6
Secret as Potential Space

Be silent!
of Nothing,
ever,
to anyone –
there
in the embers
time
is singing.

Osip Mandel'shtam

In our clinical work, sometimes, it is more important to sustain a person in living than to rid him of his illness. Winnicott (1967) summed this up in his statement, '. . . absence of psycho-neurotic illness may be health, but it is not life' (p. 100).

The demand for *life*, and if that is not possible, for *not living*, is made upon us by the patient and is not a bias of our restitutive omnipotence as therapists. When a patient makes this demand upon us, we have every right to *refuse* it, but not to confuse it. The patient is willing to stay ill and suffer the consequences so long as he or she is *living* or *not living*. If we try to subvert his life by a cure, he either escapes us or gives up his right to be alive and ill and enters into a complicity with us that we mistake for 'treatment alliance'. Gilles Deleuze (1973), in spite of his mocking acerbity, raises an important issue. He argues that Melanie Klein establishes a contract with her patients in which the patients bring their intense experiences of living and she translates these into fantasies for them. He argues that Winnicott takes the psychoanalytic process to that limit where this contract is no longer viable. It becomes more than a mere question of translating the vécu into fantasies or interpreting it. With Winnicott, that point is reached when one has to share with the patient his experience. Deleuze asks whether this is a question of sympathy, empathy or identification. He concludes: 'What we feel is rather the necessity of a relationship which is neither legal, contractual or institutional.'

Of course the philosophers are always wiser and more just than we are; they are not harassed by the ordinary daily humiliations of

having to fail a person in his demands. The *word* is by its very nature inexhaustibly munificent and more understanding than the *act*. Yet Deleuze is right: 'Il faut y aller, il faut partager son état.' But to share and partake of another's predicament implies time and space. What is the nature of *this* time and space with such persons?

Philosophically to comprehend and share 'des états vécus' of a dead genius like Nietzsche, whom Deleuze so insightfully writes about in the context from which I quote him, is one thing; to make oneself available for *use* (to cite Winnicott's concept) to the *living* Nietzsche was another matter altogether. None succeeded.

On 4 January 1889, Nietzsche wrote to George Brandes from Turin: 'To my friend Georg! Once you discovered me, it was no great feat to find me: the difficulty now is to lose me . . . the crucified' (1889, p. 345).

If Deleuze were to make the retort that we analysts are all too adept at *losing* those who do not fit our machinery of cure, it would be hard to refute him. Still I believe it is becoming clinically possible for us to meet the *need* of such persons who insist on *living* outside contractual or institutional relationships.

During the course of any psychoanalytic treatment, we witness a patient inhabiting and fluctuating through many spaces – inside/outside, subjective/objective – and we share these with him. The total analytic situation meets the various demands of the patient in his different states through three modalities: the analytic process, the analytic relation (transference) and the analytic setting. The analytic process actualizes through interpretation and deals with the hidden meaning (Freud), the absent meaning (Green) and the potential meaning (Khan) of the patient's communications. It is here that the analyst is par excellence the 'supplementary ego' (Heimann 1956) of the patient. The transference relationship organizes that affectivity in the patient that enables him to project the roles of significant figures from his past onto the analyst in the here and now of the analytic situation. In recent decades two more functions have been added to the analyst's role in the transference relationship, namely, those of *holding* (Winnicott) and *containing* (Bion). The use of the analytic setting by the patient has come under scrutiny only recently, largely through the researches of Winnicott and Balint.

In classical analysis a patient's capacity to use the analytic setting was taken for granted and most of the analytic literature is devoted to discussions of a patient's use or abuse of the analytic process and the transference relationship. The researches of Winnicott (1955), Balint

(1968) and Milner (1969) have progressively sensitized us to the fact that a patient in certain states of distress and disturbance may be able to use only the analytic space, while he finds himself incapable of using the analytic process or the transference relationship.

