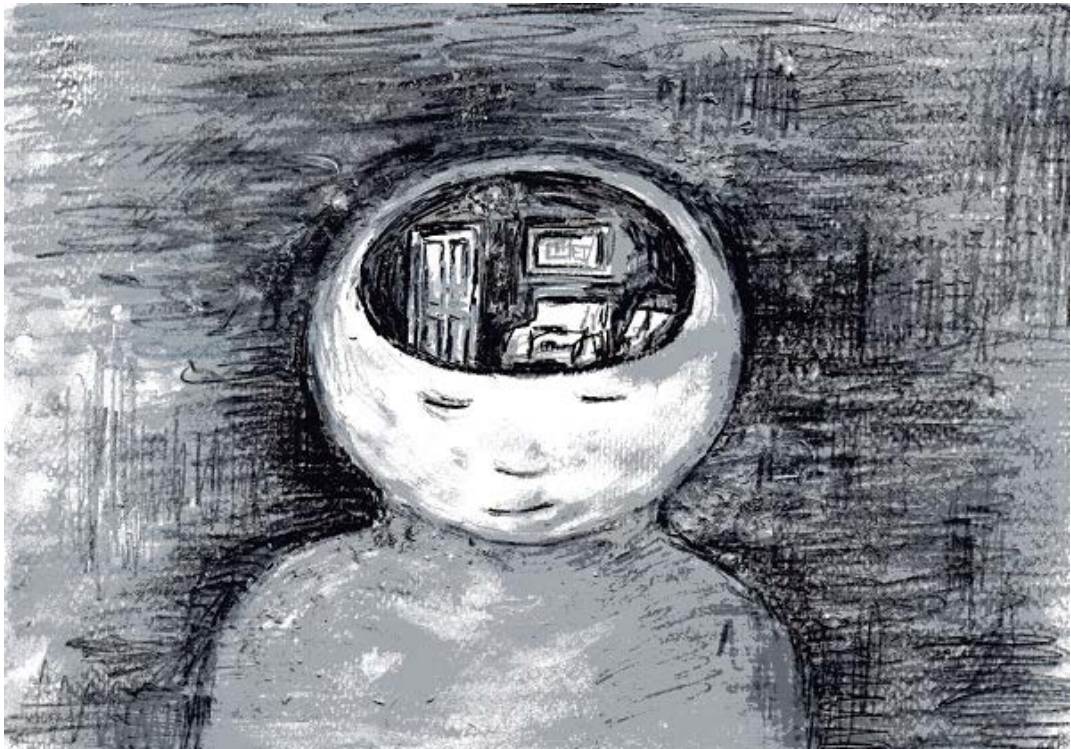


Being in the consulting room: A study of the physical space of the consulting room and its role in the therapeutic process

DEBORAH L. S. WRIGHT



**A THESIS SUBMITTED FOR THE DEGREE OF PROFESSIONAL
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Table of Contents

Acknowledgements	p2
Table of Contents	p3
List of Figures	p7
Summary	p11
Chapter 1 Introduction and background	p12
1.1 General introduction.....	p12
1.2 Background and rationale for the study.....	p16
1.2 (i) Spatial thinking applied to the psychoanalytic discipline, in particular concerning the consulting room.....	p16
1.2 (ii) ‘Spatialisation’ – use of the term in this study.....	p18
1.3 Development of research interest – Background and rationale; observation of phenomena unaddressed by current theories.....	p20
1.3 (i) Early primitive phenomena in both modern humans as well as earlier in Neanderthals and newly discovered early hominins.....	p21
1.3 (ii) Observation of phenomena in Nigerian village setting	p23
1.3 (iii) Observation of phenomena in Westminster Abbey.....	p26
1.3 (iv) Observation of phenomena in residential care.....	p32
1.3 (v) Observation of phenomena in the psychotherapy setting.....	p33
1.4 Conclusion.....	p33
Chapter 2 Sigmund Freud, spatialisation and rooms	p35
2.1 Introduction.....	p35
2.2 Freud’s theory of instincts- utilised to build my hypothetical concept of spatialisation.....	p36
2.3 Freud and Primary Spatialised Room Transference, introjected and re-projected, re-spatialised (untheorized).....	p39
2.3 (i) Freud’s rooms.....	p39
2.3 (ii) Mother and women, spatialised into rooms, introjected and re-projected.....	p43
2.3 (iii) Father and ‘Gods’ spatialised into rooms and locations.....	p47
2.4 Freud’s consulting room, transference and spatialisation.....	p50
2.5 Aphasia, the spatial layout of the brain, the mind and rooms.....	p57

2.6 Conclusion.....	p63
Chapter 3 Concepts.....	p65
3.1 Introduction.....	p65
3.2 Spatialisation, Primary Spatialised Room Transference and its Secondary Spatialisation into the consulting room– what is missing in the theory and what builds the theory to complete the gaps.....	p65
3.2 (i) Klein.....	p65
3.2 (ii) Bion.....	p67
3.2 (iii) Winnicott.....	p71
3.2 (iv) Fairbairn.....	p72
3.2 (v) Tustin.....	p73
3.2 (vi) Searles.....	p74
3.2 (vii) Bollas.....	p75
3.2 (viii) Anzieu.....	p76
3.2 (ix) Bick.....	p77
3.3 Proposed hypothetical formulation of the stages of the Room-object Spatialisation Matrix.....	p78
3.3 (i) Room-object Spatialisation Matrix: Stage 1) <i>Primal Spatialisation</i>	p78
3.3 (ii) Room-object Spatialisation Matrix: Stage 2) <i>Primary Spatialised Room Transference (Room-Object)</i>	p80
3.3 (iii) Room-object Spatialisation Matrix: Stage 3) <i>Secondary Spatialised Room-object in the Consulting Room</i>	p82
3.3 (iv) Room-object Spatialisation Matrix: Stage 4) <i>Secondary Spatialised Room-object and transference of Object in the Consulting Room</i>	p83
3.3 (v) Room-object Spatialisation Matrix: Stage 5) <i>Tertiary Spatialised Room-object, Object and Consulting Room outside the Consulting Room</i>	p84
3.4 Conclusion.....	p85
Chapter 4 Literature review.....	p86
4.1 Introduction.....	p86
4.2 Contemporary psychoanalytic literature relating to the role of the consulting room.....	p86
4.3 Psychoanalytic literature concerning dimensions and space.....	p91

4.4 Architecture, space and psychoanalytic concepts that relate to the consulting room.....	p93
4.5 Conclusion.....	p94
Chapter 5 Methodology.....	p95
5.1 Introduction.....	p95
5.2 The research study setting and its rationale.....	p95
5.2 (i) Rationale for the use of case studies.....	p95
5.2 (ii) The research study setting.....	p96
5.2 (iii) Rationale for the research study setting.....	p98
5.3 Research participants.....	p98
5.3 (i) Miss A.....	p99
5.3 (ii) Mr B.....	p99
5.3 (iii) Miss C.....	p100
5.3 (iv) Mr D.....	p100
5.4 Ethical considerations.....	p101
5.5 Data set 4 – Clinical data collection.....	p101
5.6 Steps of the project.....	p102
5.7 Research hypothesis	p102
5.8 Operationalisation for hypothesis testing with Data set 4.....	p103
5.9 Testing of the hypothesis utilising Data set 4 – Clinical data.....	p108
Chapter 6 Analysis and results of the testing of the hypothesis with Data set 4 - Clinical data.....	p110
6.1 Introduction.....	p110
6.2 Testing hypothesis – the Room-object Matrix stages- utilising Data set 4 - Clinical Data	p110
6.2 (i)) Example 1: Miss C - The fourth last session before the move from consulting room 1, (lines 3-8), and the second last session before the move from consulting room 1, (lines 20-25).....	p110
6.2 (ii) Example 2: Mr B - Mr B. – The last session in consulting room 1 (and before the Easter break) (lines 1-20) and the second and last session in the interim temporary consulting room 5 (lines 1-25).....	p115
6.2 (iii) Example 3: Miss A – The third session in the new consulting room 3 (lines 1– 10) and the fourth session in the new consulting room 3 (lines 1 – 8).....	p120

6.2 (iv) Example 4: 6.2 (vi) Example 6: Mr D - The first Session in the interim temporary consulting room 2 (lines 5-15) and the second session in the new consulting room 3 (lines 1 – 30).....	p123
6.3 Summary and conclusion of analysis and results of the testing of the hypothesis with Data set 4-clinical data.....	p129
Chapter 7 Discussion of findings and implications for practice.....	p130
7.1 Introduction.....	p130
7.2 Spatialisation as a defence – controlling the spatial array in the environment and its implications for practice.....	p130
7.3 The consulting room and the spatial array of the anatomy of mother’s body and implications for practice.....	p133
7.4 The anatomy of mother’s mind - thinking about thinking: Thinking and spatialisation – implications for practice.....	p138
7.5 Thinking about transference.....	p141
7.6 What can be learned from the differing cases chosen for this study in relation to spatialising.....	p144
Chapter 8 Conclusions and future research work.....	p146
8.1 Introduction - Summary of thesis.....	p146
8.2 Strengths and limitations of the study (leading on to future study).....	p147
8.2 (i) Strengths of the study.....	p147
8.2 (ii) Limitations of the study (leading on to future study).....	p148
8.3 Future research work that would further develop the line of my research.....	p150
8.3 (i) Future Study Idea I - Investigation of Early <i>Primary Spatialised Room Transference (Room-object)</i> (Stage 2 of the Room-object Spatialisation Matrix).....	p150
8.3 (ii) Future Study Idea II - Further Investigation of <i>Secondary Spatialised Room-object in the Consulting Room</i> (Stage 3 of the Room-object Spatialisation Matrix).....	p151
8.4 General conclusions of the study.....	p153
References.....	p155

List of Figures

- Cover illustration** – Room-object spatialisation matrix: stage 5: Tertiary Spatialised Room-object, Object and Consulting Room outside the Consulting Room, by D. Wright.....p1
- Acknowledgments Illustration** – ‘Being in the Consulting room I’, by D. Wright.....p2

Chapter 1

- Figure 1:** Diagram showing Diagram Room-object spatialisation Matrix, Stage 4: *Secondary Spatialised Room-object and transference of Object in the Consulting Room* by D. Wright... p14
- Figure 2:** Diagram Showing the order of stages of the study by D. Wright.....p15
- Figure 3:** The Rising Star Cave, by D. Wright sketched from illustration (Page 38 Shreeve, J. (2015) ‘Mystery Man’. *National Geographic*. Volume 228. Number 4: 30-57) p22
- Figure 4:** Drawing of Structures in the Bruniquel Cave, by D. Wright sketched from illustration in Drake, N. (2016) Neanderthals Built Mysterious Stone Circles. [online][Accessed 12 September 2016]. Available from: <http://news.nationalgeographic.com/2016/05/Neanderthals-caves-rings-building-francarchaeology/>)..... p22
- Figure 5:** Model of a Village, by D. Wright.....p24
- Figure 6:** Drawing of the Nave of Westminster Abbey, by D. Wright.....p28
- Figure 7:** Plan of the body of Westminster Abbey, by D. Wright.....p29
- Figure 8:** Drawing of The Shrine of Saint Edward the Confessor, by D. Wright.....p29
- Figure 9:** The Chapel of Our Lady of Pew, ceiling, in Westminster Abbey, photograph by D. Wright.....p29
- Figure 10:** The Chapel of Our Lady of Pew, ceiling, in Westminster Abbey, photograph by D. Wright.....p29
- Figure 11:** The Chapel of Our Lady of Pew, entrance, photograph by D. Wright.....p29
- Figure 12:** The Chapel of Our Lady of Pew, entrance, photograph by D. Wright.....p29
- Figure 13:** The Chapel of Our Lady of Pew, interior, photograph by D. Wright.....p29

Chapter 2

- Figure 14:** Freud’s diagrams of Mnemic symbols - S. Freud. Freud, S. (1953[1900]). *The Interpretation of Dreams*. Tr. & ed. James Strachey *et al.* *Standard Edition of the Complete Psychological Works of Sigmund Freud*, vol IV. London: Hogarth Press and the Institute of Psychoanalysis. (First Part), ix-627. (pages 538 & 541)p38

- Figure 15:** Drawing of Sigmund Freud's room in "Zoologische Station" in Trieste by S. Freud, in: Freud, S. (1990 [1876]) Letter from Sigmund Freud to Eduard Silberstein April 5, 1876. *The Letters of Sigmund Freud to Eduard Silberstein 1871-1881*, 142-150. Ed: Walter Boehlich. Cambridge, MA. Harvard University Press. (page 143).....p39
- Figure 16:** Drawing of Sigmund Freud's table in his room in "Zoologische Station" in Trieste by S. Freud, in: Freud, S. (1990 [1876]) Letter from Sigmund Freud to Eduard Silberstein April 5, 1876. *The Letters of Sigmund Freud to Eduard Silberstein 1871-1881*, 142-150. Ed: Walter Boehlich. Cambridge, MA. Harvard University Press. (page 143).....p40
- Figure 17:** Drawing of S. Freud's room in the "The General Hospital" in Vienna by S. Freud in letter to Martha Bernays, October, 1883. In Freud, E., Freud, L. & Grubrich-Simitis, I. (1978 [1998]) *Sigmund Freud his life in pictures and words*. London, W.W. Norton and Company Limited (page 150).....p41
- Figure 18:** Drawing of an aerial of Freud's Room (by D. Wright) as described in Freud, S (1961 [1882]) Letter from Sigmund Freud to Martha Bernays, June 19, 1882. *Letters of Sigmund Freud 1873-1939*, 7-10.....p42
- Figure 19:** 'Little Hans is specially frightened when carts drive into or out of the yard' from Freud, S. (1955 [1909]). 'Analysis of a Phobia in a Five-Year-Old Boy'. Tr. & ed. James Strachey *et al.* *Standard Edition of the Complete Psychological Works of Sigmund Freud*, vol X. London: Hogarth Press and the Institute of Psychoanalysis. 1-150. (page 46).....p45
- Figure 20:** Painting by Pierre Aristide André Brouillet "A Clinical Lesson at the Salpêtrière".p48
- Figure 21:** Lithograph of above painting inp48
- Figure 22:** Shows Lithograph It hangs top left inp48
- Figure 23:** Drawing of Maresfield Gardens showing Lithgraph of Charcot above the couch (top right).....p48
- Figures 24 & 25:** Photograph of Sigmund Freud's consulting room in Vienna, May 1938 by E Engleman. - <http://www.freud-museum.at/online/freud/topogr/behz-d.htm> (Accessed 25th December 2014) & Photograph of Sigmund Freud's consulting room in Vienna, May 1938 by E Engleman. <http://www.freud-museum.at/online/freud/topogr/behz-d.htm> (Accessed 22nd March 2015).p50
- Figure 26:** Drawing of Freud's Room in Maresfield Gardens with his desk chair and figures on the desk by D. Wright..... p52
- Figure 27:** Drawing of book shelves in Freud's consulting room, Mayersfield Gardens, by D. Wright..... p53
- Figure 28:** Head in glass box in Freud's study, Mayersfield, by D. Wright.....p54
- Figure 29:** (originally 'Figure 2. Schema 1/a and 1/b'p.197) Freud's drawing of the brain's workings, by S. Freud. Freud, S. (2012 [1887]) Critical Introduction to Neuropathology (1887). *Psychoanalysis and History*. 14(2):151-202.....p58
- Figure 30:** (originally Figure 3. Schema 2: Tracts of the cerebral grey p.198) Freud's drawing of the brain's workings by S. Freud. Freud, S. (2012 [1887]) Critical Introduction to Neuropathology (1887). *Psychoanalysis and History*. 14(2):151-202..... p58

- Figure 31:** (originally Figure 4 Schema 3: Sensory nuclei and substantia reticularis p.199) Freud's drawing of the brain's workings by S. Freud. Freud, S. (2012 [1887]) *Critical Introduction to Neuropathology* (1887). *Psychoanalysis and History*. 14(2):151-202..... p58
- Figures 32 & 33** - Freud's Schematic Picture of Sexuality [his Fig 1. And Fig 2] 'Schematic Picture of Sexuality' in Freud S. (1966 [1890]) Freud, S. (1966 [1892]). Draft G 1 Melancholia2 from Extracts From The Fliess Papers. Tr. & ed. James Strachey *et al.* *Standard Edition of the Complete Psychological Works of Sigmund Freud*, vol I. London: Hogarth Press and the Institute of Psychoanalysis. 200-206. (page 202).....p59
- Figure 34:** Freud's diagram representing 'the spatial or 'topographical' idea of mental life in Freud, S. (1961 [1923]). *The Ego and the Id*. Tr. & ed. James Strachey *et al.* *Standard Edition of the Complete Psychological Works of Sigmund Freud*, vol XIX. London: Hogarth Press and the Institute of Psychoanalysis. 1-66.....p60
- Figure 35 & 36:** Drawing of Phrenology heads displayed in The Science Museum, London and single head, by Wright D..... p61

Chapter 3

- Figure 37:** The Spatial Array of Rooms as an Auxiliary Mind, by D. Wright.....p69
- Figure 38:** Diagram of the stages of the Room-object spatialisation matrix, by D. Wright.....p79
- Figure 39:** Room object spatialisation matrix: stage 1 - *Primal Spatialisation*, by D. Wright...p80
- Figure 40:** Room-object spatialisation matrix: stage 2 - *Primary Spatialised Room Transference (Room-object)* which fulfils mother function, by D. Wright.....p81
- Figure 41:** Room-object spatialisation matrix: stage 3- *Secondary Spatialised Room-object in the Consulting Room*, by D. Wright.....p82
- Figure 42:** Room-object spatialisation matrix: stage 4 - *Secondary Spatialised Room-object and transference of Object in the Consulting Room*, by D. Wright.....p84
- Figure 43:** Room-object spatialisation matrix: stage 5: *Tertiary Spatialised Room-object, Object and Consulting Room outside the Consulting Room*.....p85

Chapter 5

- Figure 44:** Original Consulting Room 1 & New Consulting Room 3 by D. Wright.....p97
- Figure 45:** Temporary Consulting Room 2 by Wright, D.....p97
- Figure 46:** Diagram of the study setting – two consulting room moves by D. Wright.....p97

Chapter 6

Figure 47: Spatial Array of Consulting Rooms 1 & 3 Splitting Good and Bad, Safety and Danger, by D. Wright.....p121

Chapter 7

Figure 48: The Spatial Array of the Street Separating Safety and Danger, by D. Wright.....p132

Figure 49: Spatialising into spaces, buildings and people: the more thinking the more spatialising, by D. Wright..... p140

Figure 50: Diagram showing where Transference and Room-spatialisation are related and where they are separate, by D. Wright.....p142

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Summary

This study originates from my observation of phenomena relating to patients' relationships with the consulting room, where they project onto the room, at times seemingly unrelated to the transference to me. I utilise Freud's theory of instinct, as well as three data sets (1- Historical and Cultural, 2- Sigmund Freud's Writings, 3- Object Relations and Winnicottian theories) to formulate my hypothesis to explain the phenomena better: The Room-object Spatialisation Matrix. Spatialisation simultaneously involves a psychological projection of meaning and physically acting upon the environment, utilised to master the undifferentiated, relentless, internal pressure of instinct. I suggest that this can take place within a matrix of stages, the first of which - *Primal Spatialisation*, takes place into mother/parts of mother to create the object, this is pre-object and therefore pre-transferential. I suggest that a difficulty in utilising mother as the first object of spatialisation, can lead to Stage 2 of the Matrix - *Primary Spatialised Room Transference (Room-Object)*, where spatialising into the spatial array of room spaces and the objects within them replaces or supplements the mother function. Stage 3 - *Secondary Spatialised Room-object in the Consulting Room*, is where the consulting room is used as other rooms were used before as a direct displacement from one room to the other, separate from transference to the therapist. Stage 4 - *Secondary Spatialised Room-object and Transference of Object in the Consulting Room*, is like Stage 3 but includes the transference to the therapist. Stage 5 - *Tertiary Spatialised Room-object, Object and Consulting Room outside the Consulting Room* includes the spatialising of the original spatialised room, the object, the therapist in the transference and the therapist's consulting room. I test this hypothesis utilising Data set 4- Clinical Data, in order to demonstrate the hypothetical matrix stages in particular the pre-transferential aspects.

Chapter 1

Introduction and Background

1.1 General introduction

This study originates from my observation of phenomena relating to patients' relationships with the consulting room, where they project into the room, at times seemingly unrelated to the transference to me. Current theories do not completely address this, including an assumption that for the patient everything in the room is related to the transference. I consider that the role of the consulting room in the therapeutic process is both primitive (pre-transferential) and transferential and my discovery is that the former has not been noted before and the latter has not been adequately understood. Sigmund Freud invented the psychoanalytic consulting room as well as the concept of transference. However, despite his fascination with spatiality, and, as I show in his work, his projection of maternal and paternal figures into room spaces, including his consulting room, this remains untheorized. In addition, Freud made spatial diagrams to illustrate his theoretical concepts and many of those concepts have an implicit spatial concern. A neglected area of Psychoanalysis is the extent to which Freud was interested in space and objects to understand the psyche and also the Psychoanalytic process in the consulting room. Freud was deeply immersed in spatiality in culture but this has not received much attention in literature. My formulation of spatialisation simultaneously involves a psychological projection of meaning and physically acting upon the environment, utilised to master the undifferentiated, relentless, internal pressure of instinct. I suggest that spatialisation is a distinctive feature of mental life and therapeutic work. Spatialisation is part of normal development and people retreat in to it when under stress or when they are insecure. I hypothesise that the less thinking takes place, the more spatialising happens. Richard Wollheim (1969) wrote that in the mind's primitive state thoughts

become, as I suggest, spatial, and they are projected outward as a way of dealing with the emotions, so that instead of thinking actions occur in space. Linked directly with Freud's theory of projection this means that thinking primitively means thinking spatially. Object-relations theory is inadequate without spatialisation in that Object-relations are dimensional. It fits with it, and does not replace Object-relations theories; it adds another aspect, the spatialised aspect. The Room-object Spatialisation Matrix offers a missing way of understanding people's relationship with the consulting room. A fundamental feature of Object-relations is transference, transference is built on spatialisation, spatialisation is the foundation of mental functioning. You don't have an object to transfer until you have spatialisation. There is no object without spatialisation, Spatialising - leads to - Object-relations - leads to - transference. The more primitive the levels of mental functioning, the more spatial. I am now going to analyse spatialisation in this study.

