslim woman who suffered from recurring headaches and dizzy spells. Her symptoms revealed and concealed a much-needed psychic equilibrium aimed at producing a stalemate in her mental growth and development. The headaches occurred when she began to think about herself, particularly conflicting thoughts and feelings which she found intolerable because it represented signs of psychic movement and separation. The dizzy spells acted like a psychic switch that closed her mind down and enabled her to escape into a phantasy of fusion with her mother which would have posed another type of psychic threat—the potential loss of her identity. Adopting others both literally and metaphorically had the aim of filling a psychic gap left by a failure of internalisation resulting in an ‘addictive’ way of relating to others such as her husband and the wider system of health care professionals who ultimately failed her.*

Introduction

Clinical work, like any interpersonal activity, never takes place in a racial/cultural or socio-political vacuum and presents an important challenge to our capacity to think about and understand how these factors may intertwine with our patients’ suffering. It is particularly difficult to ‘apply’ some of these concerns in our manner of being with and understanding of the patient. Space permits only a brief mention of some of the important issues that have been the subject of much debate (Kareem & Littlewood, 1992; Fernando, 1991; Kakar, 1978, 1985).

It appears to be common knowledge amongst clinical practitioners and researchers in health care that people from the ethnic community are more likely to present or certainly articulate their psychological difficulties in physical terms or symptoms. But I am never really sure what it means. Is it a factual statement or an assumption and what is it based on? How do we make sense of it given that most patients (ethnic or indigenous) rarely present their initial difficulties in terms of a difficulty in relating to themselves and others? Through the process of thinking more deeply with us they may arrive at a different understanding of their difficulties and an informed judgement arrived at about the ‘psychological mindedness’ and treatability of the patient.

It raises an issue of who makes up the criteria and decision making which determines who gets referred for psychological help. Qualitative issues come to mind to do with the nature of

Correspondence to: Narendra Keval, Department of Clinical Psychology, 1st Floor, Avenue Clinic, The Avenue, Watford, Hertfordshire WD17 3HU, UK.

the interaction between the patient and the professional, be they doctor, therapist or social worker, particularly the format or language used to communicate emotional distress and how this may come to be understood or misunderstood (Sue & Zane, 1987). For example, a middle aged Muslim woman with strong religious and cultural beliefs about her power and gender role may have reservations about being alone in the consulting room with a professional without her husband present. She may ask her husband to speak for her. When she decides to speak she may describe physical symptoms rather than her relationships. How is this to be understood? It would be far too easy to appeal to a cultural stereotype that this is a typical subservient Muslim woman who is not psychologically minded and somatises her difficulties. Even if it was found to be the case that she had problems in asserting herself and was somatising, this tells us nothing about how and why she came to be like this and whether or not there was any margin for access to her emotional life that would be of potential help to her. It is easy to forget that 'psychological mindedness' is not a concrete entity that one either has or hasn't. It is about working with degrees of insight at different moments of our contact with the patient. There are moments when the patient is able to have some 'mindfulness' and other moments when they choose not to be, I would argue, for emotional reasons.

It is often these subtle factors that have to be questioned in the clinical decision making which surrounds the type of help being offered to a person from the ethnic community. Personal or professional prejudice can easily creep into our formulations about what the patient is or is not capable of being or doing and unwittingly feed into and create the larger structural phenomenon that we have nowadays come to call 'institutional racism' which systematically determines equity of access to mental health care (Griffith, 1977).

We all make assumptions, implicit or explicit, about others' racial/cultural backgrounds which will have some bearing on how we understand each other. To control for these human characteristics arguments are often put in favour of matching patients with their therapists on the grounds of racial/cultural similarity, the assumption being that the therapeutic alliance will run more smoothly and facilitate the treatment process. However, this assumption also needs to be examined more closely as it contains a belief that race/culture of both parties concerned are fixed concrete entities that can be controlled for. Similar issues concern the arguments in favour of matching on the grounds of gender. We have to be careful not to recreate the very problem that we are attempting to grapple with since concrete thinking is precisely one of the hallmarks of stereotyping, prejudice and racism. Certainly in the case that I present here, an Asian Muslim couple are faced with a psychotherapist from a different religious/cultural background. It is interesting to speculate whether this had any bearing on their capacity to engage with me. Perhaps the fact that I spoke a language she understood mitigated this problem but it remains a question.