In my clinical experience patients use the analytic space in two distinct ways: as concrete space to be in and as potential space where they sustain moods and larval psychic experiences that their ego-capacities cannot yet actualize. I am borrowing the concept of *potential space* from Winnicott (1967). In his paper, 'The Location of Cultural Experience', he states:

> From the beginning the baby has maximally intense experiences in the potential space between the subjective object and the object objectively perceived, between me-extensions and the not-me. This potential space is at the interplay between there being nothing but me and there being objects and phenomena outside omnipotent control.
>
> Every baby has his or her own favourable or unfavourable experience here. Dependence is maximal. The potential space happens only in relation to a feeling of confidence on the part of the baby, that is, confidence related to the dependability of the mother-figure or environmental elements, confidence being the evidence of dependability that is becoming introjected (p. 100).

Winnicott himself has not examined the analytic setting in terms of this hypothesis. Yet it seems to me that his squiggle-game consultations give us a vivid account of how a child uses paper as potential space in order to be privately alone with Winnicott. And this potential space of the paper is a *shared* space where both Winnicott and the child *mutually act* towards that 'significant moment' when the experience of the child can be interpreted to the child (cf. Winnicott 1970).

The most interesting clinical example of how a patient creates a secret potential space is given to us by Marion Milner (1969) in her book *The Hands of the Living God*. Milner recounts how her patient, Susan, had made a drawing the night before her first consultation. The patient had not mentioned or shown this drawing to Milner during some ten years of analysis. In her discussion of Susan's drawings, Milner does not elaborate upon the necessity for Susan, at first, to draw in secret privacy outside the analytic setting. In contrast to Winnicott's squiggle-game drawings *with* the children, Susan, when she had first started to draw, could share her drawings with

Milner only *after* the event. Susan's use of the potential space of the paper is an essential part of her 'self-cure', to use Milner's phrase. Something from the total analytic experience is suspended by Susan, to be actualized later in the potential space of the paper. I am borrowing from André Green's (1973) new slant on Freud's concept of deferred action. Green postulates:

> One major capacity of the psychic structure is the capacity to cut off, to suspend an experience, while it is still going on. This is not for the purpose of observing the experience as in the conscious mental functioning, but to shut off the awareness of it in order to recreate it, in one's own way later on. It is important to see that this cutting off or inner splitting is a precondition for the establishment of further links by association. We should distinguish the moment of the experience and the moment in which it becomes meaningful.

It seems to me that for Susan, at first, the *experience* of herself in the analytic situation became meaningful only as a *secret* – the secret of her drawing in her own isolate privacy. The potential space of the paper captures and articulates this *secret*. I shall now give some clinical material to show how a very young girl created a *secret* and used it as the potential space where she could continue to be, quite apart from her inner life or familial existence in the outside world.

A colleague had asked me to see a young woman urgently because, according to him, she was having a psychotic breakdown. This patient, whom I shall call Caroline, arrived in a most confused and agitated state. All she could tell me in the first consultation was how her husband had jilted her in a most brutal and humiliating manner a week earlier. He had now left her to live with another woman. She kept repeating, 'He has destroyed me!' and her crying was both intense and incessant. I was struck by her utter incapacity to relate to me. She had hardly looked at me once during some two hours of consultation, even though she was sitting facing me. I had been told by the referring consultant that she was a doctor and for the past week had been unable to work. Alongside this acute feeling that she could not relate to me, there grew in me across the time of the consultation a sentient conviction that Caroline felt safe and viable in the space of my Consultation Room. It was this latter conviction that persuaded me to say to Caroline that I was willing to take her into analytic treat-

ment if she so wished. Caroline accepted my offer with a blank absence of response.

Caroline turned up for her sessions five times a week with a punctuality that was almost frightening. This absence of resistance left me clueless as to what was happening to her, inside or outside analysis. Her mood-swings were dangerously volatile. Fortunately I had been able to find a physician of great ability to look after Caroline medically. It would have been impossible for me to hold Caroline in analysis or in life without the medicating care provided by my physician colleague. Caroline was not a silent patient. She either cried vehemently, moaning 'My husband has destroyed me', or she would arrive in a manic state and talk wildly about everything and everybody in her environment but herself. After some three months of analysis, I knew no more about who Caroline was than I had after the first consultation.

It was very tempting to interpret her absence or, to use André Green's more telling phrase, her suspension of experience in the analytic setting as resistance, either from anxiety or hostile suspiciousness. There was a distinct flavour of secretiveness to all her behaviour in analysis and I chose to respect it, both as her right and as her privacy.

