Beginnings

How we can be possessed by a story that cannot be told

I want to tell you a story about a patient who shocked me.

When I was first starting out as a psychoanalyst, I rented a small consulting room in Hampstead, on a wide leafy street called Fitzjohns Avenue. It was near a number of well-known psychoanalytic clinics and a few minutes walk from the Freud Museum. At the south end of Fitzjohns Avenue, there is a large bronze statue of Freud.

My consulting room was quiet and spare. There was a desk just large enough for writing up notes and preparing my monthly bills, but no bookshelves or files – the room wasn't for reading or research. As in most consulting rooms, the couch wasn't a couch, but a firm single bed with a dark fitted cover. At the head of the bed was a goose-down cushion, and on top of that a white linen napkin that I changed between patients. The psychoanalyst who rented the room to me had hung one piece of African folk art on the walls many years

before. She still used the room in the mornings and I used it in the afternoons. For that reason it was impersonal, ascetic even.

I was working part-time at the Portman Clinic, a forensic outpatient service. In general, patients referred to the Portman had broken the law; some had committed violent or sexual crimes. I saw patients of all ages and I wrote quite a few court reports. At the same time, I was building up my private practice. My plan was to reserve my mornings for clinic work; in the afternoons I hoped to see private patients who had less extreme or pressing problems.

As it turned out, my first private patients were fairly demanding too. Looking back, I see many reasons why these first cases were difficult. Partly, there was my own inexperience. I think it takes time – it took me time – to realise just how very different people are from each other. And it probably didn't help that I'd received a number of referrals from senior psychiatrists and psychoanalysts trying to help me get started. Doctors often refer patients to junior analysts that they don't want to see themselves or can't place anywhere else. And so I was struggling with:

Miss A., a twenty-year-old undergraduate. Although the psychoanalyst who'd assessed her described Miss A. as 'suffering uncontrollable bouts of crying, depression and pervasive feelings of inadequacy', she presented as a cheerful young woman who insisted that she did not need treatment.

In time, however, I learned that she was bulimic and regularly, compulsively, cut herself. Because she had only attended her sessions sporadically, two other therapists had given up seeing her.

Professor B., a forty-year-old research scientist, married with two children. He'd recently been accused of plagiarising a rival's work. The vice chancellor had referred the matter to the disciplinary committee. If he was found guilty – and Professor B. told me it was likely that he would be – he might be given the chance to resign discreetly. His physician had put him on antidepressants and asked me to see him for psychoanalysis. Professor B. vacillated wildly between states of hectic triumph – mocking colleagues on the disciplinary committee, for example – and utter dejection.

Mrs C., who owned and operated a small restaurant with her husband; she was a mother of three. She wanted help because she felt anxious and suffered panic attacks. In our first meeting she said that she 'found it difficult to relate honestly', but it was only after several months of therapy that she told me that she was having an affair with her children's nanny, a woman who had been working for the family for the past seven years, since shortly after the birth of her first child. Now – contrary to an agreement with her husband – Mrs C. was secretly trying to get pregnant because she could not bear the thought of losing her nanny.

Another of my earliest patients was a young man named

Peter. He was undergoing treatment at a large psychiatric hospital nearby. Three months before we met, Peter hid in the cupboard of a local church, where he tried to kill himself by taking an overdose of various drugs and then slitting his wrists. He also stabbed himself in the neck, chest and arms with a small knife. He was discovered by a cleaner. Although she was frightened, the cleaner held him as they waited for the ambulance. 'Who did this?' she asked him. 'Tell me, who did this to you?'

The consultant psychiatrist at the hospital asked me if I'd see Peter five times a week for psychoanalysis. She felt that daily therapy, together with a weekly meeting with her, was Peter's best chance for recovery, for returning home to his fiancée and to his work.

Peter was twenty-seven and worked as a structural engineer. Before he was hospitalised, he and his fiancée had bought a one-bedroom flat outside London. He had been having difficulties at work and was anxious about money – but none of this seemed to explain his violent attack on himself. Part of my job, then, was to work with Peter to identify the causes of his suicide attempt – if we couldn't understand the forces that had pushed him to attack himself, there was every reason to think it would happen again.

Peter was tall and lanky, but carried himself as some depressed people do, shoulders hunched forward, head down. His manner was depressed too – he spoke haltingly, with little

eye contact. Once positioned on the couch, he hardly ever moved.

Peter attended all of his sessions, and was almost never late. After several months, he left hospital and was able to return to his life. But increasingly, in our sessions, I felt him disappear to a place I couldn't find, let alone understand. 'You've been silent a long time – can you tell me what you've been thinking about?' I asked in one session.

'A holiday in Devon – when I was a child,' he replied.

There was a long pause. Could he tell me more? He replied that he wasn't thinking about anything in particular, he was just thinking about being alone.

I had the thought that he wanted to be away from me, on holiday from analysis, and told him so. 'Could be,' he replied.

It was as if Peter was trying to protect himself from my intrusiveness, as if he was complying with the conventions of analysis – being on time and answering my questions, for example – but in such a way as to prevent any meaningful connection developing between us. He seemed to have little faith in our talking.

But I did learn that Peter had a history of making friends and then turning on them. In his professional life too he'd quietly go about his work, then suddenly get into a row with his boss and quit. This had happened several times. I tried to use this information to show Peter that he seemed to have two psychological positions open to him – acquiescence or

blowing everything up. He seemed to agree, but I never felt this idea was meaningful to him. And soon this pattern was enacted in the analysis. Peter went from going along with me to mocking me. After one particularly tumultuous week, Peter stopped coming to his sessions. I wrote to him, proposing that he talk to me about his decision to end his treatment, but I received no reply.