Different settings will have different policies about whether or not they comply with the patient's specific requests as regards choice of therapist. Some decisions will be governed largely by resource constraints while others will be determined by points of view. Either the request is accommodated and then taken up in the course of the interview to see what can be learned about the patient, or it is refused on the grounds that this would be colluding with the patient's concrete thinking and be ultimately unhelpful to them. They may be asked to seek help elsewhere.

From an analytic point of view the main concern would be to understand the nature of the request for 'matching', however reasonable and politically correct it may be. The question would need to be asked why this patient with this type of difficulty makes this particular request. What can we usefully learn about the way they function and present their difficulties? It is the individual meaning of the experience that concerns us. If we take the area of psychosomatic difficulties, the very problem of concreteness can feed into our thinking about the

role of race/culture in our understanding of the patient. Instead of being imaginative we can become rigid and stick adhesively to racial/cultural categories and mimic the psychosomatic problem.

What may feel like a particular obstacle or nuisance to our clinical or theoretical purity can often be turned into a valuable opportunity for learning about the patient. When a patient is unable to speak fluent English and an interpreter has to be used, one is immediately faced with the prospect of working within a triangular situation rather than the normal therapeutic dyad. We have an opportunity to observe how each party relates to each other and construct various hypotheses or make inferences about the way in which the psychic difficulty in the patient manifests within this triangular scenario in the 'here and now' of the situation.

Finally, the conceptual tools we use in our practice are always underpinned by a set of beliefs or ideology that will have many origins. Take the area of psychosomatic problems. There is a fundamental assumption being made here of a duality between psyche and soma which we try to help the patient make a connection with. Is it a meaningful connection across all cultures? Are there concepts and frameworks embedded in a culture that allow this connection to be made meaningfully or can this duality be described as ethnocentric?

Our theoretical background will inevitably affect how we choose to understand what our patients bring to us. The very fact of my working analytically means that I choose to understand the patient that I discuss here in a predominantly Western developmental framework. This may or may not be meaningful to the patient for all sorts of reasons and raises interesting questions about what underlies it. Is it a part of her defensive organisation that aims to keep her psychic integrity or are we missing some crucial point here that relates to my lack of understanding of the way she has construed herself in terms of quite a different meaning system that relates to her culture and religion. Perhaps my approach could be equally puzzling to her as her way of construing might appear to me.

Categories of race/culture constantly impinge on our daily lives. Impingement is not even accurate, it is more subtle than that and often difficult to articulate to oneself let alone others. It's not unlike the psychosomatic problem where the struggle is to symbolically bridge the gap between two domains of functioning which interact in puzzling but interesting ways. It is this puzzle that makes clinical work in a multi-cultural setting or with patients from the ethnic community so challenging and interesting. It forces us to stretch our imaginations to understand how the inner world is given expression through and formed by the myriad of overlapping templates of experience that we categorise as familial, racial/cultural and so on (Rustin, 1991). The challenge is attempting to understand their symbolic intricacies rather than treating them as concrete entities to be ticked off a checklist. The latter may have a part to play in the wider scheme of things but not in psychotherapeutic work.

I cannot claim to have done justice to unravelling these points here but what I have done is taken a pragmatic approach using the conceptual tools available to me, hopefully in a spirit of enquiry in order that the patient could be helped in some small but significant way.

The psychosomatic problem

The term psychosomatic refers to a relationship between one's mental or emotional life and the soma, the physical or concrete domain. Inside and outside, below and above the surface. We assume there is a connectedness between the geography of the internal and external space. The symptom is thought to be the interface. Putting it crudely, something is going on inside and you see the effect on the outside. But what is this something that causes so much pain and cannot be articulated? Is there a logic behind the symptoms? Why does a patient have these particular symptoms from a whole multitude that they could have presented with?