Then one day Caroline had an accident. She had not noticed the traffic lights changing, and she banged her car into another one in front of her. A most courteous gentleman had emerged from the other car to look into the damage done. Caroline was so resourceless in the situation that he offered to meet her for lunch the next day and arrange matters. He was much taken by her. Caroline is a plump and pleasant looking girl of some twenty-seven years of age, and there is an ebullient helplessness in her general way of being that is rather attractive. Within a week Caroline was living in the care of her new friend in his house. This was indeed a great relief and respite, both for her physician and for me. Her mood-swings had been so excessive that we had started to think seriously of hospitalizing her. The newfound friend made this unnecessary. He was deeply devoted to her and had the patience of Job with her mad antics. The moment Caroline started this relationship, quite a different person emerged from her being.

Caroline had been married for some six years and lived most docilely with an outrageously cruel and delinquent young husband. Now she began to act out and test the love and care of her friend with a vehement vengefulness. She mistrusted his motives and was violently

rageful. She put him into the most embarrassing social situations. Fortunately for everyone concerned, her friend had an inexhaustible capacity to contain and tolerate her nuisances. In analysis her cry now changed from 'I have been destroyed by my husband' to 'I have lost myself somewhere in my life.' It is not my intention to discuss this phase of her treatment here. Gradually Caroline began to personalize into a coherent being and her moods became related to her actions.

It was at this stage, when she had been in treatment for some nine months, that she arrived one day for her session and, before lying down, paused and said to me: 'I know now what is the matter with me! I have hidden myself.' She lay down and continued: 'I have never told you what I did at three and a half years of age.' She recounted how one day she had taken two silver candlesticks from her mother's dining room and buried them in the garden. There had been a lot of searching around for them. Police had been called and eventually the insurance had paid up the price. They were an expensive item. She had a sense of all that was going on in the house about the candlesticks but had said nothing. Some five months after this event the parents had moved to a new house in a different city. The whole episode had been forgotten. Then one day when she was nine years of age, during vacations, her parents had returned with her for a visit to the old house, of which they were very fond. The new occupants of the house were friends of theirs. When everyone was having tea, Caroline had gone into the garden, dug out the candlesticks and returned them to her parents. She concluded her account laughingly: 'Real hell broke loose and my father gave me a big thrashing.'

In the weeks following this communication, Caroline was able to give a detailed account of the familial circumstances surrounding her act. When Caroline was three her mother had given birth to premature twins and had suffered from toxaemia of pregnancy. The whole climate in the home had changed. A nurse had been employed to look after the twins, who were both girls. The mother had sunk into a severe depression and was for years incapable of taking an active part in the running of the family. The parents hadn't even taken vacations until their visit to the old house the summer the mother had started to work again. It was then that the patient had dug up the candlesticks and given them back to her parents.

From the very beginning of her treatment, I had from choice allowed Caroline the privacy of her antics, inside and outside analysis. There

was a definite risk involved, which I felt it was her need and demand that I take, by providing clinical coverage and holding (in terms of time and space) so that she could *transcribe* whatever she was reaching after in her chaotic and bewildered way. What further aggravated this situation was Caroline's incapacity to work during this phase; she had to give up her job and hence she was stranded with herself all day long. Her friend went to work early and returned late in the evening. Because of her confused mental state, I could get no true picture of her daily existence. Not only was each session an isolated *happening*, with no before and after, but it was also a clutter of bizarre bits and pieces of her random perceptions and volatile affects. Yet I had this sure feeling that Caroline was making a very private *use* of the analytic space and, gradually, even of me as a person. But she kept it all strictly to herself.

Once she told me about the candlestick episode, everything changed in her manner of talking in analysis. She had taken some three sessions to tell all the story. This was the first time Caroline was able to sustain continuity of theme from one session to the next. What was even more important was that I began to have some inkling of her way of *using* me. I interpreted to her that, by burying the candlesticks, she had found a way of *absenting* herself from the changed and traumatizing familial environment. I deliberately used the word *absenting* rather than *hiding*. Here I was exploiting a concept of André Green's (1973). I interpreted that the candlesticks symbolized all the good nourishing experiences of her infancy and early childhood from good-enough mothering. She then split off these experiences and *absented* them from the ongoing life of the family, in which she felt precarious and could merely exist, and which threatened to destroy even the goodness of her past relation with her mother. There was a distinct precocity in her capacity to use such a self-protective manoeuvre at this early age. The burying of the candlesticks created a secret where she could continue in suspended animation a part of her that she could no longer live and share with her parents, especially the mother. The *secret* encapsulated her own *absent* self.