I contacted the psychiatrist, who told me that Peter had stopped seeing her too.

Two months later, a letter arrived from Peter's fiancée, informing me that he had taken his own life. She explained that, during the month leading up to his death, Peter had grown increasingly disturbed and withdrawn. The family had held a funeral at West London Crematorium the week before. She wrote that she was grateful for my attempts to help him. I sent a letter of condolence to her, and then informed Peter's psychiatrist.

I'd known that Peter was a high-risk patient. When I took him on, I'd enlisted the help of a supervisor, an experienced psychoanalyst who'd written a book on suicide. He had repeatedly pointed out to me the many ways in which Peter seemed to idealise death. Now I went to see him again, anxious that there was something I'd missed. My supervisor tried to reassure me. 'Who knows?' he said. 'Being in analysis with you might have *kept* him from suicide for the past year.' Still, Peter's death disturbed me greatly. Of course, I knew that we all have

the capacity to act in self-destructive ways, nevertheless I had a kind of faith that the desire to live was more powerful. Now, instead, I felt its fragility. Peter's suicide made me feel that the battle between the forces of life and death was far more evenly pitched.

Six months later, I received a message on my answering machine. I heard the unmistakable sounds of a public telephone – the pips, the coins falling – and then Peter's voice: 'It's me. I'm not dead. I was wondering if I could come and talk to you. I'm at my old number.'

The instant I heard Peter's voice, I felt faint, confused. For a moment I persuaded myself that the answering machine was malfunctioning, that I was listening to a very old message from Peter that had never been erased. And then I laughed – out of anger, out of relief. And because I was stunned.

That evening, when I wrote to the consultant psychiatrist to tell her that Peter wasn't dead, I did what many people do when they're angry: I made a joke. 'Unless there are payphones in hell,' I wrote, 'Peter is still alive. He left a message on my answering machine earlier today, asking for an appointment.'

Peter came to see me the following week. In a matter-of-fact way, he told me that he, not his fiancée, had written to inform me of his death. He'd also intercepted my condolence note. 'It was touching,' he said.

'Oh that *is* interesting,' my supervisor said. 'It's surprising

this doesn't happen more often. When you think of all those adolescents who say "you'll be sorry when I kill myself" – you'd think more of them would fake it.' We decided that I should only take Peter on again if I felt he was really prepared to make a serious commitment.

After several meetings, Peter and I agreed to resume his sessions. Ultimately, his disappearance and return proved helpful, because it clarified something that we had never understood: his need to shock others.

In the sessions that followed it slowly became clear that Peter enjoyed thinking about the distress he caused when he suddenly quit work or ended a friendship. He'd blown up the analysis twice – first when he quit and then, a second time, when he faked his suicide. In the first phase of his analysis, I hadn't realised just how attached Peter was to violently upsetting others. But why?

Peter's parents had divorced when he was two and his mother had remarried soon after. During this second phase of his analysis, Peter sought out his biological father and spoke frankly with his mother. He discovered that his mother had been having an affair with the man who became his stepfather, and that his father and mother both drank heavily. He also discovered that the first two years of his life were very different from the story he'd been told. His mother and father both admitted that they couldn't cope and had been violent with him when he was a baby.

Peter told me that his dad didn't remember much, just that it was a terrible, unhappy time, an unhappy marriage. 'My mother cried, she kept saying that she was sorry,' Peter said. 'She was only twenty when I was born and no one was there to help her. She said that sometimes she felt she was just going crazy.'

Her confession gave Peter some relief. For as long as he could remember, he had felt afraid. He told me that it helped to know that he was frightened of *something*. For a small child, violence is an overwhelming, uncontrollable and terrifying experience – and its emotional effects can endure for a lifetime. The trauma becomes internalised, it's what takes hold of us in the absence of another's empathy. So why did Peter turn on those close to him?

Peter's behaviour made it clear that he couldn't allow himself to feel weak. Dependence for him was dangerous. Peter's story might be summed up as, 'I'm the attacker who traumatises, never the baby who is hurt.' But Peter also felt bound to turn on himself. When Peter assaulted himself in the church, he enacted this same story. As he told me, 'I thought – you pathetic little crybaby. I can do this to you and you can't stop me.'

I believe that all of us try to make sense of our lives by telling our stories, but Peter was possessed by a story that he couldn't tell. Not having the words, he expressed himself by other means. Over time I learned that Peter's behaviour was

the language he used to speak to me. Peter told his story by making me feel what it was like to be him, of the anger, confusion and shock that he must have felt as a child.

The author Karen Blixen said, 'All sorrows can be borne if you put them into a story or tell a story about them.' But what if a person can't tell a story about his sorrows? What if his story tells him?

Experience has taught me that our childhoods leave in us stories like this – stories we never found a way to voice, because no one helped us to find the words. When we cannot find a way of telling our story, our story tells us – we dream these stories, we develop symptoms, or we find ourselves acting in ways we don't understand.

Two years after Peter left his message on my answering machine, we agreed to stop his psychoanalysis. I thought there was more work to do, but he felt that it was time.

All of this happened many years ago. Since then Peter hasn't asked to meet again, but I did run into him recently, at the cinema. We recognised each other across the lobby. Peter said something to the woman he was standing with and they walked over. He extended his hand and then he introduced me to his wife.