I utilise Freud's theory of instinct (1915, p.120) as being unformed internal pressure of instinct put into spatial form, as well as three data sets (1- Historical and Cultural, 2- Sigmund Freud's Writings and the perspectives of Wollheim on thinking and 3- Object Relations and Winnicottian theories) to formulate my hypothetical addition to the theory of transference to explain the phenomena better: The Room-object Spatialisation Matrix. I suggest that this can take place within a matrix of stages, the first of which - *Primal Spatialisation*, takes place into mother/parts of mother to create the object, this is pre-object and therefore pre-transferential. I suggest that a difficulty in utilising mother as the first object of spatialisation, can lead to Stage 2 of the Matrix - *Primary Spatialised Room Transference (Room-Object)*, where spatialising into the spatial array of room spaces and the objects within them replaces or supplements the mother function. Stage 3- *Secondary Spatialised Room-object in the Consulting Room*, is where the consulting room is used as other rooms were used before as a direct displacement from one room to the other separate from transference to the therapist. Stage 4 - *Secondary Spatialised Room-object*

and transference of Object in the Consulting Room (see fig. 1), is like stage 3 but includes the transference to the therapist. Stage 5 - *Tertiary Spatialised Room-object, Object and Consulting Room outside the Consulting Room* includes the spatialising of original spatialised room, the object, the therapist in the transference and the therapist's consulting room. These stages can be

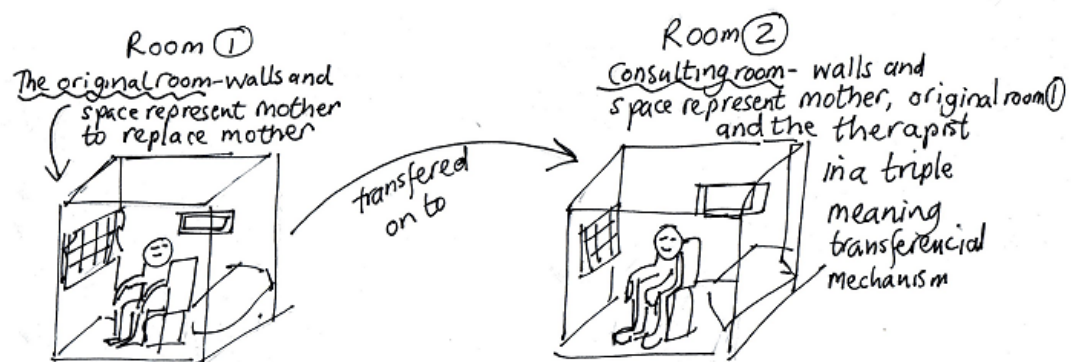


Figure 1: Diagram showing Room-object Spatialisation Matrix, Stage 4: *Secondary Spatialised Room-object and Transference of Object in the Consulting Room* by D. Wright

moved in and out of, the stages representing a regressive, defensive function (re-enacting the spatialising to re-create the object and defend against its loss), as well as a maturational one as a form of rudimentary containing mind. I suggest that spatialised room transference into rooms (Room-objects) can fulfil the role of an external auxiliary thinking/mind space as a replacement for and an addition to mother's or, in the case of the consulting room, the therapist's containing mind. My claim is that part of this hypothetical Room-object Spatialisation Matrix is pre-object and therefore pre-transferential. My methodology is an attempt to magnify the primitive spatial level of thinking. I utilise Data set 4- Clinical Material, to test my hypothetical formulation of the Room-object Spatialisation Matrix, in order to demonstrate the matrix stages, in particular the pre-transferential aspects. The diagram below (fig. 2) shows the order of the parts of the study and the associated chapters in which they are shown.

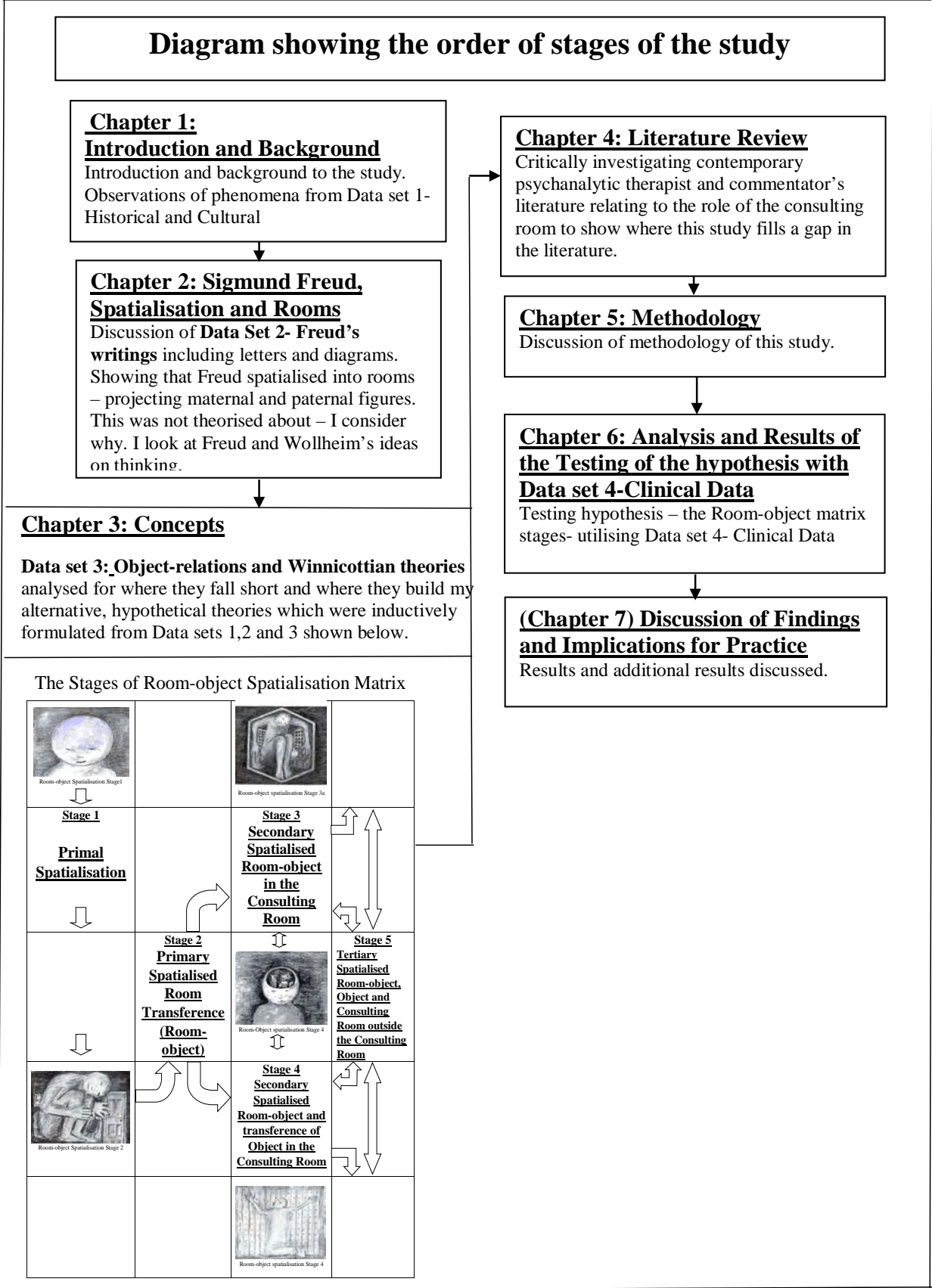


Figure 2: Diagram showing the order of stages of the study by D. Wright

1.2 Background and rationale for the study

1.2 (i) Spatial thinking applied to the psychoanalytic discipline, in particular concerning the consulting room

Robert Tally discussed Michel Foucault's characterisation of this 'epoch of space':

As Foucault announced, '[t]he great obsession of the nineteenth century was, as we know, history: with its themes of development and suspension, of crisis, and cycle [...]. The present epoch will perhaps be above all the epoch of space. We are in the epoch of simultaneity: we are in the epoch of juxtaposition, the epoch of the near and far, of the side-by-side, [...] our experience of the world is less that of a long life developing through time than that of a network that connects points and intersects with its own skein.' (Foucault 1986: 22). Although it would be difficult, and misleading, to identify a particular date or moment when this occurred, a recognizable *spatial turn* in literary and cultural studies (if not the arts and sciences more generally) has taken place. One cannot help noticing an increasingly spatial or geographic vocabulary in critical texts, with various forms of mapping or cartography being used to survey literary terrains, to plot narrative trajectories, to locate and explore sites, and to project imaginary coordinates. [...] [T]he spatial or geographical basis of cultural productions have, in recent years, received renewed and forceful critical attentions. (Tally, 2013, pp.11-12; author's emphasis)

Robert Tally identifies this '*spatial turn*' as relating to post war perspectives in the later half of the 20th Century; 'progress of history in the wake of such destruction, and a changing view of temporal movement may have opened the way to those who demanded that greater attention be paid to spatial concerns.' (Tally, 2013, p12) Perspectives on space have developed in some disciplines in this '*spatial turn*'. However, psychoanalytic perspectives on spatial meaning from

an unconscious perspective remain relatively underdeveloped theoretically. Harold Searles began to look at human's relationship with the non-human world and the 'matter of regression to a primitive level of thinking, comparable with that found in children and in members of so-called primitive cultures, a level of thinking in which there is a *lack of differentiation between the concrete and the metaphorical.*' (Searles, 1962, p 23). He also wrote that:

This whole subject may be likened to a vast continent, as yet largely unexplored and uncharted. [...] I am not trying to nail down conclusively, once and for all, this subject of the nonhuman environment in human living but rather to open it up, unprecedentedly widely and deeply, to the curious, seeking eye. (Searles, 1987[1960], p xi).

I consider, that in my study, I am continuing this opening up that Searles writes of, thinking about the non-human environment and the concrete and the metaphorical in relation to the role of the consulting room.

In relation to the space of the consulting room, Gary Winship and Shelley MacDonald wrote that:

Containment is both a space and a process that takes place within that space. There has been a growing interest in the intersubjective space or the "analytic third" (Ogden, 2004) of the therapeutic relationship. This is, essentially, the mental amalgam of both client and therapist. [...] We might say that the consulting room itself becomes part of the therapeutic triangulation and operates as the primary container. (Winship and MacDonald, 2018, p73)

Here Winship and MacDonald write of the 'intersubjective space', a space where 'intersubjectivity', between the patient and the therapist takes place. Stern writes of intersubjectivity - that for the infant, 'mental states [...] become the subject matter of relating. This new sense of a subjective self opens up the possibility for intersubjectivity between infant

and parent and operates in a new domain of relatedness.’ (Stern, 1985, p.27). In this study I am developing further this ‘growing interest in the intersubjective space of the therapeutic relationship’, which Winship and MacDonald discuss, and I am extending their concept that the consulting room itself ‘operates as the ‘primary container’. I am suggesting that the consulting room can operate as a ‘primary container’ but that it can do so as a separate operation from or as a top-up to the containing function of the therapist in the transference. I suggest that the role of the consulting room as a primary container can relate to earlier room use as a primary container (as a replacement or top-up to the mother function) re-spatialised into the consulting room, both as a separate use of the room from the transference, or a top-up to the containing function of the therapist in the transference.

1.2 (ii) ‘Spatialisation’ – use of the term in this study

The term ‘spatialisation’ has been used to describe social meaning related to spaces. In this study I use the term ‘spatialisation’ not only for the purpose of ascribing meaning to space, but also to refer to the psychological and physical mechanisms by which this happens, as well as for the motivation behind its use. Rob Shields wrote about ‘spatialisation’, that it related to: ‘approaches to the meaning of the environment which have included work in the area of geography, environmental psychology, and semiotics’ (Shields, 1991, p.11) and he writes that:

social divisions are spatialised as geographic divisions and how places become ‘labelled’, much like deviant individuals. Habits such as spatialising important conceptual oppositions [...] have been studied as pathologically irrational forms of behaviour [...] Nonetheless it betrays a systematic ‘disposition’ towards the world (cf. Foucault [...]).

(Shields, 1991, p.11)

Shields points to the significance of the meaning that places and spaces give to societal and psychological divisions and concepts. He mentions Foucault, who wrote of spatialisation in political terms, and Shields refers to spatialisation as relating to ‘pathologically irrational forms of behaviour’ and habitual disposition. By comparison, my use of the term spatialisation here is to bring out a different dimension to this phenomenon. I am attempting to bring out the dimension of the meaning, method and motivation by which these irrational behaviours and dispositions manifest themselves. I propose a formulation and understanding of the concepts of spatialisation that not only takes into account the meaning that is projected onto the environment, but also the psychological and physical mechanisms intrinsic to the process of spatialising whereby this projection takes place. The very idea of an object, including an object of transference, is spatial. That is not about the meaning of spaces, but the creation of meaning through spaces. This differs from the concept of ‘psychogeography’, which Guy Debord writes of:

Psychogeography sets for itself the study of the precise laws and specific effects of the geographical environment, whether consciously organised or not, on the emotions and behaviour of the individual [...] to their influence on human feelings, and more generally to any situation or conduct (Debord, 2008[1955], p.23).

Debord suggests that the environment influences the emotions, thoughts and experiences of the individual in it. I am suggesting that geography (space) not only influences emotions, thoughts and experiences, but that they are experienced as spatial through a projection into space and spatialised contents of space, ie. objects. I go on to suggest, that the environment can be ‘set up’ such as in the Abbey example (see p26) to meet the spatialising expectations and needs of the individual and that there is a spatialising interaction of individual and environment. What I argue is, that the spatialisation involves a projection of meaning onto – as well as a working of this meaning into the environment. At the primitive level, this is in order to have an experience at all,

which is not the same as Debord's influence of space. Therefore, in order to understand more about this, it is important to unfold the motivations for and mechanisms by which such spatialisation is brought about. For the purposes of this thesis, the term spatialisation is used to describe mechanisms which involve a form of projection encompassing physical and psychological aspects. It involves doing things outside the self in the environment, which are physical acts, which only makes sense in a space, that simultaneously involve a psychological projection of meaning. In this study I am examining spatialisation into rooms and, in particular, the consulting room.

1.3 Development of research interest – background and rationale; observation of phenomena unaddressed by current theories

Here, in thinking about the background and rationale for this study, I set out a coherent lodging of my thesis, and the relevant precursors on which the thesis is built. In this section I give examples from Data set 1 - historical and cultural data - that show anthropological, and previous clinical and residential care experience. In this section I show a range of examples of observations of spatialising phenomena demonstrating a range of stages of spatialising from the primitive establishment of objects (pre-transferential), to later re-spatialised transferential stages. These contribute to the formulating of my hypothetical Room-object Spatialisation Matrix Stages. For example, in the pre-human and early modern human examples, the stone rings inside Bruniquel Cave might be attempts to create a spatialised material figure – pre-object – or part object, a representation of the inside of mother's body, like my hypothesised Room-object Spatialisation Matrix Stage 1- *Primal Spatialisation*. Whereas the images of 'Stylized female figures' (Dinnis and Stringer, 2015, p.136) and 'vulvae' (Dinnis and Stringer, 2015, p.134) carved into the walls of caves might be more transferential as re-spatialised representation of

mother. In the Nigerian village example parts of the environment are spatialised as good and bad part objects, which is also the case in the Westminster Abbey example, and more advanced transferential spatialising occurs in the Chapel of Our Lady of Pew with the actual mother figure a re-projection of the internalised, original, primal spatialisation.

1.3 (i) Early primitive phenomena in both modern humans as well as earlier in Neanderthals and newly discovered early hominins

There is evidence for innate primitive importance of space usage (spatialisation) in both modern humans as well as earlier in the spaces of Neanderthals and a newly discovered earlier hominin.

Rob Dinnis and Chris Stringer describe how 40,000 years ago ‘caves and rock shelters served as artists’ canvases for paintings and engravings. Evocative images range from clearly symbolic, abstract motifs to the stunning naturalistic charcoal depictions.’ (Dinnis and Stringer, 2015[2013], p.106 -107). Other caves are marked out with images of ‘Stylized female figures’ (Dinnis and Stringer, 2015[2013], p.136) and ‘vulvae’ (Dinnis and Stringer, 2015[2013], p.134) carved into the walls of caves, ‘perhaps these figures designated the back of the cave as a sacred place, possibly even a female place; [...] a birthing chamber, safe within the familiarity of the gorge but removed from everyday life.’ (Dinnis and Stringer, 2015[2013], p.135). These examples show that something, perhaps instinct based, is projected and acquires meaning through spatialisation, in which it becomes an object in the first place, which can be introjected and re-projected and therefore captured in a representation.

Stone rings discovered in 2016, inside Bruniquel Cave, (see fig. 4) were 176,000 years old and attributed to Neanderthals. Nadia Drake wrote that ‘[t]here, several large, layered ring-like structures protruded from the cave floor, the seemingly unmistakable craftwork of builders with a purpose. [...] The mysterious structures are built from nearly 400 stalagmites’ (Drake, 2016,

pp.2-3). They are ‘craftwork’ with a meaning and a purpose. Stringer writes; ‘these must have been made by early Neanderthals, the only known inhabitants of Europe at this time. [...] If there is still – buried debris from occupation, it would help us to determine whether this was [...] something which had more symbolic or ritual significance.’ (Stringer, 2016, p.1) Stringer is identifying the age and significance of the find as being unique as a Neanderthal built structure of that age, as well as considering the usage of the rings as being made for ritual purposes. This is the earliest example of a crafted made meaning space that might be attempts to create a

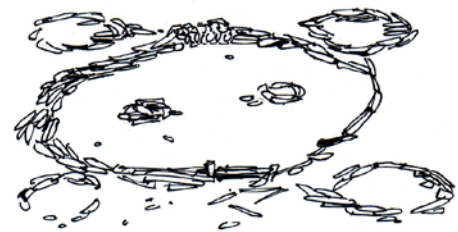


Figure 3: The Rising Star Cave by D. Wright

Figure 4: Structures in the Bruniquel Cave by D. Wright

spatialised maternal figure, like my hypothetical Room-object Spatialisation Matrix Stage 1 - *Primal Spatialisation*. Ninian Smart wrote:

There is ample evidence that religious rites were practised in early prehistoric times and it may well be that the sense of the sacred has been part of man's experience from the beginning. It is notable that before the emergence of the human species proper (*homo sapiens*), Neanderthal Man – some 150,000 years ago - practised the ritual interment of the dead. This seems to point to a belief in an afterlife of some kind and to belief in an 'invisible' world. (Smart, 1971[1969], p.33).

Lee Berger and his team published their findings in September 2015 of bones in the Dinaledi chamber of the Rising Star Caves in South Africa (Fig. 3) of an earlier hominin (*H naledi*) than Neanderthals practicing ritual burial in the cave space:

Based on current evidence, our preferred explanation for the accumulation of *H.naledi* fossils in the Dinaledi Chamber is deliberate body disposal [...]. Our interpretation of events raises questions about the meaning of deliberate and repeated body disposal to this ancient group of individuals. Recent evidence has extended the record of complex behaviour [...]. Deliberate disposal of bodies in the Dinaledi chamber implies that morphologically primitive hominins like *H.naledi* may have had their own distinctive patterns of behavioural complexity' (Berger et.al, 2015, pp.5-6).

So here we have evidence of newly discovered pre-humans apparently also showing signs of the use and meaning making of space, place and objects. Jamie Shreeve wrote in his commentary on Berger and his team's paper: 'Until now only *Homo sapiens*, and possibly some archaic humans such as the Neanderthals, are known to have treated their dead in such a ritualised manner. [...] The notion of such a small – brained creature exhibiting such complex behaviour seems so unlikely that many other researchers have simply refused to credit it.' (Shreeve, 2015, p.53). All of these examples show, what I am suggesting is a primitive human (and pre-human) mechanism of spatialising where meaning (individually or collectively) was created through the spatialisation. In relation to Smart's thoughts above, about an 'afterlife [...] in an 'invisible' world' (Smart, 1971[1969], p.33), perhaps this, in a primitive sense, means life in another place, which is a form of spatialisation. This may perhaps relate this world post-life to the pre-life womb space (also an 'invisible' world) so it is a pre-object spatialisation, post-object; a post-object spatialisation. The Rising Star Caves and the Reliquary (see p30) show aspects of this womb like space with the idea of an entrance but an impossible exit for the bones as they sit permanently in the womb like area.