Caroline responded to my interpretation by telling me of repetitive psychosomatic illnesses between the ages of five and nine. These illnesses had kept her away from school. She said that she never missed going to school during these illnesses, even though she was an active, sportive and gregarious child. She added: 'I had to withdraw every now and then, and be with myself it seems.' To which I said: 'To be with yourself and with your secret at the same time.'

When we were working in this area of her creating a secret where she could suspend a part of herself, Caroline asked me: 'Why have you never interpreted that over the past two months? Almost every Friday I have forgotten something in the waiting room, or don't you know of it?' I told her that I knew of it all right, since my staff had always informed me, and I had instructed them to return whatever item it was to her on Monday when she would return to analysis. She quizzed me: 'Why didn't you tell me?' And I answered: 'Because you never told me yourself and I respected your secret play with the waiting room and my staff.' She became pensive and started to cry quietly. I think it was the first time I had seen Caroline cry in a session, with an affect that was related to what was being said or experienced. After a while I interpreted to her that I had registered the fact that she had started to leave things behind during the phase in which she had become very suspicious that her man-friend was trying to control her life; that I had understood it to mean that she was using the space of the waiting room to leave behind, over the weekend, some object that stood for a very private bit of herself. Thus a bit of her was safely there for her to collect on Monday, and she also saved her friend from whatever anger or rage might erupt from this part of her; that now, knowing about the candlestick episode, I would say that she was using my waiting room as she had used the garden in her childhood, to find a place where she could leave a bit of herself in secret. The reason, I added, that she had not used the Consultation Room was that I might have noticed the 'left object' straight away and she would have had to take it with her; if I had found it later, I would have sabotaged her secret by interpreting it. She couldn't take that risk.

From this point onwards her mode of communicating in the sessions changed. I was surprised to witness in her a joyous capacity to recall and narrate, with a sparkling vividness, experiences from all areas and phases of her life. I am not concerned with that material here. Briefly, the story as it emerged was that she had some four buoyant carefree years from nine to thirteen years of age. Then the twins had fallen ill with a crippling illness that took years to remedy. During this period Caroline became a devoted ally of her mother in the nursing of her sisters. Just as that was ending, she met her future husband and *capitulated* (her phrase) to him. He was truly evil and she became his willing victim. She had given up all hope of a personal life shared with someone. This had ended with his brutal jilting of her, and her breakdown.

My argument here is that a person can *hide* himself into symptoms or he can *absent* himself into a secret. Here, the secret provides a potential space where an absence is sustained in suspended animation. Like the antisocial tendency (Winnicott 1956), the secret carries a hope that one day the person will be able to emerge out of it, be found and met, and thus become a whole person, sharing life with others. I am grateful to Pontalis for drawing my attention to a passage in Freud's letter to Fliess (6 December 1896):

> As you know, I am working on the assumption that our psychical mechanism has come about by a process of stratification: the material present in the shape of memory-traces is from time to time subjected to a rearrangement in accordance with fresh circumstances – is, as it were, transcribed. Thus what is essentially new in my theory is the thesis that memory is present not once but several times over, that it is registered in various species of 'signs' (Freud 1950*a*).

What has been even more enlightening for me towards an understanding of the function of a secret is the commentary on this letter by Laplanche and Pontalis (1973):

> This idea might lead one to the view that all phenomena met with in psycho-analysis are placed under the sign of retroactivity, or even of retroactive *illusion*. This is what Jung means when he talks of retrospective phantasies: according to Jung, the adult reinterprets his past in his phantasies, which constitute so many symbolic expressions of his current problems. On this view reinterpretation is a way for the subject to escape from the present 'demands of reality' into an imaginary past.
>
> Seen from another angle, the idea of deferred action may also suggest a conception of temporality which was brought to the fore by philosophers and later adopted by the various tendencies of existential psycho-analysis: consciousness constitutes its own past, constantly subjecting its meaning to revision in conformity with its 'project' (p. 112).