In asking these sorts of questions it is clear that we are attempting to make sense, a translation process of moving from the concrete to the symbolic domain. We are trying to place the phenomenon in a language or framework that will enable us to make this movement. If we think about it, it is precisely what the psychosomatic patient is unable or struggling to do, create a container where the symbolic function can take place to allow the pain to be thought about and understood. A breakdown in this capacity means that the patient 'thinks' with his body, if one can call it that, or articulates their distress via the body. The aim of therapeutic work would be to help the patient create a container for thinking, that is to say help them bridge the split that they have created between their psyche and soma.

Freud (1926) believed that behind each symptom lay a disturbance in the patient's internal relationships which could not be fully acknowledged because of the pain it created. A compromise is therefore sought where the 'story' behind the pain is partly revealed and concealed. A parallel could be drawn with the content of dreams where a story or stories which capture the nature of a patient's predicament is being expressed via a rich and often idiosyncratic symbolism. The parallel is not an accurate one as the 'psychosomatic story' reveals actually a failure of symbolism where the drama being played out is more archaic in nature (McDougall, 1974). This failure is expressed in the problem of linkage between the psyche and soma and reveals a larger problem of the split in the personality which constitutes the real illness (Winnicott, 1966).

Bion (1962) formulated this problem of linkage as part of a broader issue of containment and the development of mind itself based on the earliest relationship between the mother and infant, the primary link, widening out to include the father and beyond to other significant relations in the child's life. Put simply, containment refers to the mother's capacity to retain her reverie and thinking in the face of her infant's anxiety without becoming too anxious herself so that her child's internal experience becomes less frightening and therefore more manageable. In other words, there is a container, a mindful object called mother who is able to process her child's anxiety. It involves a crucial link between two minds so that one hopes the child can gradually build up an internal model of relatedness. The mother holds her child in mind leading to the child holding or managing his own mind in identification with the mother. In short, the child is able to do for himself what his mother has done for him.

This function of linking is thought to be the building blocks of all relationships in the child's inner world and acts as a container. A breakdown in the primary link between mother and infant can often lead to a profound disturbance in the capacity of the infant to think and process anxiety and can lead to an alternative object into which the anxiety is projected. This may be the infant's own body. When this becomes a habitual strategy there is an absence of a mindful object in the patient's mind leading to a certain 'mindlessness', meaning that they behave as if they no longer have a functioning mind.

Findings from research on babies suffering from serious psychosomatic difficulties in the first months of life suggest that the mothers of these babies failed in their function as a protective shield against exciting stimuli, precisely through overindulging the use of this function. Instead of a primitive form of psychic activity akin to dreaming which would permit most babies to sleep peacefully after feeding, these babies need the mother to be physically present because of a breakdown in the capacity to symbolically create a good internal state of being.

Fain's work (1971) suggests that these babies experience their mothers as 'tranquillising' not 'satisfying'. A 'tranquillising mother' cannot allow her baby to create an identification with her which would enable him to sleep without continual contact with her. Similar observations have been made in cases of infantile asthma and allergic children. This work suggests it is a failure in the mother's capacity to both separate from and allow separation by her infant which results in a pathological dependence. There are some parallels here with Esther Bick's

work (1968, 1986) on the function of the 'second skin' which has to compensate for deficiencies in the first containing skin but the failures in internalisation are thought to be due to the failure of the mother's capacity to provide an adequate concrete skin container not an overindulgence of it. The end result however is the same, a serious symbolic gap so that the mother's absence is not compensated for psychically.

Fain's work suggests that psychosomatic difficulties are likely to arise where the mother cannot allow her infant to develop an internal fantasy life or autoerotic substitutes for the maternal relationship, instead she continually offers herself as the only object of satisfaction and psychic viability. This type of failure in self-regulation has led McDougall (1974) to describe the mode of relating as an addictive one. The infant comes to need the mother as an addict needs his drug, a total dependence on an external object.