1.3 (ii) Observation of phenomena in Nigerian village setting

The next example is of a village in the Oban hills area of Nigeria, where I worked in the early

1990's, and observed the dividing up of spaces into sacred and profane as a way of managing the environment and living within it. This is what I am calling spatialising – the village itself is spatial and is moved around and in and out of using spatial ritual. The village (see fig. 5) was surrounded by rainforest that was considered dangerous and threatening, containing wild animals, reptiles and insects. Since, here, the outside of the village was dangerous, 'bad' and the inside safe, 'good' (see Klein (1946) in Chapter 3, p64), outside dangers as well as inside social cohesion were managed by a variety of spatialising techniques. These included rituals performed by the chief and the elders in the central meeting-building and the elders in the elders' meeting area (the highest point in the village), as well as rituals at the sacred tree which spanned the

Figure 5: Model of a village by D. Wright

nearby river. The community believes that, in order to safely move in and out of the village, all members of the village transform into animals. The outside of the village is the profane/bad/dangerous area and inside is sacred/good and safe. Within the array of the village are the designated sacred locations - the sacred tree above the river, the highest point and the meeting building. These locations and the rituals that take place there manage the sacred and profane by keeping safety and danger in place. Mircea Eliade (1959), wrote that the 'sacred tree, the sacred stone are not adored as stone or tree; they are worshipped precisely because they are *hierophanies*, because they show something that is no longer stone or tree but the *sacred*'

(Eliade, 1959, p.12). The meaning of the array of the space and the objects within it are changed – changed and manipulated – in order to create a required meaning by psychological projection and physical manipulation. Karl Figlio writes of: ‘a culture steeped in animism and magic, in which people believe they make things happen through the power of words or other acts. But in animistic culture, words or acts imitate or invoke what appears to the senses. ‘(Figlio, 2000, p.12). I understand these processes as acts of spatialising, including ritual belief, projecting and physical manipulation performed to control instincts or a nascent internal world. Eliade wrote:

One of the outstanding characteristics of traditional societies is the opposition that they assume between their inhabited territory and the unknown and indeterminable space that surrounds it. [...] At first sight this cleavage in space appears to be due to the opposition between an inhabited and organized – hence cosmicized – territory and the unknown space that extends beyond its frontiers; on one side there is a cosmos, on the other a chaos. [...] The sacred reveals absolute reality and at the same time makes orientation possible; hence it *founds the world* in the sense that it fixes the limits and establishes the order of the world. (Eliade 1959, pp. 29–30)

The sacred in Eliade’s conception thus ties in with and is constitutive of the ordered world; it defines and fixes its limits. What Eliade has described as ‘chaos’ is separate from what is good and sacred inside. Harold Searles writes that in pre-modern societies people were:

at the mercy of an animistic, and often anthropomorphised, nonhuman environment which was basically hostile, chaotic, utterly uncontrollable. It may perhaps be counted man’s proudest achievement that he has come, largely through the medium of scientific endeavour, to realise so many of his uniquely human potentialities, to free himself to the extent that he has from an ancient, overwhelming awe of the nonhuman (Searles, 1987[1960], p.7)

but goes on to point out that ‘science itself, which along with the more ascetic components of Christian religion has tended to foster in man a conviction that he is basically alien to his nonhuman environment, has yielded abundantly convincing data, from various sources, to show him how closely akin he is to that environment.’ (Searles, 1987[1960], p.8). Searles is saying that science may allow for rationalisation about the ‘chaotic’, which Eliade writes of, but that we are still ‘closely akin’ to the environment. I am suggesting that spatialising, even if with more individually based projections than larger group ones that I write of in the Nigeria example, or a large scale system of space organising such as the Chinese Feng Shui one, designed for spatialising purposes, to control and organise spaces with projected instinctual feeling (such as fear or anxiety) safely organised, is still a basic and primitive mechanism for functioning. As Karl Figlio writes; ‘Harold Searles argues that the pull of identification reaches beyond primitive object relations, even beyond the non-human world, and reaches right back to the inanimate world’ (Figlio, 2000, p.11). I argue that there is a primitive human mechanism to spatialise involving projection and actual physical manipulation of physical spaces in order to control psychological space.

1.3 (iii) Observation of phenomena in Westminster Abbey

Along similar lines, Karl Figlio and Barry Richards (2003) write that ‘containment’:

occurred in premodern societies, but, in the absence of continuous physical reminders of the social, it would have been carried more by the intense, if episodic, regimes of psychic management of rituals and by manifest symbolic associations, as in the layout of a cathedral. (Figlio & Richards, 2003, p.412).

Figlio and Richards refer in this context to the ‘shared illusion’ (Figlio & Richards, 2003, p.420) of society ‘generated through collective imagination’ (Figlio & Richards, 2003, p.420). In Westminster Abbey, as with any religious building for any culture or period, the building is

designed and shaped in a way that is required of the function and meaning of the space. As Jacques Le Goff wrote; 'Indo-European tradition had evolved a way of interpreting space symbolically' (Le Goff, 1992[1985], p.85). Pilgrims passing through the space of the abbey journeyed through an experience which was psychological, emotional and physical with many different spaces marked out with art works containing symbols giving context to and providing an authoritative understanding of the experience of the individual. Johan Huizinga writes that '[t]he spirit of the Middle Ages, still plastic and naïve longs to give concrete shape to every conception. Every thought seeks expression in an image [...] [b]y this tendency to embodiment in visible forms all holy concepts' (Huizinga, (1990[1924]), p.147). This representation, albeit concrete, is not the same, as the primitive stone rings. It may be retrogressive, but it is not the same as object creating. This representation, as with the cave paintings, is the more advanced introjected and projected spatialised (as with my hypothesised Room-object Spatialisation Matrix, stage 2, *Primary Spatialised Room Transference (Room-Object)*). The individuals' projections, associations and unconscious fantasies connected to or prompted by that space, are thus facilitated, reinforced – and also: limited – by the construction of the space in the architecture and art works and relate to the 'common symbolism' (Freud, 1923, p.242) contained in these.

There are dense layers of meaning here; there is the space created with signs and symbols to facilitate the needs and expectations of the pilgrim and to provide a facilitating setting for a recreation of an experience. There is then the facilitation of the emotions connected with the meaning. In order to do this the separated spaces are in a relationship with each other, they are divided up with different meanings as part of the overall control of meaning and experience. This dividing up of space can involve, as shown in the example of the village, clearly defined areas of good or bad, safety or danger, sacred or profane, regarding the spatial structures within which

ideas find their expression, as well as the margins of such structures. Mary Douglas (1966) writes that

all margins are dangerous. If they are pulled this way or that the shape of fundamental experience is altered. Any structure of ideas is vulnerable at its margins. We should expect the orifices of the body to symbolise its specially vulnerable points. Matter issuing from them is marginal stuff of the most obvious kind its spittle, blood, milk, urine, faeces or tears by simply issuing forth have traversed the boundary of the body. (Douglas, . (1999 [1966]), p. 122).

Margins, according to Douglas, can be dangerous because they are borders between domains that, psychically, need to be protected from confusion for psychic stability. Here, Douglas is in tune with psychoanalytic thinking about what Meltzer calls ‘zonal confusion’ (Meltzer, 2019[1974], p.113). As can be seen in the Nigerian village example, the sacred location keeps



Figure 6: The Nave of Westminster Abbey by D. Wright

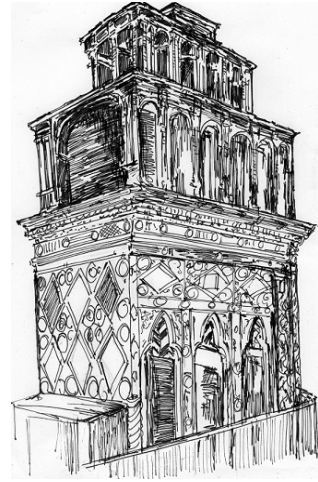


Figure 7: The Body of Westminster Abbey by D. Wright

Figure 8: Shrine of Edward the Confessor by D. Wright



Figure 9 & 10: The Chapel of Our Lady of Pew, ceiling, in Westminster Abbey photographs by D. Wright



Figures 11 & 12: The Chapel of Our Lady of Pew, entrance and Figure 13: the chapel interior, photographs by D. Wright

the profane location in position. The meaning of the sacred location holds the profane at bay and the proximity of the profane throws the meaning of the sacred location into relief. In the case of Westminster Abbey, the building's inside and outside also represent the limits of the sacred and profane respectively. As with the village model, spatialisation is employed to keep these locations separate and protect the sacred from the profane. Gargoyles were created to cast the bad off the building into the outside like tears or sweat out of a body, purifying and keeping sacred the contents inside. If we take the 'body' of the Abbey to represent the human body Douglas's observation that - 'body symbolism is part of the common stock of symbols, deeply emotive because of the individual's experience.' (Douglas, 1999 [1966]), p.122) can be brought to bear on the building. The insides of the Abbey can thus be seen to represent the original object of spatialisation, – the mother's body, the most powerful and potent object of spatialization. The nave and the aisles, like the main arteries of the body, pass through different locations of particular sacred meaning (such as chapels) towards the most sacred area behind the screen; the reliquary (see fig. 6 and 7). The reliquary (The Shrine of Saint Edward the Confessor) (see fig. 8) is like the womb of the building where the most sacred and powerful objects in the Abbey, the relics, are contained. The sacred bones contain the greatest most efficacious good projection and relate to a fantasy of merging with the sacred bones providing 'comfort and salvation' (Miccoli, 1990 [1987], p.47). In the reliquary the kneeling spaces afford the pilgrim an opportunity to get even closer in to the sacred relics, the treasure. However, as with the womb it can be approached but never quite reached, creating a constant seeking to control that experience and that space. As Figlio writes 'I have argued that we are driven to know mother from the outside and the inside' (Figlio, 2000, p.21). As with the village model, there is dividing up of the sacred space inside into various localised areas (chapels) of sacred which keep profane in position outside.

The Chapel of Our Lady of Pew (see figs. 9, 10, 11, 12 and 13), ‘Pew’ meaning a small chapel or enclosure, venerates Mary, Mother of Jesus, and contains a pink alabaster statue of Mary holding the baby Jesus. According to the Dean and Chapter of Westminster Abbey:

The painted vaulting of this recess with its carved boss of the Assumption [see figs 9&10] dates from the second half of the fourteenth century and in the back wall of the recess, facing the Ambulatory, was a shallow niche with a bracket on which stood an image of our Lady [...] The walls of the recess were elaborately painted and are studded with hooks evidently for votive offering. The outer doorway with its painted wooden half-gates and iron bracket for an alms-box are also original. (Dean and Chapter of Westminster Abbey, 1994 [1988], p.59)

For the pilgrim, this chapel was a spatialising experience. At the womb like entrance, (fig 11 &12), the pilgrim would deposit money in the alms box for the poor, so they might projectively be looked after in the way in which the pilgrim hopes to be looked after by the mother, defending against the possibility of the mother function not being good enough. The small dark chapel which glows pink, creating a womb like interior, (see figs 9, 10 and 12) allowed the pilgrim to get close in to mother. Around the statue of the mother there are hooks on which to hang ‘votive offerings’, objects to gain favour from the transferential mother figure. This is a more advanced spatialising stage of a re-projection of the internalised, original spatialisation of mother into an actual transferential object mother figure, like the therapist, to spatialise into (as in my hypothesised Room-object Spatialisation Matrix stage 4 *Secondary Spatialised Room-object and transference of Object in the Consulting Room*).

A more recent example of spatialising, into the domestic space of rooms, is given by Judith Flanders who writes:

In the 1960s, builders renovating a house in north London found, bricked up behind a fireplace, a basket holding two shoes, a candlestick and a drinking vessel [...]: votive offerings to the house-gods of the 16th Century, resurfacing in the twentieth. Houses, according to myth, folk tale and legend, have souls, and possibly even minds. While we may no longer subscribe to these beliefs on a conscious level, many small rituals based on those beliefs were performed until recently: clocks were stopped and mirrors veiled on the death of a member of the household, while on the day of a funeral window – blinds were habitually drawn, covering the house’s ‘eyes’. (Flanders, 2014, p.165)

I suggest that this can be thought of as a spatialising projection of aspects of protective family members into the actual walls of a room, these objects are already humanised, already introjected from a spatialised, maternal transference. As well as this the house itself is anthropomorphised, with its own ‘eyes’ (to see outside danger) and ‘mind’ that can contain and protect the inhabitants inside.

1.3 (iv) Observation of phenomena in residential care

I observed phenomena relating to client’s relationships with rooms, when I worked as a residential care manager in a home for people with mild learning difficulties and mental health problems, before and during my psychotherapy training. I was used to working with resident’s spatialising and manipulating of physical space to control the psychological space. This included ritualising before going out of the building or out of their bedrooms, much like the ritualising and spatialising in the Nigerian village scenario. I repeatedly observed the importance of the client’s bedrooms to them. An example of this can be seen in the case of one of the clients (Mr X) who has frequent psychotic episodes and went through long periods of not wanting to leave his bed room. It was the only place where it seemed that he felt he had some sort of mind. He occasionally went to the kitchen where he colonised one end with his music system and where

playing CD's was a form of control of the environment. Another control was refusing food and only drinking milk, like an infant. Mr X had a mentally ill mother and violent Father with whom, as a child, there were a lot of experiences with guns. It seemed that his room was not only the safest place but provided the safest feedback.

1.3 (v) Observation of phenomena in the psychotherapy setting

Whilst working as a psychotherapist, I have observed phenomena relating to patient's relationship with the consulting room, which at times seems unrelated to the transference to me. It appears to be a very specific relationship with the room, much like the example of Mr X above that fulfils a function for the patient as separate from me. This includes patients' ritualistic behaviours whilst moving in and out of the consulting room, using the toilet, hall ways and interim areas, including use of door and objects such as cushions, all of which I have observed to be heightened during consulting room moves. I have also noticed that room moves bring out the meaning of patient's relationships with the consulting room as well as rooms from their past. While the current view is that unconscious communications of the patient relate to either transference, or an avoidance of the transference, I think it is important to recognise the more primitive, pre-transferential states of mind. I am also suggesting that it is a place where patient may go that relates to their relationship with rooms which they originally formed as a top-up to the mother function or at times replacement of that and that this is an important communication to understand. I will be providing detailed clinical evidence in Chapter 6.

1.4 Conclusion

In this chapter I have introduced my study I have given examples of background phenomena observed from Data set 1- historical and cultural- including primitive, early human and pre-human space usage -which I am calling spatialising, as well as examples from residential care

and the consulting room. These contribute to my hypothesised formulation of the Room-object Spatialisation Matrix. I now go on to look at Data set 2- Sigmund Freud's writing, which also forms part of the evidence for the formulation of my hypothesis.

Chapter 2

Sigmund Freud, Spatialisation and Rooms

2.1 Introduction

In Chapter 1, I introduced my study by discussing phenomena that I have observed in the consulting room, not fully explained by current theory, where patients seem to relate to the consulting room at times separately to me in the transference. I discuss examples from Data set 1 (historical, anthropological, and previous clinical experience), that I utilise to formulate my hypothetical alternative theory to explain this phenomena better.

In this Chapter, I consider Data set 2 - Sigmund Freud's writings, showing his relationship with spaces and spatiality. Freud showed intense and repeated use of spatial imagery and he made meanings for specific spatial locations and their relationship to each such as; The Acropolis, Athens, Pompeii, Rome, Notre Dame, Paris, Charing Cross and Loch Ness. He also made meaning of buildings and objects in those locations, as well as rooms and their contents, including projecting maternal and paternal figures into the spaces of rooms. None of this was theorised. I argue that, although Freud's interest in rooms informed his creation of the consulting room as part of the development of psychoanalysis, it seems that something of his interest has been lost, but perhaps still exists without any formal theorizing. There is, for example, an implicit spatial concern in contemporary psychoanalysis, which is also a root idea for various areas of Psychoanalytic thinking. This considers spatiality in dreams, obsessionality and hysteria, as well as spatialisation in Freud's conceptualisation of projection as an unformed internal pressure of instinct put into external form, which is necessarily spatial. Formulations of

Psychoanalysis have retained spatialising as an unconscious element, and I wish to bring it to the fore in this study regarding the physical space of the consulting room, and its role in the therapeutic process.

The question of why spatialising has been little theorised, including by Freud, is both a ‘background’ question to this study and also intrinsic to the need for doing the study and the position it takes up in the literature. Why would Freud, who showed such great spatial concerns throughout his life and work, including in his approach to the filling up and usage of his own consulting room, not theorise about that? The answer to that, which I will address in this chapter, is surely an underpinning factor to the relatively unconscious position that the consulting room has continued to take up in its role in the therapeutic process.

2.2 Freud’s theory of instincts - utilised to build my hypothetical concept of spatialisation

Freud suggests in his cultural theories in *Totem and Taboo*: ‘It is not to be supposed that men were inspired to create their first system of the universe by pure speculative curiosity. The practical need for controlling the world around them must have played its part.’ (Freud, 1955 [1913], p.78). Freud (1957 [1915]) also observes that thoughts and feelings which cannot be contained or controlled within the self, need to be projected outside it, where they might be controlled through physical manipulation. In this context, two aspects become particularly relevant. Firstly, there is the projective creation of space which either represents instincts, as I will show in Freud’s model, or represents objects, in Object-relations theory, as I show in Chapter 3. Secondly, there is the manipulation and control of the space with its objects, giving this representation meaning. Freud wrote that internal instinctual stimuli make ‘demands on the

nervous system and cause it to undertake involved and interconnected activities by which the external world is so changed as to afford satisfaction to the internal source of stimulation' (Freud, 1957[1915], p.120). These 'interconnected activities' thus combine to form the mechanism of 'spatialisation' – activities in the external world that bring about change externally, so as to 'afford satisfaction' to the instincts internally, while simultaneously providing a representation of the internal world in the material one. I am using Freud's concept of the mechanism and function of projection as a model for the re-presentation of internal need and demand in an external form, where it can be managed and brought into line with satisfactions through the external world. This spatialising is 'the manner in which the process of mastering stimuli takes place' (Freud, 1957[1915], p.120). Freud writes that '[t]he object of an instinct is the thing in regard to which or through which the instinct is able to achieve its aim' and that this object 'becomes assigned to it only in consequence of being peculiarly fitted to make satisfaction possible' (Freud, 1957[1915], p. 122). Thus, spatialisation is a mechanism that simultaneously involves a psychological projection of meaning and physically acting upon the environment, utilised to master the undifferentiated, relentless, internal pressure of instinct. To spatialise means to manipulate things in the physical world, so as to make an initial projection come true and flesh out a psychologically required meaning.

Additionally, Freud wrote about space being fashioned by projection, after observing that some of his patients manifested their unconscious feelings spatially. He called these manifestations 'mnemic symbols':

Their symptoms are residues and mnemic symbols of particular (traumatic) experiences. We may perhaps obtain a deeper understanding of this kind of symbolism if we compare them with other mnemic symbols in other fields. The monuments and memorials with which large cities are adorned are also mnemic symbols. [...] [W]hat should we think of

a Londoner who paused to-day in deep melancholy before the memorial of Queen Eleanor's funeral [...] or [...] a Londoner who shed tears before the Monument that commemorates the reduction of his beloved metropolis to ashes [...]? Yet every single hysteric and neurotic behaves like these two unpractical Londoners. Not only do they remember painful experiences of the remote past, but they still cling to them emotionally (Freud, 1957[1910], pp.16–17).

Freud also writes of the placing of several of these memorials on a kind of mourning path. Memorials are structures in places and internally structured. What Freud finds, in the monuments are the products of a marking out of space – the creation of a physical representation of an emotional state. He utilises these creations as exemplifications of mnemonic symbols. These symbols are objects in space, into which feelings are not only projected but which are, in turn, constitutive of these feelings in the first place. Freud describes these mnemonic symbols with diagrams (see fig.14): 'there lies a second system which transforms the momentary excitations of the first system into permanent traces. The schematic picture of our psychical apparatus would then be as follows [Fig. 14]' (Freud, 1953[1900], pp.538).

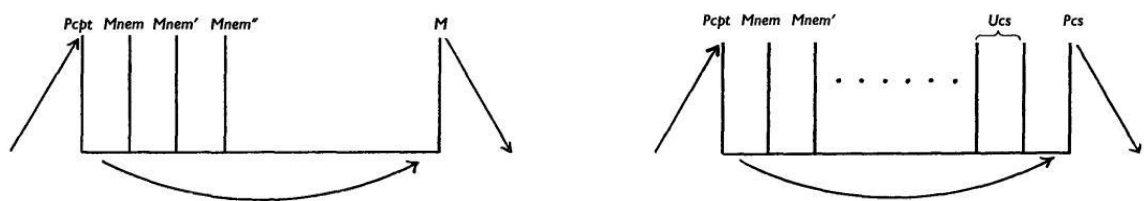


Figure 14: Freud's diagrams of mnemonic symbols

The greater our need for containment that cannot be met by our significant others, the higher a perceived threat and the greater the pressure of internal instincts, the less we will be able to think and the more this primitive form of functioning, which I am calling spatialisation, will become utilised. Projection recasts and develops the internal world into the dimensional form of the

external world, and in doing so it also creates the objects the ego finds, into which internal unease can be projected.

2.3 Freud and Primary Spatialised Room Transference, introjected and re-projected, re-spatialised (untheorized)

2.3 (i) Freud's rooms

In this section I suggest that Freud's fascination with the control, ordering, denoting meaning to, writing about and making diagrams of the interiors of the rooms he inhabited (which I give examples of), is not only a spatialising activity, but that it also relates to my hypothetical Room-object Spatialisation Matrix, Stage 2 - *Primary Spatialised Room Transference*, as he transferred maternal and paternal figures into room spaces. In addition, Stage 2 - *Primary Spatialised Room Transference* can be re-spatialised into other room spaces, including the consulting room (stages 3 and 4 of the Room-spatialisation Matrix). I show that Freud does this, and I discuss why this was not theorised about in Freud's invention of the consulting room or in his concept of transference.

Figure 15: Drawing of Sigmund Freud's room in "Zoologische Station" in Trieste 1876 by S. Freud

My first example of a diagram of Freud's, of a room in which he lived or worked, is in Freud's letter of April 5th 1876, to Eduard Silberstein. Freud wrote about the Zoologische Station in Trieste with a detailed account of the interior and spatial array of objects in it (see fig.15), as well

Figure 16: Drawing of Sigmund Freud's table in his room in "Zoologische Station" in Trieste, 1876 by S. Freud

as his desk (see fig. 16) and the objects on it:

My little room has an odd floor plan, one window, in front of which is my work table, with a great number of drawers and a large top, a second table for books and ancillary implements, three chairs, and several shelves holding some twenty test tubes. Last but not least, there is also a sizeable door, which, if you follow its lead, takes you outside [Fig. 4]. [here fig. 15]. On the left side of the table, in the corner, stands the microscope, in the right corner the dissection dish, in the centre four pencils next to a sheet of paper (my drawings are therefore cartoons, and not without value), in front stands a series of glass vessels, pans, bowls [...] so that when I am busy working there is not a spot left on which I can rest my hand [fig. 5]. [here fig. 16] (Freud, 1990[1876], p.146).