This discussion helps me to understand retrospectively a certain quality that characterized Caroline's behaviour before she told me of her secret. Her way of talking randomly often struck me as rather mad. I could interpret all sorts of fantasies into it, but, in fact, it was meaningless. There was no retroactive elaboration, psychically or

symbolically, of any experience. Now I can begin to see how Caroline's secret had helped her consciousness *escape* its own past.

Caroline lived in the instant here and now of explosive affects and random behaviour. I can see now that what is hidden inside or repressed lends itself to endless rearrangements and even retroactive *illusion*. But what is absented into a secret stays out of reach for any sort of further elaboration. Hence I now consider erroneous my remark that the candlesticks *symbolized* the early good relationship to her mother. What was important for Caroline was the *act* of burying them and not any symbolic meaning they may have had. This *act* concretized and encapsulated into a secret the point at which her growth in *mutuality* with her mother had been disrupted. The potential space of the secret imprisoned that fact and kept it frozen. But it also disabled Caroline from being able to elaborate or correct it in terms of new experience. The location of a secret of this type in psychic topography is neither inside nor outside a person. A person cannot say, 'I have a secret inside me.' They are the secret, yet their ongoing life does not partake of it. In analysis what Caroline could report was either the bric-a-brac of daily existence or nothing. And to have treated her incapacity as resistance would have engendered only reactive guilt in her. This is a very specific issue with such patients: their tendency towards compliance makes them over-receptive to any interpretation that makes them feel guilty. Hence my quote from Deleuze, who rightly protests the translation of lived life into mere fantasies. Such interpretation of fantasies creates a pseudo-psychic reality to which the patient gets addicted. This leads to those interminable deep analyses which we often hear about these days.

Clinically, it is only if we succeed in gradually creating an atmosphere of *mutuality* with these patients that they can share their secret with us. This sharing of the secret amounts to that 'experience of mutuality' (Winnicott 1970) that is the essence of the mother's capacity to adapt to the baby's need. What had enabled Caroline to share her secret was my capacity to contain and hold all the confusion and risk her behaviour perpetrated inside and outside analysis over the first eight months, as well as my capacity to allow her to *use* the waiting room in a private way for the weekend gap in analysis.

Lastly, I want to suggest that the creation of a secret creates a *gap* (Green 1973) in the person's psyche, which they reactively screen with all sorts of bizarre events, intrapsychic or interpersonal. We as clinicians are then required to discriminate between the true experience of such persons and their reactive behaviour. In Deleuze's

phrase, these patients have to be enabled to *share* their experience with us, not merely report on it in terms of fantasies or through symptomatic gestures. What was important for Caroline when she left things behind, such as her umbrella or a packet of chocolates or a book, was the *act* of leaving them. It was this *act* that I held for her and unobtrusively shared until she was ready to share it mutually.

I have tried to give a clinical example of how a child absented herself into a secret when her ongoing life with her mother broke down and how she gradually linked up with it in her analysis. Secret is only one way of encapsulating such experiences. Pseudologia fantastica often provides similar potential space to a person. And sometimes during analysis even repetitively forgotten dreams have this function.

I have found in Carl Jung's autobiography *Memories, Dreams, Reflections* an interesting corroboration of my hypothesis that the secret can provide a space in which the threatened ongoing life of a child can be sustained intact. Jung recounts how in his childhood, when he started to associate with his 'rustic schoolmates', he found that they alienated him from himself. The years from seven to nine were full of turbulent inner crisis for Jung. Then at the age of ten 'my disunion with myself and uncertainty in the world at large led to an action which at the time was quite incomprehensible to me.' Jung carved a manikin on two inches of his ruler, wrapped it in wool, placed a stone by it and put all these in a case which he hid in 'the forbidden attic' of his house. He wrote letters to the manikin in a secret language and from time to time he would clamber into the loft unnoticed to leave them there with the manikin. Jung (1963) concludes his narrative:

> The meaning of these actions, or how I might explain them, never worried me. I contented myself with the feeling of newly-won security, and was satisfied to possess something that no-one knew and no-one could get at. It was an inviolable secret which must never be betrayed, for the safety of my life depended on it. Why that was so I did not ask myself. It simply was so.
>
> This possession of a secret had a very powerful formative influence on my character: I consider it the essential factor of my boyhood (pp. 34–5).