The psychosomatic patient aims to make substitute objects in the external world compensate for the lack of symbolic objects which are absent or damaged in their inner world. Such solutions are doomed to fail and the patient is equally doomed to an endless repetition of an addictive attachment to the outer world and external objects. When they describe their relations with sexual partners they treat them as though they were feeding mothers on whom they are desperately dependent yet the partners are also highly interchangeable because the focus is on someone to be there, much like the function of a security blanket, a transitional object. Illness strikes them when faced with the prospects of separation or abandonment by people who unconsciously represent the addictive mother of the infant. Safety is sought desperately in the external world in terms of 'adhesive relationships' (Meltzer, 1975) with others that aim to fulfil the function of the close proximity of the mother's concrete skin. These often take the form of exploiting the multiple splits in the care provision so that the 'body' of the health care provision can start to enact the psychosomatic problem, namely moving from one professional or service to another, keeping the personality split.

Case study: adoption as a psychic defence

This case describes an unfinished consultation because the patient and her husband dropped out of the process but I think enough was gleaned from the experience with them to arrive at some tentative understanding of her difficulties. Whilst I have tried to describe the experience of the consultation as it unfolds, it is not in strict sequence as the intention is to describe key moments in the interview to illuminate the main themes of this paper. I have also altered some details in order to keep the patient's confidentiality.

Just a brief word about how I do a consultation. I am interested in the historical facts that are presented to me by the referrer or the patient but I see the task of my assessment as using this information to focus on a dynamic that recurs in the patient's life, a pattern and quality of relating to themselves and others that might emerge. I am interested in how this dynamic gets enacted in the patient's external life and how it might become enacted with me in the transference so that I might be able to show it to the patient. I need to know their capacity for tolerating emotional contact and thinking about themselves, whether their anxieties are continuously projected or not, whether their 'story' is manic, detached, paranoid, disjointed, segments missing and so on. I may ask for an early memory if it is not volunteered, a dream or a sexual fantasy as I see fit, to select the recurring story. For some patients, asking them to think about themselves at different stages of their lives is a first experience in beginning to make their own links or connections or become more aware of their own feelings.

A 38-year-old Gujarati speaking Muslim woman whom I shall call Mrs B had a long history of headaches and dizziness which had been thoroughly investigated but no obvious cause had been found. She and her husband travelled from one hospital to another often in

different parts of the country to locate a cure. Whilst the referral letter indicated that she had a 4-year history of headaches, I learnt from her that she experienced these frequently as a child. There were other discrepancies in the details such as the number of siblings in her family and the timing of her father's death, all of which pointed to something that did not quite square which was yet to be discovered in my meeting with her.

Mrs B was born in Zimbabwe, Africa and attended school until she was 12 years old, then she stayed at home with her mother. She had 11 siblings, six brothers and five sisters. All her brothers suffered from headaches and dizziness. Her father was a wealthy businessman who died when the patient was in her late twenties. Mrs B had an arranged marriage at the age of 35 years to her present husband who was 40 years old. She was his third wife having divorced his previous partners. An 18 year old son and a 14 year old daughter lived with them until the conflict between the daughter and Mrs B led to her leaving home and staying with her birth mother. Mrs B led a very restricted social life, spending most of the time at home with her husband by her side in case she fell from one of her dizzy spells.

The consultation

When Mrs B arrived with her husband there was a long delay in coming up the two flights of stairs to the waiting room. I was reminded of the long delay in getting this couple to come to this first appointment. By the time the appointment letters reached them they had moved to a different address by which time they were making plans to go abroad. It was a slow start.

I went to the stairs and saw the couple slowly walking upstairs. Mrs B wore a long traditional dress with an elegant scarf covering her head. Mr B was holding her hands and helping her up the stairs like a little girl. He greeted me warmly and spoke fluent English. He was dressed casually in clothes that looked like English tweed. I found it hard to place them together as a couple in my mind. Something did not square. He told me that his wife wanted him to accompany her in the consultation as she was too anxious to speak alone.