The next example is from Freud's letter to Martha Bernays (October 5th 1883) from the Dermatological Department of the General Hospital, 'he described and sketched his new room and his furniture' (Freud, Freud & Grubrich-Simitis, 1998 [1978], p.104) (see fig. 17). Ernest Jones wrote a translation:

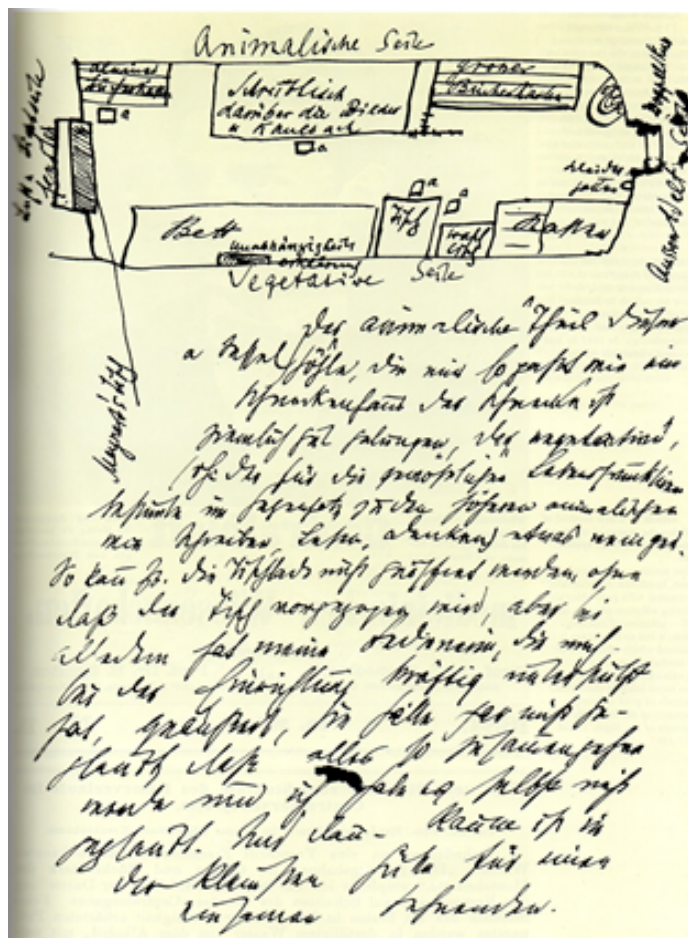


Figure 17: Drawing of S. Freud's room in The General Hospital in Vienna by S. Freud, October, 1883

The 'animal' part of this cavern which fits me as well as a snail-shell fits the snail, is fairly successful, the 'vegetative' part (i.e., the one intended for the ordinary functions of life in opposition to the higher 'animal' functions like writing, reading or thinking) rather less so. [...] Space is in the smallest hut for the lonely longing one. (Freud, Freud & Grubrich-Simitis, 1998 [1978], p.327).

So here it can be seen that Freud was dividing the room into parts related to physical and psychological functions, as well as evaluating the size of the space depending on the emotional state of the person within it. It might be considered that the dividing of physical and psychological happened in the creation of the consulting room, and that the psychological aspects of psychoanalytic technique were theorised (and 'successful') whereas the physical aspects of the room were not theorised about and therefore we could say did not appear 'successful'.

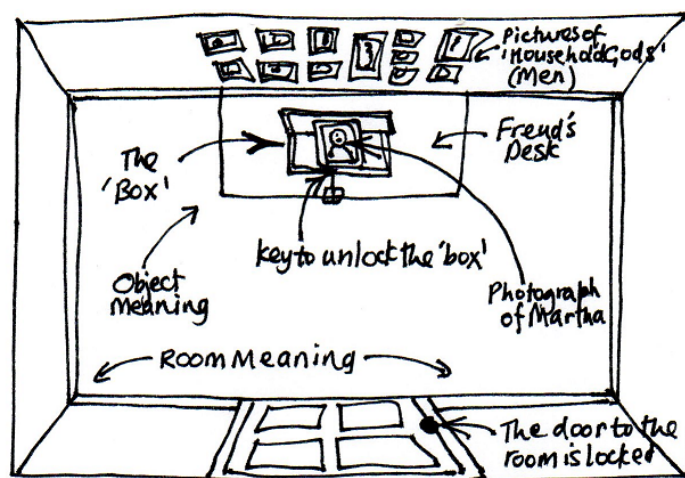


Figure 18: An aerial view of Freud's room, 1882, by D. Wright

In the next example, shown in a letter of 1882 to his fiancée, Martha Bernays, Freud significantly shows projections of male and female figures into and onto the walls of his room and the spatial array of objects within it (see my fig.18):

My precious, most beloved girl I knew it was only after you had gone that I would realize the full extent of my happiness and, alas! the degree of my loss as well. I still cannot grasp it, and if that elegant little box and that sweet picture were not lying in front of me, I would think it was all a beguiling dream and be afraid to wake up [...] I would so much like to give the picture a place among my household gods that hang above my desk, but while I can display the severe faces of the men I revere, the delicate face of the girl I have

to hide and lock away. It lies in your little box and I hardly dare confess how often during the past twenty-four hours I have locked my door and taken it out to refresh my memory.

(Freud, 1961[1882], p.8)

I am suggesting this relates to my hypothetical Room-object Spatialisation Matrix, Stage 2 - *Primary Spatialised Room Transference*, as he transferred maternal and paternal figures into room spaces, projected onto the walls and objects of the room. Within the scenario in the letter we can see a possible projection of the father in the pictures of 'household gods' (men) and the 'box' and 'lock' represents the mother, women and/or Martha relating to the space of the mother's body.

2.3 (ii) Mother and women, spatialised into rooms, introjected and re-projected

I am suggesting that the box and lock metaphors relate to mother and female projection onto the space and objects of that room. The lock metaphor is mentioned again in a letter to Martha in August 18, 1882. In Freud's description of his fantasy of an ideal home that they could have, and the meaning of the furniture, and objects in it. Again, here we have meaning attributed to the spatial array (phantasy) of the home space and control and meaning attributed to the space:

it occurs to me that we would need two or three little rooms to live and eat in and to receive a guest, and a stove in which the fire for our meals never goes out. And just think of all the things that have got to go into the rooms! Tables and chairs, beds, mirrors, [...] pictures on the wall, glasses [...], and an enormous bunch of keys – which must make a rattling noise. And there will be so much to enjoy, the books and the sewing table and the cosy lamp, and everything must be kept in good order or else the housewife, who has divided her heart into little bits, one for each piece of furniture, will begin to fret. [...]

And of course we will have to go on telling each other every day that we still love each other. There is something terrible about two human beings who love each other and can find neither the means nor the time to let the other know [...]. If they are left untouched for too long, they diminish imperceptibly or the lock gets rusty; they are there all right but one cannot make use of them. (Freud, 1961[1882], pp.27,28)

Here, Martha is to divide up her heart to attach it to each part of the spatial array of the room and its furniture and objects. This is not dissimilar to the way in which Freud was treating the rooms he lived and worked in, in previous letters, with the furniture and objects labelled (see figs. 15, 16 and 17). However, in this example with Martha, as with the previous example (fig. 18) there is a female projection, but because of the introjection and re-spatialisation, in the Room-object Spatialisation stages to which I refer, the body is also constructed from the phantasy relating to the various objects in rooms, here onto the furniture, and there is also the box and lock metaphor. Freud refers to their relationship as a 'lock', this seems to be a sexual reference, and it is also an echo of the locked 'box' and the locked door, in order to look in the 'box', in his letter to her of two months earlier (fig.18). Boxes are a common metaphor for Freud, 'the English 'box' was related to the German 'Büchse' ['receptacle'], [...] 'Bückse' is used as a vulgar term for the female genitals [...]' (Freud, 1953[1900], p.154). Freud wrote about the possible meaning of a box within the analytic work in the case of Dora where she;

brought out a small ivory box, ostensibly in order to refresh herself with a sweet. She made some efforts to open it, and then handed it to me so I might convince myself how hard it was to open. I expressed my suspicion that the box must mean something special [...]. The box – [in German] [...] was once again only a substitute [...] for the female genitals. There is a great deal of symbolism of this kind in life, but as a rule we pass it by without heeding it. (Freud, 1953[1905(1901)], p.77).

Freud also uses the metaphor of a house: ‘the dwelling-house was a substitute for the mother’s womb, the first lodging, for which in all likelihood man still longs, and in which he was safe and felt at ease’ (Freud, 1961[1930], p.91) and of a room, ‘[i]t seems to me more likely that a room became the symbol of a woman as being the space which encloses human beings’ (Freud, 1963 [1916], p.163). Freud also reported a dream of his mother, involving wardrobes and cupboards:

I saw myself standing in front of a cupboard [‘Kasten’] demanding something and screaming [...]. Then suddenly my mother, looking beautiful and slim, walked into the room [...]. I had missed my mother, and had come to suspect that she was shut up in this wardrobe or cupboard [...]. The wardrobe or cupboard was a symbol [...] of [...] mother’s inside (Freud, 1960[1901], pp.49-51).

Freud’s mother had just given birth to his sister. This dream resonates with his case study of ‘Little Hans’, where Hans describes the spatial manifestation of his unprocessed feelings about the birth of his sister. According to Freud, when Hans refers to boxes transported on carts, (see fig, 19)

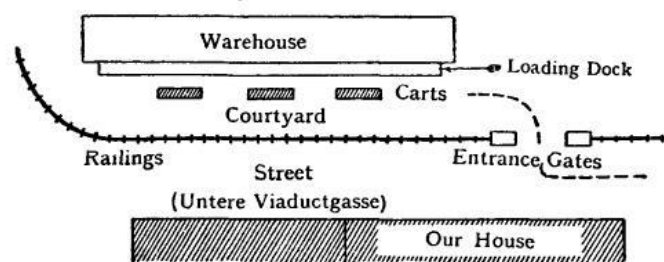


Figure 19: ‘Little Hans is specially frightened when carts drive into or out of the yard’ (Freud 1955 [1909])

The boxes represent his mother’s womb with the baby sister. ‘We can now recognize that all furniture-vans and drays and buses were only stork-box carts, and were only of interest to Hans as being symbolic representations of pregnancy; and that when a heavy or heavily loaded horse fell down he can have seen in it only one thing – a childbirth, a delivery’ (Freud, 1955 [1909], p.128). In the same way, Freud’s mother emerges ‘beautiful and slim’ from the cupboard. A

greater insight into Freud's dream about his mother can perhaps be gained from Joseph Berke's observation that Freud experienced his mother as 'emotionally unavailable' and, we might think, possibly physically less available. He writes:

Amalie became pregnant again with her second son, Julius. This baby also carried the same name as Amalie's brother and beloved companion. Baby Julius died when Sigmund was two years old from an infection and Amalie's brother passed on at around the same time from tuberculosis. Both losses left his mother heartbroken and emotionally unavailable to Sigmund. (Berke, 2015, p.xiii).

This may give us an insight into Freud's fascination with rooms. Rooms may represent the mother or a replacement of her care when she is absent emotionally and/or physically. Another room of significance for Freud was the 'cabinet' he was given when his family moved to a larger flat in 1875, when he was nineteen:

The 'cabinet', a long and narrow room separated from the rest of the flat, with a window looking onto the street, was allotted to Sigmund; it contained a bed, chairs, shelf, and writing-desk. There he lived and worked until he became an *interne* at the hospital; all through the years of his school and university life the only thing that changed in it was an increasing number of crowded book-cases. In his teens he would even eat his evening meal there so as to lose no time from his studies. He had an oil lamp to himself, while the other bedrooms had only candles. (Jones, 1967[1953], pp.45-46)

Here Freud was given a special room, unlike his siblings, who had to share rooms, and it also featured special objects. Perhaps the room represented a special time of just him and mother – it was a room for just him. I suggest that this may be the original site of spatialisation (Room-spatialisation) which was introjected and re-projected into the rooms we have looked at, such as the General Hospital (see Fig 17), and the Zoologische Station in Trieste (fig.15). These are the

first rooms he lived in after leaving home, where he may have re-projected his projection into the ‘cabinet’, which he may have substituted for the role of mother. Before Freud invented the concepts of transference or the consulting-room, he transferred the meaning of people onto the space of a room and the objects within it. Freud wrote of a dream relating to the stairway leading to his consulting room: ‘That night I had the following dream: *I was very incompletely dressed and was going upstairs from a flat on the ground floor to a higher storey [...] [m]y consulting-room and study are on the upper ground floor* (Freud, 1900, p.238). Later Freud goes into more detail about architectural metaphor in ‘The Genitals Represented by Buildings, Stairs and Shafts’, where he writes that in relation to stairs ‘from my own knowledge derived elsewhere that climbing down, like climbing up in other cases, described sexual intercourse in the vagina’. (Freud,1900, p.365) So, there is a female reference of going up into his consulting room, perhaps like his reference to the womb (p 43).

In this section we looked at Freud’s projection of maternal and female figures (or mother function) and we now go on to look at Freud’s projection of paternal/ masculine figures, as well as, again, into his consulting room.

2.3 (iii) Father and ‘Gods’ spatialised into rooms and locations

Returning to Freud’s letter to Martha of 1882 (Fig. 18), in which we have looked at his female projections, I will now look at male aspects. Freud writes of ‘my household gods that hang above my desk [...] display the severe faces of the men I revere’ (Freud, 1961 [1882], p8). These are perhaps male family members as well as other men that he reveres on the walls of the room. I suggest that the significance of Charcot, who may have fulfilled a father like role for Freud, or even an idealised father, was incorporated into Freud’s consulting room. Freud hung a picture of Charcot in his Consulting room, which is a black and white lithograph (see fig. 21) of a painting



Figure 20: Painting by Pierre Aristide André Brouillet 'A Clinical Lesson at the Salpêtrière'



Figure 21: Lithograph of above painting in Freud's consulting room



Figure 22: Shows lithograph it hanging top left in Freud's consulting room in Berggasse 19, Vienna



Figure 23: Drawing of Maresfield Gardens showing lithograph of Charcot above the couch (top right) by D. Wright

by Pierre Aristide André Brouillet (see fig. 20) entitled ‘A Clinical Lesson at the Salpêtrière’ which shows Charcot demonstrating hypnosis on the Salpêtrière patient, Marie "Blanche" Wittmann. Freud hung the lithograph in his consulting room in Berggasse 19, left of the door, above the shelves, (see fig. 22) and later in his room in Maresfield Gardens, (see fig. 23) above the couch. In a letter to Martha in November 24, 1885 Freud wrote about being a student of Charcot:

I am really very comfortably installed now and I think I am changing a great deal. I will tell you in detail what is affecting me. Charcot, who is one of the greatest of physicians and a man whose common sense borders on genius, is simply wrecking all my aims and opinions. I sometimes come out of his lectures as from out of Nôtre Dame, with an entirely new idea about perfection. (Freud, 1961 [1885], pp.184-185)

Here he uses his meaning of the building (Notre Dame) to represent something of his feelings about Charcot for him, as an entirely new ideas about perfection’. This is a complex set of symbols layered up. Ernest Jones writes of Freud’s relationship to Paris and Notre Dame;

Of his life in Paris as a student of Charcot’s in the winter of 1885-6, Freud had so much to say [...]. The very name of the city had a magic. [...] Freud wrote: ‘Paris had been for many years the goal of my longings, and the bliss with which I first set foot on its pavements I took as a guarantee that I should attain the fulfilment of other wishes also.’ [...] [U]ndoubtedly the building that most impressed him in Paris was Notre-Dame. It was the first time in his life that he had the feeling of being inside a church. He mentioned climbing the tower on two occasions [...]. He entered into the spirit of Victor Hugo’s *Notre-Dame* [...] and even said he preferred it to neuropathology. His choice of souvenir of Paris was a photograph of Notre-Dame. (Jones, 1967 [1953], pp.171-172)

Notre-Dame as a space became important in itself for Freud, within the spatial array of Paris which has a ‘magic’ spatial manifestation of the idea that he will fulfil his wishes there, which he

also related to Charcot, representing his interactions with Charcot and the feelings of 'perfection'. He shows his feelings for a person (Charcot) equated with his feelings for a space (Notre Dame) which is then re-projected on to the wall of the consulting room. This relates to what I am calling Room-spatialization. In hanging Charcot on his consulting room wall, Freud was bringing something of his feeling about Charcot and his feeling of Notre Dame 'an entirely new idea about perfection', (Freud, 1961 [1885], p.185) into the room. This related to Charcot's 'genius' and him being an idealised paternal figure, spatialised onto (and placed on in the form of the lithograph) the walls off the consulting room, perhaps to imbue the consulting room with these qualities, like the 'household gods' he 'revered' in fig 18, perhaps affording protection, assistance or 'perfection'. I now look further at representations relating to paternal projections (relating to his father) spatialised in the consulting room.

2.4 Freud's consulting room, transference and spatialisation





Figures 24 and 25: Freud's consulting room in Vienna, May 1938. (E. Engleman)

Freud had many objects in the consulting room associated with classical Rome and Greece which I suggest incorporate meanings projected relating to Freud's Father. Freud describes the meaning and act of sitting on the Acropolis and how it relates to his feelings about his Father: 'The very theme of Athens and the Acropolis in itself contained evidence of the son's superiority. Our father had been in business, he had had no secondary education, and Athens could not have meant much to him' (Freud, 1964 [1936], p.247) and that '[I]t must be that a sense of guilt was attached to the satisfaction in having gone such a long way' (Freud, 1964 [1936], p.247). This contrasts with his description of Charcot and his 'genius'. Freud wrote that Rome represented 'unattainable aims' (Freud, 1953[1900], p.195), unlike Paris, that promised to fulfil wishes, Freud recounted an experience when his Father told him:

A Christian came up to me and with a single blow knocked off my cap into the mud and shouted: "Jew! get off the pavement!" "And what did you do?" I asked. 'I went into the roadway and picked up my cap,' was his quiet reply. This struck me as unheroic conduct on the part of the big, strong man who was holding the little boy by the hand. I contrasted this situation with another which fitted my feelings better: the scene in which Hannibal's father, Hamilcar Barca, made his boy swear before the household altar to take vengeance

on the Romans. Ever since that time Hannibal had had a place in my phantasies. (Freud, 1953 [1900], p.197)

Here there is something else paternal represented, something flawed, imperfect, unheroic, different from Hannibal, as a boy, at the 'household altar' and contrasting with his own 'household gods' which alongside the Charcot's image on the wall looking down as the men he 'reveres'. He had many objects from classical Rome and Greece which may contain some of that meaning for him (see figs 23, 26 and 27). Eugene Victor Walter wrote that 'Edmund Engleman, , who photographed Freud's household [...] [see figs. 24 and 25] reports his impressions: 'Antiquities filled every available spot in the (consulting) room. I was overwhelmed by the masses of figurines which overflowed every surface'. (Walter, 1988, p.103) and Ro Spankie wrote about Freud's consulting room 'there are over 2000 antiquities'. (Spankie, 2015, Back-cover).



Figure 26: Drawing of Freud's room in Maresfield Gardens with his desk chair and figures on the desk by D. Wright

Freud also uses Rome as an example of his theory of the mechanisms of memory:

in mental life nothing which has once been formed can perish [...]. We will choose as an example the history of the Eternal City. Historians tell us that the oldest Rome was the *Roma Quadrata*, a fenced settlement on the Palatine. [...] [W]e will ask ourselves how much a visitor, whom we will suppose to be equipped with the most complete historical and topographical knowledge, may still find left of these early stages in the Rome of today. (Freud, 1961 [1930], p. 69)

Freud had a statue of the Gravida, which Freud wrote of as relating to ‘burial by repression and excavation by analysis (Freud, 1959 [1907], pp.5-18). Freud’s patient Pankejeff, ‘The Wolfman’ wrote; ‘Freud himself explained his love for archaeology in that the psychoanalyst, like the archaeologist in his excavations, must uncover layer after layer of the patient’s psyche, before coming to the deepest, most valuable treasures.’ (Gardiner Ed.,1989 [1972], p.139). So Pankejeff is describing the patient’s psyche, much like Freud’s description of Rome and memory (1961 [1930]). Freud also had statuettes of Osiris, of which Ro Spankie wrote, ‘It has been noted by several commentators that despite having four Osiris figures on his desk, Freud makes no reference to the complex relationship between Osiris and Isis; siblings, lovers and parents, [...] reveals resistances in Freud’s self-analysis to traumatic events in his own childhood’ (Spankie, 2015, p.84). There is an idea here that the objects (Osiris) represents something unconscious for Freud, unanalysed and what I would call spatialised. Hilda Doolittle refers to one of the Osiris figures in her account of her analysis with Sigmund Freud:

I told him about the little statues or images in the house that Lawrence had first spoken of [...] The Professor [Freud] said, “Come and see if we can find them.” We went into the other room; he brought out various treasures from behind the glass doors. [...] The Professor brought out a wooden Osiris [...]. We went back to the couch.’ (Doolittle, 2012 [1956], p.172). And on another occasion, ‘the Professor has gone into the other room to find a new dog to show me. He brings back a broken wooden dog’ (Doolittle, 2012

[1956], p.147).

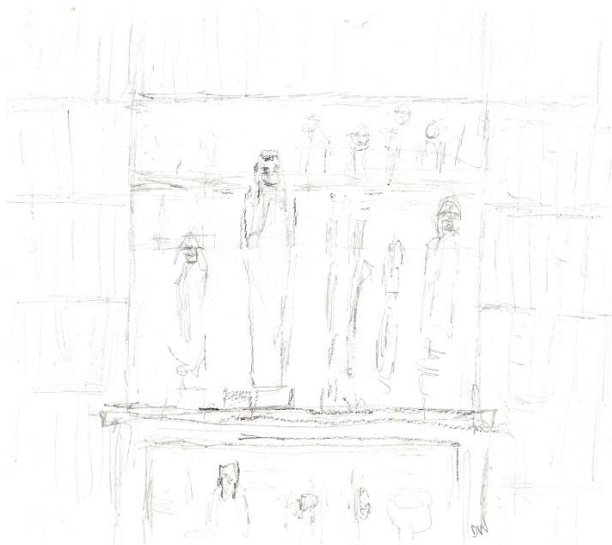


Figure 27: Drawing of book shelves in Freud's consulting room, Maresfield Gardens, by D. Wright

Freud was doing something publicly with a patient (Hilda Doolittle), and privately with his feelings about these items and indeed the entire interior of his consulting room. Freud wrote that, 'everything connected with the present situation represents a transference to the doctor.' (Freud, 1955 [1913], p.138). Did he intend for the meaning of his objects to be utilised and connected to



Figure 28: Head in glass box in Freud's study, Maresfield Gardens, by D. Wright

him or were the objects, including the entire spatial array of the room and pictures on the walls, also there for his own spatialising usage? Or were they intended for use in the transference for the patient? Could he be missing that the patients may, like him, have their own projections and spatialising relating to his room, in which they also resided, as an experience of their own history of spatialising, separate from him as a transference object? In one of the few texts in which Freud writes about this about this, he writes:

I am certainly not the first person to have been struck by the resemblance between what are called obsessive actions in sufferers from nervous affections and the observances by means of which believers give expression to their piety. The term ‘ceremonial’, which has been applied to some of these obsessive actions, is evidence of this [...] they serve important interests of the personality and that they give expression to experiences that are still operative and to thoughts that are cathected with affect. They do this in two ways, either by direct or by symbolic representation; and they are consequently to be interpreted either historically or symbolically [...] The same patient could only sit on one particular chair and could only get up from it with difficulty. (Freud, 1907, p.117-120).

Here he writes of actions which have an obsessive quality, their purpose (I call spatialising), and of a patient who spatialises about their chair. I am suggesting that this is primitive and pre-transferential. Freud writes on transference that ‘the patient sees in his analyst the return – the reincarnation – of some important figure out of his childhood or past, and consequently transfers onto him feelings and reactions which undoubtedly applied to this model. It soon becomes evident that this fact of transference is a factor of undreamt-of importance’ (Freud, 1940, p.52). Freud was doing things within the spatial array of the consulting room with objects, meanings of and arrangements of objects, and what I call spatialising that he at no point theorised about. What was the role that Freud intended his consulting room and its objects to fulfil for his patients in

their treatment? Doolittle suggests of Freud's consulting room:

Inside the Cathedral we find regeneration or reintegration. This room is the Cathedral. [...] The house is home, the house is the Cathedral. He said he wanted me to feel at home here. The house in some indescribable way depends on father – mother. At the point of integration or re-integration, there is no conflict over rival loyalties. The Professor's surroundings and interests seem to derive from my mother rather than from my father, and yet to say the “transference” is to Freud as mother does not altogether satisfy me. (Doolittle, 2012 [1956], p.146)

So here Doolittle was considering both mother and father in the consulting room which she described as 'cathedral' and 'home'. Doolittle continued with the 'cathedral' metaphor for the consulting room; 'the cathedral of my dream was Sigmund Freud. “No,” he said, “not me – but analysis.” (Doolittle, 2012 [1956], p.147). Doolittle is writing about transference onto Freud as Father or Mother, but she is also describing a transference onto the consulting room, something like a cathedral, a home. I have been discussing cathedrals and their meanings as a place of common and personal meanings (Westminster Abbey) as well as Freud's association to Notre dame. Similarly, Mahon described the consulting room as the 'house of transference' (Mahon, 2005, p.29).

I suggest that this model is transferred onto the consulting room which is 'put in the place of' a person or another room. This is like my hypothesised Room-object Spatialisation Matrix -Stage 3- *Secondary Spatialised Room-object in the Consulting Room*. There is a replacement of the person or room with the walls of the consulting room, and that this is also of great 'importance'. I am suggesting that this is part of the role in the consulting room (untheorised about) where the space of the room and its meaning can represent projected feelings about a person to the space of

a room and then re-projected into the consulting room, which can be imbued with the original room meaning. Freud did not write a spatial theory for the consulting room- such as Feng Shui (p 26), that Eastern carpets and pillows, rugs on the walls, objects and so on, as well as the way that they are arrayed, play an active part of the psychic reality for himself and his patients. I suggest that to this day, psychotherapists copy Freud's foreign rug arrangement, either on their walls (behind the couch) or floors as well as couch coverings and cushions. In Mark Gerald's photography project 'In the Shadow of Freud's Couch: Portraits of Psychoanalysts in Their Offices' he wrote 'The Victorian consulting room of Sigmund Freud, with its oriental rug-draped couch, set a mood and technique that governed psychoanalytic life for much of its first century' (Gerald, 2009). In forty-one of Gerald's photographs of psychoanalysts in their consulting room, ten of the photographs of rooms showed eastern rugs. This is a quarter of the rooms. An example of this can be also found in Wayne Myers' case study where he writes that after giving an interpretation to his patient, 'She took one of the Moroccan carpets I have thrown across my couch and wrapped herself in it, as in a swaddling blanket. (Myers, 1994, p.1167). We identify with Freud and, like him, leave the significance of spatialisation unconscious.

I am suggesting that analysts have copied Freud's original consulting room, as if there were a spatialising system (such as that Feng Shui as discussed p 26) which Freud created to facilitate efficacious therapeutic work, as if, as Freud wrote:

Miraculous cures properly so-called take place in the case of believers under the influence of adjuncts calculated to intensify religious feelings—that is to say, in places where a miracle-working image is worshipped [...], or where the relics of a saint are preserved as a treasure [...], the reputation of the place and the respect in which it is held act as substitutes for the influence of the group [...]. Where so many powerful forces converge, we need feel no surprise if the goal is sometimes really reached. (Freud, 1953 [1890], pp.289-290).

2.5 Aphasia, the spatial layout of the brain, the mind and rooms

In a letter to Martha of October 9th, 1883, Freud wrote:

It seems as though the waves of the great world do not lap against my door; at other times I have to fight against the sensation of being a monk in his cell [...]. Strange creatures are billeted in my brain. Cases, theories, diagnostics, formulas have moved into brain accommodations most of which have been standing empty, the whole of medicine is becoming familiar and fluid to me [...]. When a letter from you arrives the whole dream fades, life enters my cell [...] and gone are the empty theories “according to the present status of science,” as they are invariably called. Then the world turns so warm, so gay, so easy to understand. My sweet [...] Oh Marty, it is so much more lovely to be a *human* being than a warehouse for certain monotonous experiences. But one is not allowed to be a human being for an hour unless one has been a machine or a warehouse for eleven hours. (Freud, 1961 [1883], p.68)

So here in 1883, he is thinking about a cell (small room) which he uses as a metaphor for himself, and the ‘accommodation’ of the brain, so there is a thinking about where the brain lives, where thinking lives and how Martha (and his connection and feelings towards her) change his ‘great emotional and excitable state’ when a letter arrives and his thinking. Here we have the beginnings of brain, mind, rooms and the changing of emotional states.

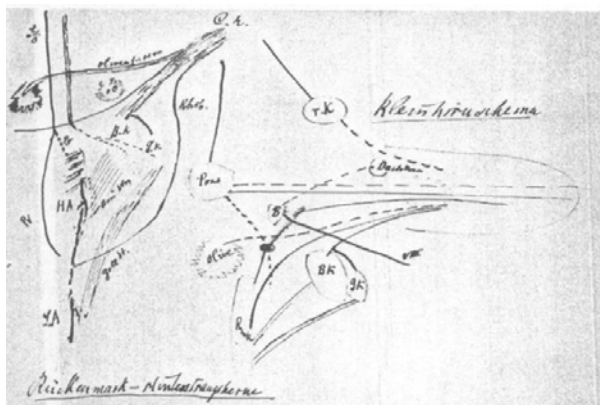


Figure 29: (originally 'Figure 2. Schema 1/a and 1/b' p197) Freud's drawing of the brain's workings

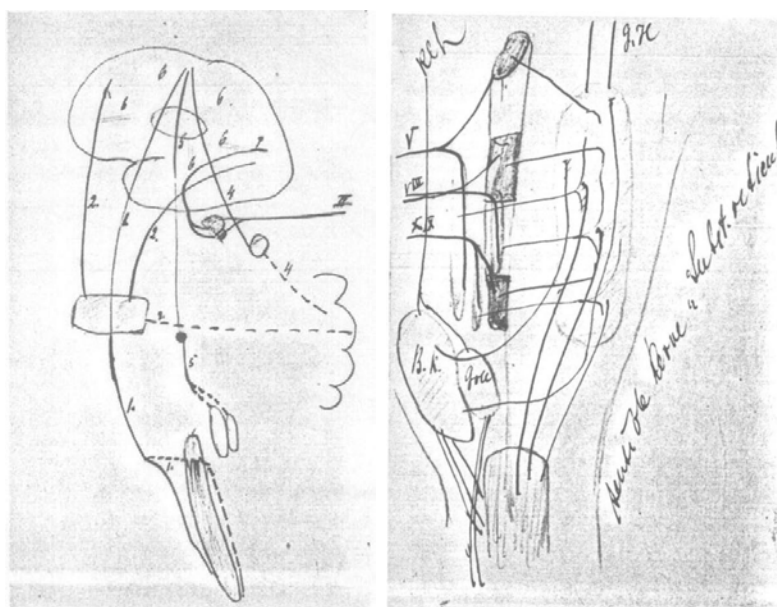
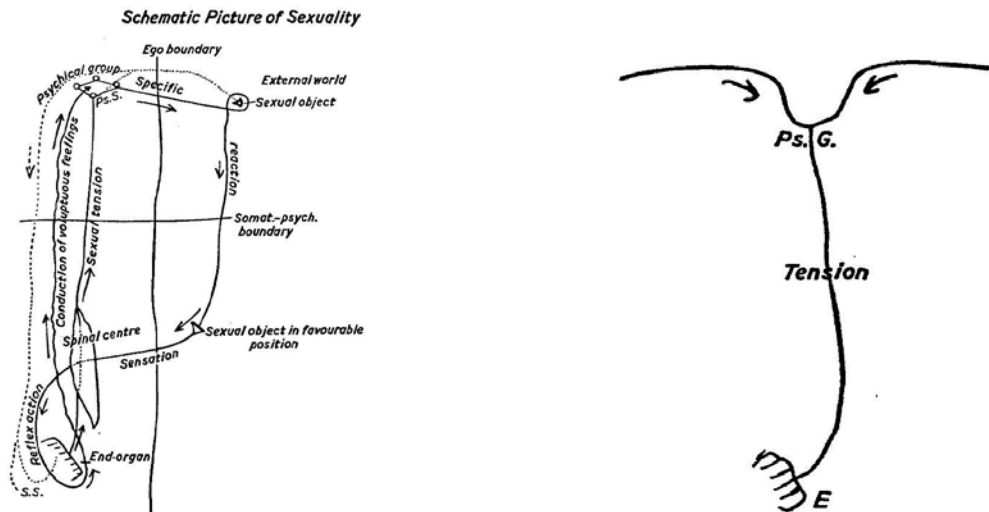


Figure 30: (originally Figure 3. Schema 2: Tracts of the cerebral grey p198) Freud's drawing of the brain's workings

Figure 31: (originally Figure 4 Schema 3: Sensory nuclei and substantia reticularis p199) Freud's drawing of the brain's workings

Freud's diagrams of brain mechanics around this time are reminiscent of his room drawings above, and also to later diagrams of psychological mechanisms all of which have a spatiality of their own. For example, in 'Critical Introduction to Neuropathology' (Freud, 2012 [1887] pp. 197 - 199) he shows the above three diagrams (figs. 29, 30 and 31). Not only do these seem to relate to the way in which he was treating his rooms, they also relate to his later diagrams of psychological mechanism which came after in his formulation of psychoanalytic theory.



Figures 32 and 33: Freud's diagrams of 'Schematic Picture of Sexuality'

Here are some examples of his diagrams to exemplify psychoanalytic theory below. Note the similarity here of fig. 30 to Freud's 'Schematic Picture of Sexuality' (Freud, 1966 [1892], pp.202-205) (Fig. 32). Freud also uses room metaphor in relation to psychoanalytic theory and the brain:

The crudest idea of these systems is the most convenient for us—a spatial one. Let us therefore compare the system of the unconscious to a large entrance hall, in which the mental impulses jostle one another like separate individuals. Adjoining this entrance hall there is a second, narrower, room—a kind of drawing-room—in which consciousness, too, resides. [...] The impulses in the entrance hall of the unconscious are out of sight of the conscious, which is in the other room; to begin with they must remain unconscious. (Freud, 1963 [1917], p.295)

In 1923, Freud wrote about the unconscious again, exploring the ego 'spatially', again, with a diagram that looks like one of his room drawings, here representing the workings of the mind:

We have said that consciousness is the *surface* of the mental apparatus; that is, we have ascribed it as a function to a system which is spatially the first one reached from the external world—and spatially not only in the functional sense but, on this occasion, also

in the sense of anatomical dissection [...] The state of things which we have been describing can be represented diagrammatically (Freud, 1955 [1923], pp.19-24) [fig. 34].

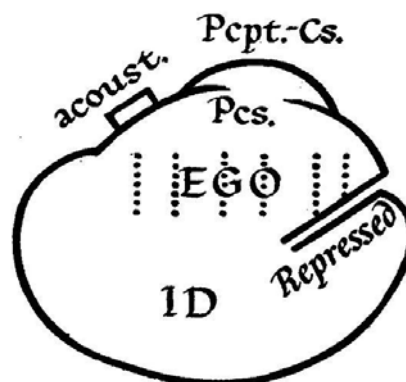


Figure 34: Freud's diagram representing 'the spatial or 'topographical' idea of mental life'

In 'Aphasia, A critical study' Freud wrote that brain – "localization", i.e., of the restriction of nervous functions to anatomically definable areas, which pervades the whole of recent neuropathology' (Freud, 1953 [1891], p.1), where different functions are located in different parts of the brain, was unfounded. These ideas of brain localization were of great interest generally at the time. This can be seen in the phrenology model (see Figures 35 and 36) where the brain is made up of different spaces or spatialized areas.

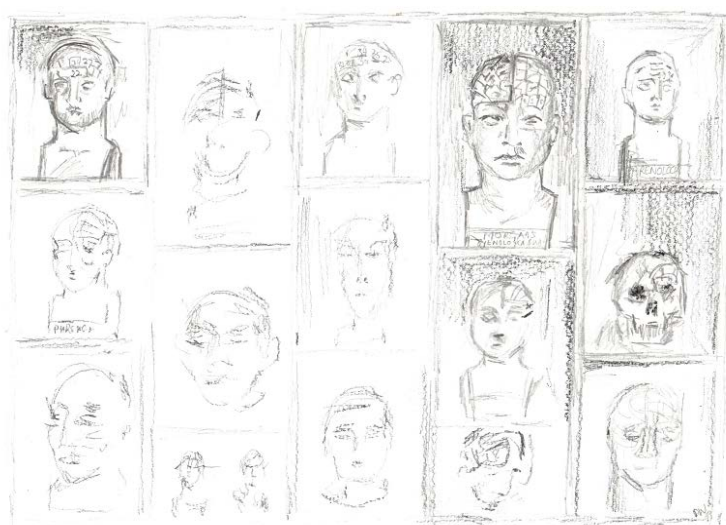


Figure 35 & 36: Drawing of Phrenology heads displayed in The Science Museum, London and single head, by D.Wright

Stengel wrote:

Freud's book on aphasia is known to a small circle of experts only. [...] Not only did Freud make valuable contributions to neurology but he laid the foundation of psychoanalysis. It has gradually been recognised in recent years that his anatomical, neurological and psychoanalytical works form a continuum. The book on aphasia demonstrates this clearly. It was the first of the author's studies dealing with mental activities and thus provides a link between the two apparently separate periods in his working life. [...] It appeared when neurologists were intensely preoccupied with the localization of cerebral functions. [...] Freud was the first in the German speaking world to subject the current theory of localization to a systematic critical analysis. In challenging both a powerful scientific trend and its most influential representatives he showed himself an independent thinker of considerable courage. (Stengel, in Freud, 1953 [1891], pp. ix-x)

Freud's alternative theory to localization was that the brain has an integrating function:

we must not search for the physio-logical substratum of mental activity in this or that part of the brain but we have to regard it as the outcome of processes spread widely over the brain. It follows from these two premises that certain lesions, the gross symptoms of which do not differ materially, must still differ in their psychological effects (Freud, 1953 [1891], p.17)

This illustrates Freud's interest in exploring an integrated theory of the brain (and shows building blocks to his psychoanalytic theory which will come later), in spatial versus integrated, he is writing that integrated thinking and functioning is still spatial, but not in the form of localized functions previously accepted by neurologists. Integration integrates is the way forward in theoretical terms. Throughout his work he developed theory on the integration of mind and

body. This may give us a sense of why his own spatialising, and theory about spatialising was minimized, although place remains, as in the ego, id, super-ego, ego-ideal of the structural model. These locations are places, and the places are sets of agencies such as the internal world as Klein conceive of it. Wollheim writes about states of mind directed upon spatial things:

It is clearly not enough, for a conception of the mind to be reckoned spatial, that we should attribute to the mind states which have as their objects, or are directed upon, things that are themselves spatial: for instance, the fact that we attribute to the mind thoughts about people and scenes, which are three-dimensional, (Wollheim, 1969, p.216)

and that the mind is ‘a theatre upon whose stage the figures of fancy or imagination make their appearance. (Wollheim, 1969, p213) Wollheim writes about psychotic spatialising which is even more primitive:

I should reckon it both proper and illuminating to say that our ordinary conception of the mind, while not that of a place, is one which, when distorted, is that of a place. This distortion, spelt out, is the story of our life read in reverse: as such, it marks the path of a regression. Now I may have suggested that the conception of mind involved in the unconscious states we have been considering in some detail is a fully spatial conception: which would be wrong. For there are conceptions that go beyond it in spatiality: conceptions, in other words, more distorted yet. I now want to suggest that it might be possible to characterize the varying stages of mental disturbance, or the stations on the path to psychosis, by the degree to which the patient conceives of the mind, supremely of his mind, as a place. (Wollheim, 1969, p.217).

Wollheim is saying that the more one can think in one’s own mind about one’s mind, then spatialising is reduced, however the extreme end of spatialising is psychosis. This is related to Freud’s (1907) writing on obsessive thinking and actions and the chair in the consulting room (p.

54) being used for these purposes. This is what my study will take up where this has remained untheorized.

2.6 Conclusion

In this chapter I looked at Freud's use of space and meaning of locality, spatial diagrams as well as projection of maternal and paternal figures into the space of rooms. I suggest the first spatialising of which Freud was consciously aware (hypothesised matrix stage 2, *Primary Spatialised Room transference (Room-object)*) may have been the 'cabinet' which was introjected and re-projected into many of Freud's rooms, including his own consulting room. I suggest that evidence of spatialisation into rooms by Freud has not been taken up in psychoanalytic theory, perhaps because it was so personal and habitual for Freud and perhaps not entirely conscious. Then later generations, in identification with Freud, repeat his retaining of spatialisation in an unconscious or minimally conscious state. That is why there is so little literature about it. However, Freud's fascination with the development of the mind included his attempt to find the original spatialisation, which creates the object world and is retained in transferences. Freud's conceptualization of projection (unformed internal pressure of instinct put into spatial form) is necessarily spatial and I utilise his instinct theory for building my alternative concept. Wollheim wrote that the more we look at the mind's primitive state the more we see spatialisation. I will go on in the following concepts chapter to look at the construction of my hypothetical concept in view of what is missing in current theory and showing the current theory utilised to construct it.

Chapter 3

Concepts

3.1 Introduction

In the previous chapter, I looked at Data Set 2- Freud's writing. In this chapter, I use this Data set 2, Data Set 1 (in Chapter 1) and Data Set 3- Object-Relational and Winnicottian theory to show a consistency with a range of mail-line psychoanalytic theories in the Kleinian, Object-relational and Winnicottian tradition. In addition, I highlight particular aspects of these theories in which there appears to be a gap, which I believe I can fill with my hypothetical theory of the Room-

object Spatialisation matrix, which I develop and present in the process.

3.2 Spatialisation, Primary Spatialised Room Transference and its Secondary Spatialisation into the consulting room– what is missing in the theory and what builds the theory to complete the gaps

In this section I look at Object-Relations and Winnicottian theories including the areas of incompleteness and my specific response to it.