As they sat he proceeded to tell me that they had tried everything, all the medical tests had found no organic cause. There was a desperation in his tone of voice. Mrs B looked irate and in pain. As I was told that she could not speak English I asked in her mother tongue, Gujarati, how she was feeling at this moment. She replied that she was in constant pain in her head—her whole head was hurting. Sometimes the pain circulated in different parts of her head. She stopped talking and told me that her husband would explain. He proceeded to do so in English and as he spoke I felt his wife felt increasingly excluded and alone in her pain and I wondered why she had done this. He chose to speak in English when his wife and I had just been conversing in Gujarati a few moments ago. It seemed as if the triangular conversation and linking had been broken abruptly into a dyadic link excluding his wife.

Strong feelings were being evoked in me, particularly a feeling of helplessness and a wish to give up by referring them on to someone else. They were conveying that not only had everyone given up on them but that the professionals involved had not been helpful. The couple had felt frustrated by them all. In their eyes they had all failed. A powerful dynamic was already in place: getting rid of uncomfortable thoughts and feelings which might be an enactment of the psychosomatic problem, namely, getting rid or evacuating mental/emotional pain into the head. The message was loud and clear. I too was being prepared for this unfortunate outcome.

I kept this in mind and asked how they came together as a couple. He told me it was an arranged marriage. His first wife had an affair with another man while he was abroad. On his return she had changed all the locks of the house to prevent him from entering. He had one son and a daughter from this marriage who had been living with him until the conflict

between the daughter and his new wife. He said that they were both competing for his attention. What was being conveyed was an oedipal or triangular situation in which unbearable feelings of being outside were reacted to by the wish to get inside.

He was not making it clear why his wife had changed the locks, the story was vague and incomplete. He said his second marriage was on the rebound so that failed, but he loved his present wife because she was 'obedient'. These words stayed in my mind as well as the experience of listening to a story lacking in content and elaboration. I asked him what he meant by his wife's obedience to which he told me that it was her passivity that he admired but in his telling me this I began to feel distinctly irritated with his attitude which described his wives as inanimate objects, not persons in their own right but objects who had failed to fulfil some crucial function for him. They could all be replaced and most importantly it was they who had the problem. Perhaps husband and wife shared an unconscious phantasy of dissociating aspects of themselves into others be it a sexual partner or parts of the body.

Mrs B told me quite spontaneously that her mother was a very anxious and depressed woman throughout her life whilst her father was a gregarious man who was short tempered and largely absent. One of her sisters had half her face paralysed while the other was lethargic and unable to move. I was reminded of how everything was slow when I first tried to engage with this couple. There was some difficulty in movement or paralysis in this family and in the patient's psyche. She said she had no intention of getting married and was quite happy living with her mother and siblings. She had even adopted a friend's daughter back home who would sit by her side and look after her 24 hours of the day. They were inseparable just like now it was she and her husband who were inseparable.

She described this in a matter of fact way without any real content or feeling about this state of affairs. The 'little girl' was described as having just sat there by her side whom she missed but it wasn't clear what she missed her for. Another sister had adopted a brother's son because she had no children. Adoption aimed to fill a psychic gap in this patient and her husband. In her early life all the siblings had huddled around the parents' bed at night, all inseparable until the morning. This became enacted with the children they adopted who sat by their side.

I decided to see the patient on her own to give her space to tell me about herself but I wondered whether I too was becoming entangled in a dynamic of one-to-one relationships which were fused and inseparable. At the same time, I was mindful of stepping onto sensitivities that the couple had expressed about being seen alone with me. However, neither objected to my request. On her own Mrs B was assertive about telling me how much pain she was in, the uselessness of the medication and that she could not see the sense in my wanting to explore her early life. She felt I was delving into areas which had no significance for her when everything was fine in her life except the headaches.