3.2 (i) Klein –

Splitting and projection, projective identification

Melanie Klein (1946) writes the following about what I see as a core dimension of spatialization:

The processes of splitting off parts of the self and projecting them into objects are [...] of vital importance for normal development as well as for abnormal object relations. [...] [W]hen the ego ideal is projected into another person, this object becomes predominantly loved and admired because it contains the good parts of the self. Similarly, the relation to other persons on the basis of projecting bad parts of the self into them is of a narcissistic nature because in this case as well the object strongly represents one part of the self. [...] The need to control others can to some extent be explained by a deflected drive to control parts of the self. When these parts have been projected excessively into another person, they can only be controlled by controlling the other person. (Klein, 1946, pp.103 - 104)

In the case of the defence mechanism Klein describes above, I extend Klein's theory here, as the 'control' that Klein writes of, of bad, intolerable, anxiety-provoking feelings and thoughts, which cannot be contained in the self, does not only take place – or better: is not only placed - within people, but rather within anything in the environment, such as buildings, rooms and objects.. This can be a notion of a room as a good mother, inside of which all is good and outside of

which all is bad. Historically, I argue, this can be seen to relate to the splitting of the sacred and the profane. The primitive mechanism of spitting good and bad is utilised as part of the spatialisation process. The phenomena that I looked at in chapter 1, in the Nigerian village and Abbey examples of spatialisation, involve the splitting of sacred and profane which Klein writes of. In projective identification (1946) Klein suggests the projection is identified with by the receiver of the projection which increases the efficacy of the projection. In the case of spatialisation into room spaces, if the space is manipulated and modified to receive the projection and there is an unconscious phantasy, that the space will then effectively receive the projections, then this increases the efficacy of the successful projection of the feelings/instincts.

Positions; ‘depressive’ and ‘paranoid schizoid’

Klein’s ‘Paranoid Schizoid position’ (1946) and the ‘Depressive position’ (1946) are oscillated in and out of depending on the capacity, need and circumstances to tolerate internal object pressure. I build on this idea where my Room-object Spatialization Matrix stages are moved in and out of depending on need. Although spatialisation can be seen as a primitive mechanism utilised from birth as a part of emotional and psychological functioning, it is also frequently utilised in adulthood to retreat into - a defence to which the psyche retreats when stressed – as the mastery of the undifferentiated, relentless, internal pressure of instinct.

Transference

Transference has an essential spatial dimension, and in the consulting room an account of transference is not adequate without it. Hinshelwood wrote that:

Klein laid down that the total of all free associations that come into a patient’s mind can be referred to the transference, however remote from consciousness the link may be: ‘For many years transference was understood in terms of direct references to the analyst in the patient’s material. My conception of transference as rooted in the earliest stages of

development and in deep layers of the unconscious is much wider and entails a technique by which from the whole material presented the *unconscious elements* of the transference are deduced'. (Klein, 1952, p.55). This has developed as an emphasis on the total situation (Hinshelwood, 1989, p.17).

I am adding to this theory by suggesting that there is a projection or rather re-projection to the consulting room that is related to previous projections onto rooms which were utilised for Room-object spatialisation. This re-projection may run parallel to a transference, but in addition may also be instead of it, as a separate pre-object, pre-transferential projection as well as a projection of the spatial aspect of mother, as seen in my hypothesised Matrix stage 3 *Secondary Spatialised Room-object in the Consulting Room*. I am not dismissing the idea of transference but there is a more elemental level – I am going to magnify that primitive spatial level of thinking.

3.2 (ii) Bion

Containment

Wilfred Bion described his concept of containing, as a way of managing the threat of disintegration and what he would call 'nameless dread', (Bion, 1962, p.309):

When the patient strove to rid himself of fears of death which were felt to be too powerful for his personality to contain he split off his fears and put them into me, the idea apparently being that if they were allowed to repose there long enough they would undergo modification by my psyche and could then be safely reintrojected. (Bion, 1959, p.312)

The mother, I suggest, is not only the first site of containment as Bion described it, but of the aspect of being an object that I have called spatialising. If the mother functions as a sufficiently good first object for the child's spatialising work, then part of the mother's role must be found in

the process of containment (Bion, 1959), which involves the mother's mind being an auxiliary mind for that of the child. The mother detoxifies the raw emotions and thoughts by digesting them and feeding them back to the child in processed form. Through this process the child learns how to think. I argue that, if the mother's capacity for this is insufficient, children begin to mark out spaces in their inanimate environment (such as rooms) as replacements for the containing function. Thus, the mother is not only a spatialised object, but the non-containing mother forces the infant back on its earlier spatialisation, when it was first creating an object world. Mother, partly through being an object with objects inside, that is a projective target for the infant's earliest spatialisation, is then the source of transference, was also spatialised and so transference from her now included this spatialised aspect. Regressive reliance on spatialisation in the absence of maternal containment includes mother who is herself spatialised, which would then provide the spatialisation – invested in mother – to which the infant could then resort when other aspects of mother were lost. I am suggesting that adding to Bion's formulation of containment (Bion, 1959), if the mother is unavailable/partially unavailable to function as the container, then one option for the child is to create a rudimentary container for rudimentary detoxification via spatialisation (projection). Karl Figlio and Barry Richards (2003) specify the scope and nature of the containing function of nonhuman environments:

this containing function, which I am attributing to street lighting, tarmac, and its postmodern equivalents, is not of the same order as the containing function of the mother or of any human agent. In a narrow, technical sense, what I am talking about is probably not containment because the container is not capable of receiving, responding to, and modifying the subject's projections [...]. There is projection, but no reception and detoxification as specified in Bion's concept of containment. [...] The role of the public utilities in the life of the mind must therefore be in an important way the creation *of* that

mind, that is to say, their containing function must have been projectively invested in them. (Figlio & Richards, 2003, p.412).

It is the projective investment, I argue, that is also the core driving force of the mechanism of spatialization of projections; namely, to create a fantasy of containment. Figure 32 shows a



Figure 37: The spatial array of rooms as an auxiliary mind introjected as an auxiliary mind

drawing of mine that illustrates the spatial array of rooms utilised through spatialisation to create some sort of containment through creating this rudimentary auxiliary mind which then can be introjected (taken inside) the mind. The meaning given to a space as a rudimentary mind, replaces the function of the mind of the mother and is then taken back inside the self (introjected), to act as an auxiliary thinking space. This rudimentary, auxiliary mind thus replaces a genuine capacity to think, with ideas that can be made to stand in for thinking (e.g., - in the case of fig.37: rooms). I argue that this is precisely the objective of the mechanism of the spatialisation of projections; to create a fantasy containment. As I show in the case of the abbey, the containment happens through phantasy of the roll of the environment, it being the fantasy object to be controlled. If there has been insufficient containment in the early stages of

development, then this may be the only kind of containment obtainable with a fantasised exchange like mother. So, transference from mother to a space, then the use of that space on its own as a resort when containment fails, becomes a replacement for mother and the space of mother's body and the space and containing function of her mind. This is perhaps what Bion wrote about in relation to the patient's relationships with rooms:

Presenter: She told me since her mother's death she has kept her parent's bedroom intact; she has never moved any clothes, furniture, ornaments or photographs.

Bion: The advantage of 'the facts' is that they make it easier to talk about the furniture of the room than the furniture of her mind or character. But it is a step in that direction; it is a way of 'getting to know' who she is. It is a sort of 'transient' relationship; a sort of 'transference'. It is felt to be more bearable to know your self than to be ignorant of your self. But on the way to knowing her self it is easier for this patient to know the furniture of her house. She might get to know the furniture of her mind in time. (Bion, 1994, Kindle location 2524)

I am going on to suggest that patients' relationship with the consulting room as a secondary spatialisation of their primary room spatialisation serves as a top-up to the containing, thinking, function of the therapist, just as the primary room spatialisation was a top-up to the mother function. And further that patients who are unable to utilise the therapist in the transference, may need the consulting room to be in this top up role, for them to engage in the therapeutic process at all.

3.2 (iii) Winnicott

Developmental aspects of theory; environmental mother, true self

Donald Winnicott's theoretical stages or experiences relate to maturational achievements or processes which, all being well with the environmental conditions, are along a progressive

trajectory. These include ‘holding’ (Winnicott, 2002 [1967], p.111), the ‘mirror-role’ (Winnicott, 2002 [1967], p.111), ‘transitional objects’ (Winnicott, 2002 [1953], p.1), ‘intermediate area’ (Winnicott 2002[1953], p.14) and ‘the capacity to be alone’ (Winnicott, 1958, p.416). For Winnicott, maturation entails the ability to lead a creative, individual and meaningful life. When things go wrong in this maturational process, when mother is not ‘good enough’, and the baby is left waiting ‘ $x + y + z$ ’ (Winnicott 2002 [1967], p.97), Winnicott suggests options such as the possibility of forming a ‘True and false self’ (Winnicott, 1965, p.140) or the ‘antisocial tendency’ (Winnicott, 1975, p.306). These are to defend against disintegration or annihilation of the self. Both of these options contain a ‘hope’ (Winnicott, 1975, p.309) that the true self is still intact and protected and that creativity through the maturational processes can still be achieved. Winnicott wrote:

As I have already indicated, one has to allow for the possibility that there cannot be a complete destruction of a human individual's capacity for creative living and that, even in the most extreme case of compliance and the establishment of a false personality, hidden away somewhere there exists a secret life that is satisfactory because of its being creative or original to that human being. (Winnicott, 2002 [1971], p.68)

However, Winnicott’s trajectory is deficient. It is not just a question of whether everyone can manage, all or some of the time, to utilise the true and false self-positioning. Winnicott’s theory of maturation lacks an essential component: spatialisation. While his theories of psychic development address the task of adapting to an external world, none of them include the crucial fact that the external world is framed in spaces. I aim to make my point by comparing his theories with spatialisation. Spatialisation and its consequences, such as the stages of my hypothetical Room-object Spatialisation Matrix, clarify or extend object relational thinking. In my view, transitional space implies a dimensional aspect, which is not explored. Spatialisation is the foundation of mental functioning and a site into which people retreat to gain stability, before

moving again to a more symbolic level. As I have argued, spatialising starts with mother to spatialise into, but if mother is not good, spatialising ‘tops up’ the mother function in rooms. Following Winnicott, I am informed by his concept of a pre-object environmental mother which is projected onto the walls of the room in Room-spatialisation. This maintains ‘hope’ and defends against disintegrations, creating a ‘holding’ together mother substitute space, that allows for the self to feel intact.

3.2 (iv) Fairbairn

Splitting: Inside bad and outside good

In William Ronald Fairbairn’s theory, relating to the circumstances of deprivation discussed above, when mother is not ‘good enough’, good and bad objects are split. Splitting for Fairbairn is like that for Klein, but the ‘good’ is projected outside into mother and ‘bad’ inside to retain hope of things becoming better. Fairbairn wrote:

The child not only internalizes his bad objects because they force themselves upon him and he seeks to control them, but also, and above all, because he *needs* them. If a child's parents are bad objects, he cannot reject them, even if they do not force themselves upon him; for he cannot do without them. Even if they neglect him, he cannot reject them; for, if they neglect him, his need for them is increased. (Fairbairn, 1992 [1952]), p.67)

My hypothesis gives another option: if mother is unavailable for spatialising, then the room becomes the projected mother function and the control, which Fairbairn and Klein suggest, is of the room. My formulation is an extension of Fairbairn’s theory, as the good is projected outside to the room space (stand in for mother function) but the self is expanded into, merged with the room space enabling it, therefore, to also remains good.

3.2 (v) Tustin

Hard, shell-like encapsulation

My hypothetical formulation of Room-spatialisation is similar to Francis Tustin's, in that it takes up an aspect of Tustin's hard, reassuring, autistic object: that it has dimensions. Objects exist in space as finite. Tustin writes of Autistic encapsulation

A hard, shell-like encapsulation is the psychodynamic differential diagnostic feature uniquely specific to autistic children. As Kanner realized, such children do not distinguish between live people and inanimate objects; they treat them both in the same way – by pressing against a hard wall, or against the hard part of a person as an inanimate object; (Tustin, 1990, p.17).

As with the above discussion regarding Winnicott's theory, where I have added that transitional objects can be spread out in space, in dimensions, I also suggest this, with Tustin's autistic object. As can be seen in figures 38 and 40, in my hypothesised Room-object Spatialisation Matrix, in my illustration for Stage 2 - *Primary Spatialised Room Transference (Room-object)*, the figure presses itself against the wall/ wall paper. The figure in that image was based on early accounts of Miss C, whose case I will treat in more detail in Chapter 6, when she talked about her relationship with her bedroom as a child, rubbing her cheeks against the wall paper and the walls to comforting herself. She said that she was conscious it was a comfort, as she felt very lonely and isolated and was often put in her room by mother which was experienced as a deprivation. Miss C was aware of making the wall a replacement for mother, whereas Tustin's description of the 'shell-like encapsulation' as more like my matrix, Stage 1 *Primal Spatialisation*, where the room is pre-object more like Winnicott's environmental mother, but the dimensional aspect. It's not just that the feeling of the wall was comforting, but that, as in the case of Tustin's autistic objects, it was felt to have limits in which she was contained.

3.2 (vi) Searles

Non-human world

Harold Searles writes specifically of the non-human world: 'It is my conviction that there is within the human individual a sense, whether at a conscious or unconscious level, of *relatedness to his nonhuman environment*, that this relatedness is one of the transcendently important facts of humans living' (Searles, 1960, p.6). And he also writes of 'a matter of regression to a primitive level of thinking, comparable with that found in children and in members of so-called primitive cultures, a level of thinking in which there is a *lack of differentiation between the concrete and the metaphorical*.' (Searles, 1962, p.23) I extend Searles thinking by adding spatialisation. His thinking on our relationship with the non-human world as well as the relationship between 'the concrete and the metaphorical' within it, is key to the building of my hypothetical formulations of spatialising and Room-spatialising. Searles also wrote about his relationship to early spaces:

My personal psychoanalysis, which concluded seven years ago, further deepened my appreciation of the significance of the non-human environment. I shall never forget, to give but one example, the grief I felt upon realising that the very building in which I had grown up, which had been sold some years before, was now lost to me forever. (Searles, 1960, p x).

I extend the idea he puts forward about his attachment to early room spaces by creating the hypothetical formulation of Room-spatialisation that addresses and extends it.

3.2 (vii) Bollas

Nesting places for our imagination

Christopher Bollas also writes about the loss of a favourite childhood place:

I have suffered the shock of losing this favoured place, and until I die it shall always be somewhere in mind. To lesser and greater extent, this is true of all of us, especially when

we move house. To leave a home, even when the contents go with us, is to lose the nooks and crannies of parts of ourselves, nesting places for our imagination. (Bollas, 2009, p.49)

Bollas suggests that favoured places from childhood relate to the imagination, with a suggestion that they are part of the mind. I extend this and say that; the space of a room can be introjected and then be re-projected into another room space or the consulting room.

John Stilgoe writes: ‘If the house is the first universe for its young children, the first cosmos, how does its space shape all subsequent knowledge of other space, of any larger cosmos? Is that house “a group of organic habits” or even something deeper, the shelter of the imagination itself?’ (Stilgoe 1994: viii). Like Bollas, Stilgoe writes about imagination, and Stilgoe suggests that the first house as a formative space. I extend this by suggesting that it stands in for the mother function. Bachelard writes:

[I]f I were asked to name the chief benefit of the house, I should say: the house shelters daydreaming, the house protects the dreamer, the house allows one to dream in peace. [...] it is because our memories of former dwelling-places are relived as daydreams that these dwelling-places of the past remain in us for all time. Now my aim is clear: I must show that the house is one of the greatest powers of integration for the thoughts, memories and dreams of mankind. (Bachelard, 2014 [1958], p.28)

Bachelard suggests that this formative space, can develop integration of thinking and is relived ‘as daydreams’. Adding to this, I suggest that my hypothetical formulation of Room-object spatialising can replace the mother function by creating an auxiliary mind in the space of the room, which can then be introjected, and re-created as an auxiliary mind through re-projection into other room spaces and the consulting room. While a house might be a transferenceal experience from mother, it is the space itself that I emphasise. That is not just an important

dimension of mother in the transference, but at more primal level, mother herself is created as an object through spatialising her.

3.2 (viii) Anzieu

Skin-ego

Didier Anzieu writes that, when the child has a difficult experience of being with the mother from the beginning, the Skin-ego provides ‘a containing and unifying wrapping around the Self’ (Anzieu, 2016 [1995], p105). When things are more problematic in development, then:

It needs strengthening. [...] The double wrapping – its own plus that of its mother – is gleaming and ideal; it provides the narcissistic personality with the delusion of being invulnerable and immortal. In the psyche it is represented by the phenomenon of the “double wall” (Anzieu 2016 [1995], p.135).

I am suggesting that this ‘double wrapping’, this “double wall”, is even more cemented and solidified by projecting the mother’s part of the double skin onto the actual walls of rooms.

Anzieu wrote of a case study of a boy called Juanito:

Juanito, who suffered from a congenital deformity, had had to undergo an operation soon after he was born. [...] The turning-point in Juanito’s treatment was a session in which he tore off a huge strip of paper from the wall; the washable paper was pasted up for children to paint freely on and that piece was not yet marked. He cut the paper into small pieces, got undressed and asked his therapist to stick the pieces all over his body, [...] In this way Juanito repaired the flaws in his Skin-ego caused by the lack of tactile and auditory contacts and bodily handling by his mother and other carers which had been unavoidable during his hospital stay. (Anzieu, 2016, pp.70-71)

This case is similar to the situation which Miss C described (p74) of touching the walls of her room and hugging them so she can feel hugged by them. I am suggesting that this patient Anzieu

writes of, is demonstrating a Room-object spatialisation re-projection into the space of the consulting room, behaving towards it as if it was this additional skin, relating to Anzieu's concept of 'double-wall' (Anzieu 2016, p.135), enwrapping or enveloping to replace mother. I build on this, with my hypothesis that the whole room and the spatial array of objects in its contents can be employed for Room-spatialisation purposes.

3.2 (ix) Bick

The skin functioning as a boundary

Bick and Anzieu show that there is an awareness of spatialisation, albeit undeveloped, in that both focus on the containing, outer layer of the being – skin: how it is dealt with and experienced. As Bick writes:

in its most primitive form the parts of the personality are felt to have no binding force amongst themselves and must therefore be held together [...] by the skin functioning as a boundary. But this internal function of containing the parts of the self is dependant initially on the introjection of an external object, experienced as capable of fulfilling this function. [...] Until the containing functions have been introjected, the concept of a space within the self cannot arise. (Bick, 1968, p.484).

As mentioned above I am suggesting that I extend the skin function to the wall function and also extend Bick's theory by suggesting that the walls provide an auxiliary containing function in absence of the 'concept of a space within the self' for thinking (as also discussed by Wollheim [1969]).

3.3 Proposed hypothetical formulation of the stages of the Room-object Spatialisation Matrix

Below, I will set out what I call (the hypothesised) the Room-object Spatialisation Matrix (see fig, 38). I conceive of it in terms of five stages.

The 5 stages of the Room-object Spatialisation Matrix descriptions:

3.3 (i) Room-object Spatialisation Matrix: Stage 1) Primal Spatialisation

The Room-object Spatialisation Matrix: Stage 1) *Primal Spatialisation* (see fig. 39) is where parts of the mother's body are spatialised to constitute the object. It is the pre-object, pre-transferential creation of mother, where spatialising is a method of creating an object, bringing together parts of the object to form a whole, which is retained in transferences. This is what is

Diagram of the stages of the Room-object Spatialisation Matrix

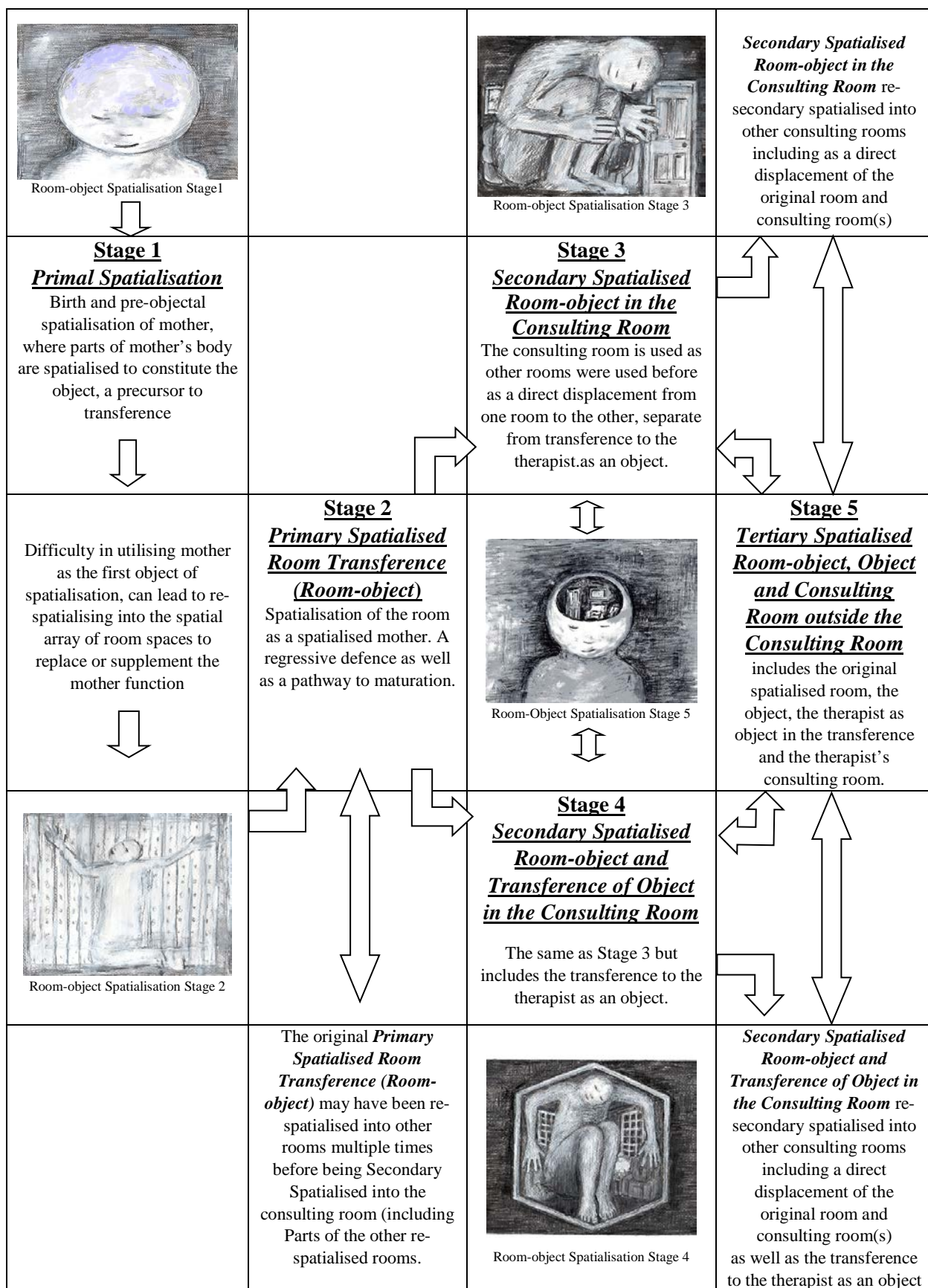


Figure 38: Diagram of the stages of the Room-object Spatialisation Matrix

new: it is developmentally prior to object relations and therefore to transference. The primitive target of the babies' earliest spatialisation and the source of future transference. It is the beginnings of anchoring experience in perceptual reality, which is spatial. It is the primitive establishment of objects by having dimensions, being in space. *Primal Spatialisation* underlies



Figure 39: Room object Spatialisation Matrix: Stage 1 - *Primal Spatialisation*, by D. Wright

all spatialisation activity, so all spatialisation is like the original spatialisation of mother as an object from parts of mother/mother's body, and this creating the object action is re-enacted via spatialisation to defend against the losing or damaging of the object the object.