It left me feeling a little helpless about the approach I was taking with her but this was an important message. She was in pain and I felt inadequate in helping her. My wish was to stop thinking with her and offer her something concrete, a magical cure that she was seeking. Like the patient's wish I was diverting my relative sense of helplessness somewhere else. The theme being repeated was the feeling of utter helplessness and the wish for this persecutory feeling to be got rid of; instead she was overwhelmed by it with no possibility of containing the pain. At this point she told me the pain was unbearable, it was her head that was causing the pain not her family. She was right in a sense. When I tried to help her verbalise her thoughts and feelings I was trying to help her use her mind to understand and potentially manage her pain but this was at odds with her wish for me to take her pain away first before she could start to think.

At some point I asked her whether she could remember any dreams, explaining to her that these pictures in her mind might help us understand why she was in so much pain. She told me that I should ask her husband because he remembered all her dreams and she wanted him back in the consulting room because her pain had increased. In that moment she re-enacted her psychosomatic problem, namely projected her capacity to think into the 'body' of her husband. He became the guardian of her mind. I drew her attention to this but she looked at me as if I had said something quite crazy. I realised later that this may have reflected her fear that I was driving her mad by trying to make things more meaningful for her.

Her husband described a recurrent dream in which her father stepped off a ship which sailed from Africa and brought the patient fruit as a gift. He was the only survivor from her family which had been massacred by a person she was unable to recognise in the dream. She said she missed her father and thought she was like him, hot tempered. I was struck by her choosing to tell me about her relationship with her father, seemingly unmoved by the horrific murder of the rest of her family members in the dream. Mrs B 'murdered' that part of the dream which involved her family members and gained exclusive possession of her father. Was this incestuous wish the forbidden fruit that she had committed murder for and had to keep anonymous? At this point she told me that the more we thought the worse her headaches became and now she wanted to stop.

In our second meeting she managed to walk up the stairs unaided. She was in much pain and told me that her headaches tortured her. She felt like pulling her hair out or banging her head against the wall to get rid of it. I reminded her that her pain got worse when we talked about her dream. Mrs B replied that if she thought too much her headache would get worse to the point that she would feel like vomiting. She said she often sat at home in complete darkness trying to keep everything absolutely still in her mind without anything disturbing her otherwise she became furious.

Her husband told me that her family was a real battleground in which they all had huge grievances towards each other. I connected the anger on her face at that moment to the murderous rage she felt inside for disturbing the feelings she wanted to keep still, the murderous rage in the dream. Mrs B replied that she was angry about many things in her life. She had no intentions of leaving home to get married, let alone leaving the country she grew up in to come to a foreign land. She was upset at having to leave her family behind, particularly her daughter but she was happy with her husband by her side. They were making plans to have a child but her illness prevented them from developing their sexual relationship.

It was becoming clear why, despite all their conscious intentions and suffering, neither of them really wanted things to change because separateness was such a daunting task. It would have meant taking ownership of one's mind to think thoughts and remember dreams. This couple had formed an unconscious 'contract' to establish a much-needed psychic equilibrium aimed at creating a stalemate in further development.

One has to ask the question why Mr B chose that particular dream to recall if it were not the case that he too had an emotional investment in this dream. He had a stormy relationship with his father and was the scapegoat of the family. There was much rivalry and competition between them all but in his father's eyes his brothers could do no wrong. Mr B sounded angry and resentful but also saddened in the way things had turned sour in the family. From the sounds of it this too was a battleground for him. Did the dream also reveal Mr B's hidden rage toward his family that he wished to eliminate so that he could have an exclusive relationship with his father? If you remember, at the beginning of the interview Mr B frequently switched from speaking Gujarati to English. Perhaps this was an unconscious attempt to 'couple up' with me to exclude his wife from our conversation, thereby ensuring he had my exclusive attention.

Before our third and final meeting I received a call from Mr B that they were unable to come as his wife had become extremely ill, unable to walk. They did not wish to continue any further meetings and wanted to be referred back where 'something' could be done about his wife's headaches.