3.3 (ii) Room-object Spatialisation Matrix: Stage 2) Primary Spatialised Room Transference (Room-object)

In Room-object Spatialisation Matrix Stage 2 *Primary Spatialised Room Transference (Room-Object)* (see fig. 40): I hypothesise that difficulty in utilising mother as the first object of

spatialisation, can lead to spatialising into the spatial array of room spaces to replace or supplement the mother function. This second stage is an introjection of the maternal object and a re-projection into a 'room', which can also be transferred to specific rooms. The room becomes a collection of objects as part of a whole mother with objects inside her or dispersed around her body from which the object is constructed. The room in which spatialisation occurs can be the



Figure 40: Room-object Spatialisation Matrix: Stage 2 - *Primary Spatialised Room Transference (Room-object)* which fulfils mother function, by D. Wright

means of anchoring experience in perceptual reality, which is spatial, as a stand in or top-up to the mother /object function. The room is a substitute mother/mother function. It is a transference from mother to a space, then that space is used, on its own, as a resort when containment fails, fulfilling the mother function as an auxiliary containing space. This *Primary Spatialised Room Transference (Room-object)* gets used to make the room an object as a defensive reaction to

maternal failure, a regressive defence and pathway to maturation. The primary room transference may have been re-spatialised multiple times before secondary spatialised in the consulting room.

3.3 (iii) Room-object Spatialisation Matrix Stage 3) Secondary Spatialised Room-object in the Consulting Room

The Room-object Spatialisation Matrix Stage 3) *Secondary Spatialised Room-object in the Consulting Room* (see fig. 41) is where the consulting room is used as the original room was used for Stage 2, *Primary Spatialised Room Transference (Room-object)*, as a direct displacement from one to another, separate from the transference to the therapist as an object. It



Figure 41: Room-object Spatialisation Matrix: Stage 3: *Secondary Spatialised Room-object in the Consulting Room*

is a relationship with the consulting room as a representative of the original primary spatialised room, this also includes the spatial array of spaces around the consulting room - such as the toilet, hall way and so on and can be extended to the street. Just as in the Stage 2) *Primary*

Spatialised Room Transference (Room-object) room, features of the *Primary Spatialised Room* stand out because they stand in for features of mother, here in this Stage 3) *Secondary Spatialised Room-object in the Consulting Room*, features of the consulting room also stand in for the features of mother as the *Primary Spatialised Room* did, but also the consulting room has features that stands in for the *Primary Spatialised Room* itself. In addition, the original *Primary Spatialised Room Transference (room-object)* may have been re- spatialised multiple times into other rooms before the consulting room, so therefore features of the consulting room may stand in for those other re-spatialised rooms also. In the case of Stage 3, this can happen before the patient is able to utilise the therapist very much at all, or able to relate to the therapist transference, therefore the role of the consulting room is providing a very important function as enabling the patient to engage at all.

3.3 (iv) Room-object Spatialisation Matrix Stage 4) Secondary Spatialised Room-object and transference of Object in the Consulting Room

In the Room-object Spatialisation Matrix stage 4 – *Secondary Spatialised Room-object and transference of Object in the Consulting Room* (see fig. 42) secondary spatialisation occurs in exactly the same way as Stage 3) *Secondary Spatialised Room-object in the Consulting Room* (described above), except here in Stage 4, the spatialisation also includes the transference to the therapist as the object. Therefore aspects of the Consulting Room, as the object/therapists room, are also associated with the therapist as object constituents of the object therapist, so for example a cushion could represent part of the therapist’s body/skin.



Figure 42: Room-object Spatialisation Matrix: stage 4- *Secondary Spatialised Room-object and Transference of Object in the Consulting Room*, by D. Wright

3.3 (v) Room-object Spatialisation Matrix Stage 5) Tertiary Spatialised Room-object, Object and Consulting Room outside the Consulting Room

The Room-object Spatialisation Matrix, Stage 5) *Tertiary Spatialised Room-object, Object and Consulting Room outside the Consulting Room* stage specifically refers to what goes on back outside the consulting room after being in or whilst in the consulting room. It is a re-spatialisation of the consulting room outside the room. So, this includes the original Stage 2 *Primary Spatialised Room Transference (room-object)* of mother/object transference to the original room and all re-spatialised rooms before the consulting room. It also includes Stages 3 *Secondary Spatialised Room-object in the Consulting Room* and Stage 4 *Secondary Spatialised*



Figure 43: Room-object Spatialisation Matrix: Stage 5: *Tertiary Spatialised Room-object, Object and Consulting Room outside the Consulting Room*, by D. Wright

Room-object and transference of Object in the Consulting Room. This Stage 5) *Tertiary Spatialised Room-object, Object and Consulting Room outside the Consulting Room* can function as a top up to the function and role of the consulting room as a container as separate from and alongside the therapist as the object in the transference.

3.5 Conclusion

In this chapter, I have reviewed a number of main-line psychoanalytic theories in the object relations tradition. I have highlighted particular aspects in which my theory of spatialization adds an important dimension, where existing theory falls short of and builds my alternative hypothetical formulations. In the next chapter I go on to look at contemporary literature relating to the consulting room to see whether anything like these formulations has been written about.

Chapter 4

Literature Review

4.1 Introduction

In the last chapter, I set out my formulation of the Room-object Spatialisation Matrix, formulated from Data sets 1 (Historical and Cultural – literature), 2 (Freud's writings) and 3 (Object-relations and Winnicottian theory). In this Chapter, I will critically review the psychoanalytic literature, relating to the role of the consulting room, to investigate whether there are any like theories, that can be found, and to show, therefore, what gap this study fills in the literature.

4.2 Contemporary Psychoanalytic Literature Relating to the Role of the Consulting Room

As referred to in Chapter 2 (p55), Myers wrote of the use of a rug in the consulting room. He writes that after giving an interpretation to his patient, 'she began to rock back and forth and to cry. She took one of the Moroccan carpets I have thrown across my couch and wrapped herself in it, as in a swaddling blanket. The transformation from seductress one moment to wounded child the next was quite startling (Myers, 1994, p.1167). The object in the room (carpet) appears to have had a transformative role in the work alongside the interpretation.

Michael Parsons wrote,

The internal analytic setting is a psychic arena in which reality is defined by such concepts as symbolism, fantasy, transference and unconscious meaning. These operate throughout the mind, of course. The point about the analyst's internal setting is that, within it, they are what constitute reality. Just as the external setting defines and protects

a *spatiotemporal* arena in which patient and analyst can conduct the work of analysis (Parsons, 2007, p.1444; emphasis mine).

Michael Parsons suggests that in the ‘spatiotemporal arena’ of the consulting room, ‘symbolism, fantasy, transference and unconscious meaning’ are present, by which he infers that symbolism and fantasy might be additional to transference, but he does not go further into this idea in relation to the role of the consulting room.

Stephen Kurtz writes of the consulting room as a ‘shared space – jointly created by analyst and patient – belonging to the realms of play and theatre. [...] [A] new playground in the safety of the consulting room.’ (Kurtz, 1986, pp.100-102), which suggests relating and transference and Patrick Casement refers to ‘relationship-space’ (Casement, 1999 [1985], p.192). We should note that ‘space’ is commonly used in psychoanalytic writing, but without regard to its essential physical spatial reference.

Elizabeth Danze wrote about the consulting room from an architectural perspective,

This special room becomes the explicit and specific territory of this uniquely formed relationship. There is no other *architectural space* that has precisely the same programmatic demands as this one. All five senses are engaged in this intimate and sublime relationship and place. [...] At the same time, the objects, items, and art present in the room might provide opportunities for association. (Danze, 2005, pp.109-118; emphasis mine).

Elizabeth Danze considers the ‘specialness’ of the physical space of the consulting room, with some descriptive architectural language and an idea of the importance of the space and the contents. She provides no case study, however, and therefore does not exemplify the possible meaning for a patient. The spatial dimension provides an, often missed, opportunity for an enriched meaning.

Henry Abramovitch takes up the case of moving consulting rooms, which I will explore in detail later, pointing out that:

the move was a case of ‘temenos lost’[...] at the time of a move, a dialectic between ‘therapeutic relationship’ and ‘therapeutic space’ emerges. A move disrupts the therapeutic unity of ‘person-place’ and forces the participants to confront how much of the therapeutic process is dependent upon the transference to *place* (Abramovitch, 1997, pp.570-572; emphasis mine).

This is an important piece of literature. It is the only paper that I could find referring to room moves, in relation to the patient’s experience of them. He also has identified that room moves ‘confront how much of the therapeutic process is dependent upon the transference to place’. This emphasis is important because it is the only reference to transference to place. He suggests its importance, but does not explicitly say that it is separate from transference to the therapist. In referring to the room as the ‘Temenos’ (a sacred space in a Greek temple precinct), he is thinking about the room itself having a healing entity of its own and opportunity for transference. His use of ‘Temenos’ is much like Freud’s description of the ‘purificatory baths, or the elicitation of oracular dreams by sleeping in the temple precincts, can only have had a curative effect by psychical means’ (Freud, 1890, p292).

Marilyn Mathew writes about a patient's experience outside the consulting room, in her own bedroom, in which she:

seems to have latched on through the window to the wind in the tree tops - [...] perhaps an unconscious reminder of the paintings of trees in my consulting room. By anchoring her external vision she found that she could let go and open up enough to allow the process of reverie and re-integration to spin a stronger internal structure and a more flexible containing membrane around herself’. (Mathew, 2005, p.387).

The visual memory of the painting seemed to act as an important mechanism for linking the two rooms, the room at home and the consulting room, although the actual painting is not described in the paper. This piece exemplifies the importance of the meaning of locations and objects within the space linking with the location of the patient's own room. Here is a reference to an item from the consulting room that has been effectively (in my formulation) introjected and then re-projected to the view out of the window of the room. This seems to suggest an efficaciousness of the experience at home relating to the consulting room introjected. It is unclear whether Mathew is saying that this is related to transference.

Benjamin Brent also provides a case study in which the physicality of the room is prominent in the work,

It was the first day of our psychotherapy. James walked into my office and, before I had the opportunity to recommend a place to sit, he said, "That's my chair," and sat down. My office consisted of a desk and two similarly appearing chairs. On the desk were pens, paper, and some articles that I had been reading. Of the two chairs, one—the one in which James seated himself—was situated at the desk. My briefcase rested just next to it. I sat down in the unoccupied chair and began to wonder what this meant [...]. Over the next several weeks, James and I engaged in a sort of musical chairs. (Brent, 2009, pp.809-810).

As it continues Brent gives interpretations and thoughts to the patient regarding the meaning of what is happening in the space. Although Brent's case study is brief, it is a good illustration of the importance of the physicality of the room within the psychoanalytic work, considering the importance of the objects in the room as they are seen and used symbolically and become of therapeutic importance (as they can be used for spatialisation in the spatial array of the consulting room). This is reminiscent of Freud's (1907) paper on the meaning of the chair in the

room (as discussed on p54). One could argue that it is a straight transference, with the patient putting the analyst in place of the father, and expropriating his dominance, however, the mechanism is nonetheless spatial.

Sylvia O'Neill writes about the creativity in the room being facilitated by the setting in the consulting room, which Donnet calls the 'site', which the patient finds and uses in the same way as a 'transitional object'; did they create or did it already exist. She illustrates this with a case study,

Carl asked whether, during his sessions, it would be possible for the wall clock to be removed, or moved at least from his visual field. In a previous psychotherapy the loudly ticking desk clock, which had disturbed him, had been obligingly shut away by the therapist in the desk. Now, my clock was about to be moved! I told Carl that my clock was actually about to be moved to the wall adjacent to him, but that perhaps in the course of his treatment we might be able to enquire into, and possibly come to understand, what was so disturbing for him about it. [...] Was it pre-existent *in the site*, this element of the psychotherapy site that allowed him to find a meaningful conjunction of his past life, his current life outside, and his immediate experience within the session? [...] Although creativity in psychoanalysis may seem to imply a creatively interpreting analyst, I have argued that a more apt and accurate standpoint is to be found in Donnet's theory of the analytic site. From this standpoint, the factor that facilitates creativity is the setting, or *site*, and the patient's transformational introjection of it. (O'Neill, 2015, pp.466-474; emphasis mine)

Here O'Neill explores the role of the consulting room with a case study. Like the Brent's example of the chair, it shows the patient's focus on the clock. O'Neill is suggesting that the

consulting room is more an intermediate area of experiencing, but that it is in the transference that the separation and intermediate area is occurring.

4.3 Psychoanalytic Literature Concerning Dimensions and Space

Donald Meltzer writes that:

‘to spell out the theoretical formulation briefly. It is our view that, insofar as an organism can be said to have a mental life and not merely to exist in a system of neurophysiological responses to the stimuli coming to it from internal and external sources, it lives in ‘the world’ and this world may be variously structured. One has perhaps become accustomed to think of ‘the world’ as four-dimensional and constituting the ‘life-space’ (K. Levin) of the organism. From the psycho-analytical viewpoint this life-space may be said to comprise the various compartments of the ‘*geography of phantasy*’ (Meltzer) moving on the dimension of time. This geography is ordinarily organized into four compartments: inside the self; outside the self; inside internal objects; inside external objects; and to these may sometimes, perhaps always, be added the fifth compartment, the ‘nowhere’ of the delusional system, outside the gravitational pull of good objects. (Meltzer, 1975, p.223; emphasis mine).

Meltzer is writing about dimensions within and around the individual, looking at Bick’s theories about skin, as well adhesive identification in Autism, as I have in Chapter 3 formulating my alternative theory. His theorisation also related to introjection and projection (including projective identification), although his formulations are not explicitly related to what I call spatialising.

Robert Young looks at various aspects of spatiality in psychoanalytic theory, such as projective identification, potential space and transitional phenomena. He also looks at countertransference and the analytic space. He wrote:

The history of thought about the mind and feelings is a terrible muddle. What I am seeking is a sense of the possibility of mental space, not what's in it. The goal of humanity and of psychoanalysis is the facilitation of a suitable space for containing, ruminating and making use of experience (Young, 1994, p.34).

Young is interested in space as a rich concept, a metaphor, rather than the literal idea of space as dimension, at a primitive or psychotic level, as Wollheim and Meltzer do and which I am developing in this study.

Rosine Jozef Perelberg looks at space in relation to time, phantasy and memory 'Within the analytic space, different dimensions of time unfold, and a tension between the old and the new is set in motion, In between the patient's presentation [...] and the analyst's response through his internal work [...] specific dimensions of time and space are created in the context of that relationship. (Perelberg, 2008, p.132).

She also looks at space in relation to

'two categories of patients that differ in terms of the impact they have on the analyst. On the one hand there are patients who create an empty space in the analyst's mind. [...] The patient may bring dreams and associations, but they do not reverberate in the analyst's mind. [...] At the other extreme there are patients who fill the consulting room not only with their emotions and their actions, but also with their words, dreams and associations. (Perelberg, 2008, p.870)

Andrea Sabbadini also focusses on the time boundaries of the analytic space as well as the physical boundaries of the consulting room. It seems that ‘space’ needs to be differentiated, and it seems that my stages of spatialisation capture the range of meaning in the literature.

4.4 Architecture, Space and Psychoanalytic Concepts that Relate to the Consulting Room

Cosimo Schinaia looks at different aspects of architecture from a psychoanalytic perspective, including the consulting room. The format that the book is more of a literature review of architectural references relating to psychoanalysis, including Danze (above) and a commentary on the interior of Freud’s consulting room. He does not discuss theory relating to the role of the consulting room or offer much insight into the analyst’s experience.

John Shannon Hendrix, and Lorens Eyan Holm, (2016) edit this book of the writings of architects (including Jane Rendell [below]) on ‘Architecture and the Unconscious’ using some psychoanalytic theory to describe and make sense of the architectural spaces. However, they also do not discuss theory relating to the role of the consulting room.

Jane Rendell looks at architecture relating to Russian constructivist theory. However, although she uses some psychoanalytic theory, such as transitional space, as well as using diagrams by Freud, as illustrations, she offers no explanation at all about how they fit with her theories, and she draws very little from psychoanalytic thinking in relation to the architectural spaces she describes. And although she uses drawings of Freud’s consulting room, these are again illustrations with no explanation nor any thinking about either Freud’s consulting room, or consulting rooms generally.

4.5 Conclusion

In this chapter I have shown that current literature on space says very little about the space of the consulting room. To the extent that literature is relevant to my topic, it usually does not distinguish spatialisation as a concrete phenomenon, from space as a metaphor for various ideas, such as containment and thinking itself, as in thinking space. This deficit makes my study timely, and I will now outline my methodology.

Chapter 5

Methodology

5.1 Introduction

In the last Chapter, I presented a critical literature review, showing that there is very little written or theorised, about the role of the consulting room. In this chapter I look at my methodology and methodological tools for this study.

5.2 The Research Study Setting and its Rationale

5.2 (i) Rationale for the Use of Case Studies

The case study is suited to my investigation of theory, and as Hinshelwood writes ‘The case study is observation under laboratory conditions’ and also that it ‘brings psychoanalysis closer to natural science experiment than to psychological or medical research. (Hinshelwood, 2013, pp.103-104). Here I am testing my hypothesis, utilising case material, which is like observing the consulting room under a ‘microscope’ (Hinshelwood,2013, p.97). Case studies provide the best possible conditions to give accurate evidence of primitive, pre- object material. In bringing clinical evidence to bear, I am concurring with Jan Abram and Robert Hinshelwood, who wrote:

There are also laboratory methods for scientific investigation of babies, developed by Margaret Mahler, Daniel Stern, Colin Trevarthen, and many others [...]. However, clinical listening to conscious and unconscious expression of experience is the primary source for understanding the issues and puzzles arising in infancy. (Abram & Hinshelwood, 2018, p.42)

Abram and Hinshelwood suggest, that ‘clinical listening’ is the ‘primary source’ for understanding early mechanisms. I follow them in my conviction of that, so the clinical case is the appropriate data source for testing for my hypothetical Room-object Spatialisation Matrix stages formulation.

5.2 (ii) The Clinical Research Study Setting

The clinical research setting was a consulting room move. More precisely, it was two consulting rooms (and an interim room used as a temporary consulting room) and two moves of my patients between these consulting rooms. These moves occurred as follows. The original consulting room 1 (see figs. 44 and 45) was located in my home, at the door end of my living room area. I used that space as my consulting room for six years. I explained to the patients 6 weeks before the move what would be happening, the time frame, where the new room would be (in the corridor adjacent to the room they were in), as well as where the interim, temporary room would be for the 2 weeks building period. They were given a map of this with the address on it and the dates.

1. During a temporary interim of two weeks, my patients moved to consulting room 2 (see figs. 44 and 45) while the new consulting room was being built. This interim temporary consulting room 2 was located in a community building, next to a church, it was known as ‘The Church Centre’ and it was situated a quarter of a mile along the main road from consulting rooms 1.
2. At the end of the interim, construction period, the patients moved into the new consulting room 3 (see figs. 45 and 46) which, like consulting room 1, was in my home, this time in the room immediately inside the front door where the kitchen had been.