Discussion

Mrs B dropped out of the consultation at a point when we were only just beginning to make sense of some of her difficulties in experiencing thoughts and feelings which one could describe broadly as oedipal in nature. Bearing in mind the consultation was incomplete I propose a tentative understanding of what may have been at the root of her problems which became 'locked' into a shared phantasy with her husband to ensure that nothing disturbed their psychic equilibrium. Mr B was a patient by default but very usefully gave us an understanding of how they both shared a common mechanism of dissociation which ensured that they were put out of touch with painful and intolerable impulses and feelings. I suspect that this was underlying Mrs B's 'splitting' headache in which she wanted to pull her hair out (thoughts and feelings) so she could escape into a phantasised retreat more akin to being in a fused state with her mother. It was a catatonic, deadly state of mind which gave her a temporary respite from the battleground that was her mind. Except that it was being played out in a different arena, her body.

Murderous impulses towards her mother and other sibling rivals to gain exclusive possession of the 'forbidden fruit', the oedipal father, had to remain hidden, indicative at one level of a wish to push towards separation from her mother. This conflicted with the pull towards merging with the mother, the dark psychic retreat she created in her mind which ran the risk of losing her identity. It seems that the rivalrous and competitive part of her personality was kept hidden both from herself and a mother experienced as anxious and depressed. Outwardly compliant and 'obedient' as her husband had put it but inwardly raging.

It was not difficult to see why 'movement' was so slow in this woman. Sluggishness and paralysis (in the family members) was aimed at paralysing psychic movement in any direction, growth and development of her mind versus fusion with her mother. She created a stalemate but it was a tortuous experience. The headaches served the function of creating a 'fog' to avoid using her mind to think and move forward in her development whereas the dizzy spells aimed to switch her mind off and provide a temporary escape into a psychic retreat.

Adopting a child to give '24 hour cover' reflects a phantasy of being physically stuck to the mother in a concrete way much like the infants described in Fain's research (1971) unable to separate and have a mind which could dream and think thoughts. It laid a flimsy foundation to grapple with the arrival of the oedipal drama and conflict. For Mrs B the phantasy of adoption provided a short cut to cope with developmental anxieties. Adoption aimed to fill a psychic gap, by providing a tactile mother who was glued and inseparable a role transferred onto her husband whom she related to in an 'addictive' way and allowed her to sidestep the oedipal crisis. It was phoney and perhaps connected to why I could not place this couple in my mind when I first met them. They gave the appearance of maturity. Neither was it of much surprise to find that their sexual relationship was also unable to develop since the arrival of a baby would have put them in touch with both pre-oedipal and oedipal anxieties that were so strongly defended against.

Patients with this type of personality organisation experience separation and discontinuity as catastrophic akin to being torn apart from the skin of the other leading to a fear of disintegration. It has strong echoes with the type of patients described in Bick's work (1968, 1986),

Rosenfeld's (1987) notion of 'thick' and 'thin' skin in narcissistic disorders and Meltzer's work (1975) on the adhesive personality. Mrs B alluded to this fear of disintegration when she wanted me to stop thinking with her because it put the contents of her mind in a jumble—what she referred to as 'vomit'.

I was correct in feeling that I would not be allowed to make too many inroads into her psychic functioning because it would disturb a much-needed equilibrium peculiar to her personality but also strongly maintained by her marriage. It is this internal predicament that gets played out with the 'body' of health services engineered in such a way as to repeat the 'adoption' of different services to fill a psychic gap in an addictive way. Perhaps this was also represented in the dream systemically in the murder of the family members and the 'family' of professionals and services who were not allowed to be effective.

It raises the important need with patients like these to create a proper functioning couple or marriage between different services to ensure that the splitting is not colluded with. These 'special patients' (Main, 1957) can often split organisations internally and externally into idealised and denigrated objects mirroring their internal split. Multi-cultural clinics can often get drawn into taking patients like Mrs B on the grounds of her ethnicity rather than suitability for treatment. Sometimes it is a case of attempting to reach a patient who has not been served well but the possibility of this needs careful scrutiny and would have to be balanced with the risks of becoming 'seduced' by concrete thinking and offers of help on the grounds of her ethnicity rather than suitability for treatment.

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