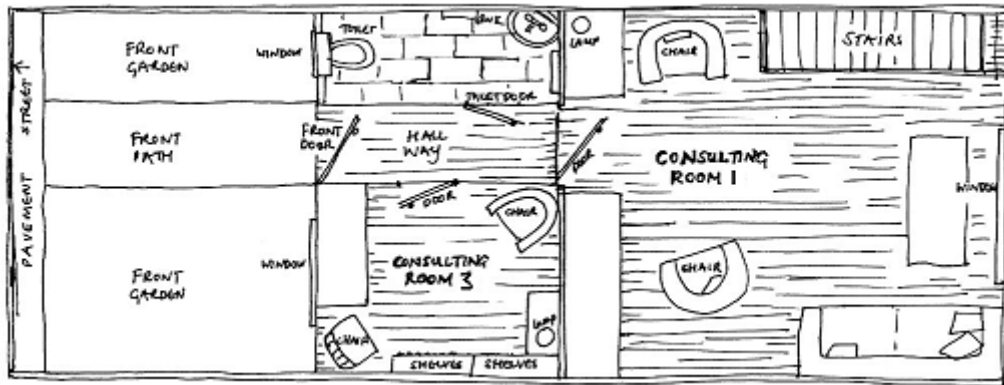


Figure 44: Original consulting room 1 & new consulting room 3 by D. Wright

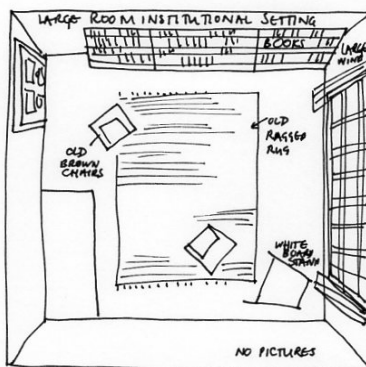
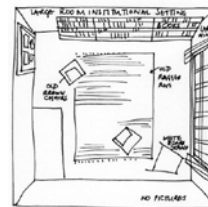
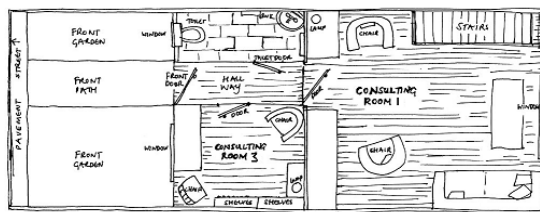
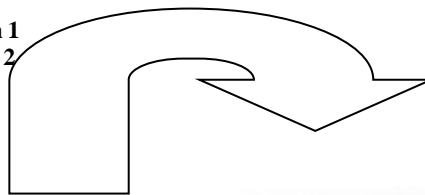


Figure 45: Temporary consulting room 2 by D. Wright

Diagram of the Study Setting – Two Consulting Room Moves

Move 1: from Consulting room 1 to temporary Consulting room 2



New Consulting Room 3 & Original Consulting Room 1

Temporary Consulting Room 2

Move 2: from temporary Consulting room 2 to new Consulting

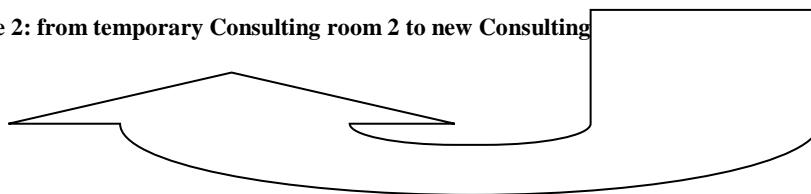


Figure 46: Diagram of the study setting - two consulting room moves by D. Wright

5.2 (iii) Rationale for the Research Study Setting

My rationale for using the period of the three room moves as a setting for this research study, was that in my experience of previous room moves, they create an increased focus on the consulting room. Spatialisation – the geography of the therapeutic process – is emphatically brought out by the moving in and out of spaces. There is therefore more expression of feelings and thoughts about the consulting room, and what I call spatialisation in relation to the consulting room to be observed. The two moves present an opportunity to observe the relationship of the patients to the three different rooms before, during and after being in them.

5.3 Research Participants

The patients were in my private psychotherapy practice. They had moved consulting rooms with me, 60 months ago, and their reactions to the moves were clearly observable. These four patient case studies form a sample of my patients from that period. One male and one female patient, who I had worked with for a number of years and done several room moves with, and one male and one female patient who I had worked with for under a year and for whom this was their first move. This offered an opportunity to look at their differing relationships with the room, offering a wealth of observations as data. One key feature, brought out by these two sets of cases, was the difference in the patient's relationship to the room depending on the amount of time they spent in the room and how many moves they have previously done in them. In particular, whether it made a difference to their transference relationship to me and their projection onto the room. I discuss this in Chapter 7. The patients whose case material utilised in this study are referred to as Miss A, Mr B, Miss C and Mr D.

5.3 (i) Miss A

Miss A was in her late teens when she began psychotherapy with me eight months prior to the room move. Her presenting problem on beginning psychotherapy was anxiety and repetitive anxious thoughts regarding foreboding dangers and potential disasters, which were “triggered” by seeing things on the news, newspapers, magazines, television programmes or films. In addition, she had suffered from a joint disorder (Hypermobility) as a child which, became acute and connected with the onset of M.E. around age 14. She lives at home with parents and one older brother. It was an increasing issue for her at home, that the four adults were living in the house together, where she felt that there was not enough space or privacy. She did not feel like she was treated as an adult at home - her room was constantly walked into by her parents, but she also liked to go into parents’ bedroom when anxious to get away from the ‘bad’ feelings in her own room. There was competition with her Father over access to her Mother. When beginning the work, the repetitive obsessive thoughts were debilitating and restrictive to normal functioning, which, together with the chronic/increased symptoms of M.E., meant that she was not working or studying. Toward the end of the time in consulting room 1, she was coming out of this, her obsessive thoughts were greatly reduced, and she had got a job. During the move she also focussed on moving into a new bedroom in her house which felt more private and grown up. paralleling the work on the new consulting room.

5.3 (ii) Mr B

Mr B, in his mid-forties, had been in psychotherapy for six months prior to the move from consulting room 1. His presenting problem was a history of depression and long-term use of anti-depressant medication. As a child he was close to his Mother, who was intrusive and dominating. His two older brothers called him a “mummy’s boy”, He talked in the sessions about having no sense of ownership over either the space of his childhood bedroom or its contents – he can’t remember having any things or toys except a womble pillow case. Approaching the room

move, Mr B built a room of his own in the garden (summer house) which he reported to be his first ever room, paralleling the work on the new consulting room

5.3 (iii) Miss C

Miss C, early 40's, had begun work with me a number of years earlier, done several consulting room moves and had been in Consulting room 1 for 6 years. Her presenting problem related to early abuse by paternal grandfather, her relationship with her Mother as well as Mother's partner (from aged 5) who was abusive to Miss C. Her father left her mother when she was two. He had been addicted to drug and alcohol. She began working with me aged twenty-seven. She had lived in many flats and rooms since leaving home and has no contact with her Mother. She had a good relationship with her maternal grandmother as a child; it was the only safe place she had to go. At the time of the room move she had moved in with her father, as a hope of a new start with him, and looked at beginning an ending of her psychotherapy. However, during the period of the room move all of the meanings for the new room, as well as her room at her Father's, (their new start and her ending therapy) fell apart, and she had to find new accommodation, and stay in the therapy.

5.3 (iv) Mr D

Mr D, in his mid-fifties, had been in therapy for a number of years at the time of the room move. He had done two previous consulting room moves, and had been in consulting room 1 for six years. His presenting problem related to early abuse and difficulties in relationships with women. His parents were from the Caribbean. His Father died when he was a teenager, which was very disturbing at that time. He left university and ran away from home, thinking he had to replace father, and lived a lot of that time in hostel accommodation. After a few years he returned home and has lived there since. He is the eldest of his siblings and lives at home with some of those siblings and his mother. He feels that he is neither appreciated by his mother, nor treated like an adult man. He owns a share of the property but he felt that he had little choice or say in his home.

He recently moved out of his childhood bedroom for his baby niece to have the room and whilst building work was going on to extend the house, he was in a temporary room that people walked through. He then moved into a new room, although he felt like it was not his choice, and he felt displaced and unsettled in his new accommodation. During the consulting room move, he did a lot of work in the new bedroom to make it comfortable paralleling the work on the new consulting room.

5.4 Ethical considerations

The research participants will remain anonymous, and every attempt will be made to ensure anonymity by changing or omitting personal information. Ethical Approval for this project was granted by the University Ethical Approval Committee on 21/02/2017. A 'Research Participant Information Sheet' was given to each patient invited to be included in the study and a 'Research Consent Form' was signed by each.

5.5 Data set 4- Clinical data collection

For the data collection of Data set 4 – Clinical data, I utilised clinical material from process notes, written after each session, as part of normal therapy note taking. The setting for this research study, and therefore the material used, took place before I began the Professional Doctorate. I had no research question in mind when I worked with the patients. The work of psychotherapy and data derived from the material are, unaffected by the research project. The use of retrospective notes is in line with the recommendation of Hinshelwood (2013). The material used as data covers a period of 6 months – 3 months prior to and 3 months after the two-week moving period. The period before the room move shows material relating to the patient's expectation of the move and the new room, as well as their feelings about the temporary interim

room for 2 weeks), and then from after the move shows their reflection on their prior expectations and their actual experience of the move and of the new consulting room. The criteria for notes being included in the study, is that they make reference to the space of the consulting rooms or the room move.

5.6 Steps of the project

Step 1) The sources leading to the formulation of my hypothesis are Data set 1 - anthropological, phenomenon, previous residential and clinical experience, Data set 2 - Freuds writings and Data set 3 – object relation and Winnicottian theory. (Chapters 1-3)

Step 2) I formulated a hypothesis from these Data sets 1-3 of the Room-object Spatialisation Matrix Stages (Chapter 3).

Step 3) Step 3 (i) Operationalisation determinants definitions for testing the hypothesis.

Step 3 (ii) I tested my hypothetical formulation of the Room-object Spatialisation Matrix Stages utilising Data set 4 (clinical material) in order to demonstrate the hypothetical matrix stages in particular the pre-transferential aspects.

Step 3 (iii) Identification /Discussion of where, when and how the stages appear, if they appear and how that might increase our understanding if these (discussed in chapter 7)

5.7 Research hypothesis

My research hypothesis is that:

Spatialisation simultaneously involves a psychological projection of meaning and physically acting upon the environment, utilised to master the undifferentiated, relentless, internal pressure of instinct. I suggest that this can take place on a matrix of stages (that I am calling the Room-

object Spatialisation Matrix), the first of which - *Primal Spatialisation*, takes place into mother/parts of mother to create the object, this is pre-object and therefore pre-transferential. I suggest that a difficulty in utilising mother as the first object of spatialisation, can lead to the second stage of the Matrix – *Primary Spatialised Room Transference (Room-object)*, where spatialising into the spatial array of room spaces and the objects within them replaces or supplements the mother function. Secondary Spatialisation can occur in the consulting room in 2 ways – firstly where (stage 3) *Secondary Spatialised Room-object in the Consulting Room* - the consulting room is used as the original site of *Primary Spatialised Room Transference*, displaced or secondary spatialised to the room, separate from transference to the therapist and additionally functions as a supplement or top-up to the function of the therapist. And secondly, where stage 4: *Secondary Spatialised Room-object and transference of Object in the Consulting Room* operates in the same way as stage 3 but includes transference to the therapist. Stage 5 - *Tertiary Spatialised Room-object, Object and Consulting Room outside the Consulting Room* includes the original spatialised room, the object, the therapist in the transference and the therapist's consulting room. These stages representing a regressive, defensive function as well as a maturational one as a form of rudimentary containing mind.

I test this hypothesis utilising Data set 4- Clinical Data, in order to demonstrate the hypothetical matrix stages, in particular the pre-transferential aspects which open the way to demonstrating that spatialising into the room is not always related to the transference to me, the therapist, and thus evidence that the new view of transference is valid – and therefore an alternative to the standard view.

5.8 Operationalisation for hypothesis testing with Data set 4

Operationalisation determinants definitions are formed from each of the matrix stages of the

hypothetical matrix in order that there is a clear criterion for how each of the matrix stages might be defined for recognition and identification in the material, during the testing of my hypothetical Room-object Spatialisation Matrix stages utilising Data set 4. This includes approaching the material with a number of factors in the operationalisation determinants; the content of the words said, the physical expressions and movements of the patient and their physical interactions with the room space as well as my own counter-transference feelings. Hinshelwood discusses 'using the recommended method of selecting occurrences by triangulation of content and counter transference' (Hinshelwood, 2013, p.153). Hinshelwood discusses triangulation here as relating to giving at least two perspectives in relation to the data (material and countertransference) that allow for a more reliable and secure interpretation, because it is supported by a credible exclusion of counter-transference distortion therefore there is more surety of its reliability. Paula Heimann wrote on the importance of the use of counter-transference: 'The analyst's counter-transference is an instrument of research into the patient's unconscious [...]. From the point of view I am stressing, the analyst's counter-transference is not only part and parcel of the analytic relationship, but it is the patient's creation, it is a part of the patient's personality.' (Heimann, 1950, pp.81-83).

Operationalisation determinants definitions:

Stage 1) Primal Spatialisation – operationalisation determinant definition:

- **Operationalisation determinants definitions -when *Stage 1- Primal Spatialisation* is recognisable in the data /material:**

Stage 1- all spatialisation is like the original spatialisation of mother as an object from parts/part objects of mother/mother's body, and this action is re-enacted via spatialisation characterised by projection and action. It is pre-object and pre-transferential.

In Material: ritualised and one-off spatialising activities such as hand washing, chair

stroking, it is non-symbolic pre transferential and therefore characterized by projection and action.

In Counter-transference: would include that the patient's feelings about the room seem separate, nothing to do the therapist, the feeling that the patient's feelings about the room are irrational, inaccessible and make no rational sense. These are pre-transferential, pre-object, primitive feelings. Also, feelings of exclusion, disconnection, no sense that the situation involves the therapist, feelings blank, bemusement or cut off.

Stage 2) Primary Spatialised Room Transference (Room-object)-operationalisation determinant definition:

- . Operationalisation determinants definitions when - *Stage 2) Primary Spatialised Room Transference (Room-object)* is recognisable in the data:

Stage 2 is an introjection of the maternal object and a re-projection in 'room', which can also be transferred to specific rooms.

In Material: the patient's talking about rooms that were either the original room where *primary spatialised room transference* took place or rooms subsequent to that, but before the consulting room that were re-spatialised.

In Counter-transference: the patient's feelings about the room seem separate, nothing to do the therapist, the feeling that the patient's feelings about the room are irrational, inaccessible and make no rational sense. Also, feelings of exclusion, disconnection, no sense that the situation involves the therapist, feelings blank, bemusement or cut off. (pre-transferential)

Stage 3) - Secondary Spatialised Room-object in the Consulting Room operationalisation determinant definition

- Operationalisation determinants definitions -when *Stage 3 - Secondary Spatialised Room-object in the Consulting Room* is recognisable in the data:

Stage 3 is where the consulting room is used as other rooms were used before as a direct

displacement from one to another separate from the transference to the therapist as an object.

In Material: it could involve ritualistic or one-off activity, including in the spatial array of spaces around the consulting room- such as the toilet, hall way and street relating to patients' emotion relating to the room which are unconscious or painful, overwhelming, and confusing. In the case of the move; obsessive fixation on the original room, high anxiety apparent inability to think about the new room, stuck, unreachable, panicking, intolerable anxiety and primitive feelings and thoughts that cannot be contained.

In Counter-transference:

The countertransference feelings are, as with stage 1 and 2 unrelated to the transference to the therapist (me) from transference: the patient's feelings about the room are separate, nothing to do the therapist, the feeling that the patient's feelings about the room are irrational, inaccessible and make no rational sense. Also, feelings of exclusion, disconnection, no sense that the situation involves the therapist, feelings blank, bemusement or cut off.

Stage 4) - Secondary Spatialised Room-object and transference of Object in the Consulting Room - operationalisation determinant definition

- **Operationalisation determinants definitions -when Stage 4) - Secondary Spatialised Room-object and transference of Object in the Consulting Room is recognisable in the data:**

Stage 4 is the same as stage 3, but includes the transference to the therapist, as the object, and therefore the room can also be related to the room and items in it relating the therapist as object.

In material: same as stage 3, above, as well potentially relating the physical space of the room and the objects in it, to parts of the therapist as object e.g. the cushion is part of the

therapist as object's body and like their skin.

In Counter-transference: could simultaneously have non-transferential aspects of spatialising (but in the consulting room) where the patient's feelings about the room are separate, nothing to do the therapist, the feeling that the patient's feelings about the room are irrational, inaccessible and make no rational sense. At the same time, clear countertransference feelings that what the patient is saying relates to the therapist and a dynamic between us, this might involve feelings towards the patient such as irritation, anger guilt or worry and so on.

Stage 5) - Tertiary Spatialised Room-object, Object and Consulting Room outside the Consulting Room- operational determinant definition

- **Operationalisation determinants definitions -when Stage 5) - Tertiary Spatialised Room-object, Object and Consulting Room outside the Consulting Room is recognisable in the data:**

Stage 5 specifically refers to what goes on back outside the consulting room after being in or whilst in the consulting room.

In Material: relating to a room outside the consulting room, that seems to be being utilised for spatialisation purposes, whether separately from or including the transference to the therapist. It may seem to represent the original spatialisation room, other rooms, or the consulting room.

In Counter-transference: The countertransference feeling contain both the non transferential, the patient's feelings about the room are separate, nothing to do the therapist, that the patient's feelings about the room are irrational, inaccessible and make no rational sense. As well as countertransference feeling give a sense that is transferential such as feelings of being excluded from the new room as projectively identified with feelings of

exclusion from being in control of the room move process or the old room, envy, anger powerlessness.

5.9 Testing of the hypothesis utilising data set 4- Clinical data

Hinshelwood (2013, pp.103&169) suggested methodology for testing theoretical concepts, using clinical material, utilising the:

hypothetico-deductive model [...] and modify it for psychoanalytic research [...]. The design consists of the setting, the logic (and research question), and the data. *The setting:* The psychoanalytic setting is highly controlled, and the technique precise if the rules of free association and abstinence are applied, if certain operational rules of prediction supplement clinical interpretation, and if the purchase on counter transference subjectivity is adequately managed. [...] in fact the clinical setting is not naturalistic observation. The case study is observation under laboratory conditions. *The logic:* Using the operational rules for interpretation [...]. *The data:* empirical data needed to provide the 'litmus paper' test of the logical prediction (Hinshelwood, 2013, pp.103-104)

I adapt this model, utilising the stages suggested by Hinshelwood; the setting (here the room moves), the logic (hypothesis and an operationalisation determinants definition of it for testing) and the clinical data. I shall track the appearance of the evidence of the 5 stages of the Room-object Spatialisation Matrix, in the data. In particular I will demonstrate the pre/non transferential aspects exemplified and where, when and how these might occur, will be discussed later in chapter 7- Discussion.

I could not utilise Hinshelwood's hypothetico-deductive method, where he compares two different theoretical concepts in the consulting room, by looking at the results of two different interpretations given to the patient from the different theoretical perspectives and tracking the results of the interpretations to see which is more effective for the patient. The clinical work in

Data set 4 that I am using, happened before I thought of this project, or my hypothetical theory and although this makes it a more reliable source of data, most of my interpretations in the material were transference (current theory). I have no example of my new hypothesis being offered as an alternative interpretation to compare and track the patient's reaction. However, as I followed the usual process of transference interpretation and had the unexpected recognition of spatial material, this makes it a robust test of my hypothesis. My study is a qualitative study utilising clinical material to illustrate my hypothesis.

Jim Hopkins wrote that 'both Darwin and Freud claimed support for their hypotheses mainly on the grounds that they served to provide good explanations for the observations they had accumulated and could be relied on to cope with more' (Hopkins, 1992, p.26) and that 'philosophical discussions of psychoanalysis have frequently focused on [...] how well psychoanalytic theories can be regarded as evidentially supported by the clinical data they are initially framed to explain' (Hopkins, 2013, p.1). Hopkins suggests that Bayes' theorem be utilised where;

'explanatory hypotheses or theories are always also predictive, [...] the hypothesis (or hypothesized mechanisms) must perforce confer a probability of the data given the hypothesis that is higher than the probability of the data given the negation of the hypothesis (supposing that there is no such mechanism). (Hopkins, 2013, p.3)

So, if the negation of the hypothesis is that the mechanism appears not to exist at all, then philosophically speaking in Bayesian terms, if my hypothesis can be demonstrated in the clinical data then it could be considered as having a probability of efficacy for further use. I will now go on, in Chapter 6, to look at the analysis and results of the testing of the hypothesis with Data set 4-Clinical Data.

Chapter 6

Analysis and results of the testing of the hypothesis with Data set 4-Clinical data

6.1 Introduction

In the last Chapter, I looked at the methodology used for this study. In this chapter I show clinical material, from Data set 4, demonstrating my hypothetical Room-object Spatialisation Matrix stages, with particular interest to the points at which the non-transferential stages occur in the material. For the description of the patients see p97 and the operationalisation determinants descriptions of the Room-object Spatialisation Matrix stages see p103.

6.2 Testing hypothesis – the Room-object Spatialisation Matrix stages- utilising Data set 4- Clinical Data

6.2 (i) **Example 1: Miss C - The fourth last session before the move from consulting Room 1, (lines 3-8), then the second last session before the move from consulting Room 1, lines (20-25)**

Background to the session

Miss C, early 40's, had worked with me for a number of years during which she had done several previous consulting room moves, and had been in consulting room 1 for 6 years. At the time of the room move she had moved in with her father, as a hope of a new start with him, and looked at beginning an ending of her psychotherapy. On hearing about the room move she had immediately made the whole event into a positive experience, mirroring her moving on with father and having a lovely home with him, as if, the act of moving into the new consulting room

(and the ‘adventure’ of the interim temporary room) would make her move to her father’s successful- and defend against that being bad.

The fourth last session before the move from consulting Room 1, (lines 3-8)

She said, “I’ve been thinking about it; the church centre is a bit of an adventure so it’s one sort of interim period. But that’s where I am in my life. An interim space, what’s important is my whole life is about changing spaces at the moment. It’ll be my last room and that seems really important. I’m not really sure why. At the moment it’s about things moving and changing environments, rooms, moving on. I think the room here is going to be a really, really, important part of the process of moving on, things moving on in a new phase, sort of doing it around me.

This is like **the operationalisation determinant definition of Stage 2) *Primary Spatialised Room Transference (Room-object)* (from now on in this chapter referred to as ‘Stage 2’)** where she is planning to utilise the rooms to magically compensate for the unconscious concerns about the bad father object (by re-spatialising the object- pre-transferentially stage 1) by keeping the good object father, at last rescuing her from the not good enough object mother. By creating the good enough rooms, there is a hope of at last having the happy family home that she had never had, now with father, and no longer needing the consulting room to spatialise into. **The operationalisation determinant definition of Stage 3) - *Secondary Spatialised Room-object in the Consulting Room* (from now on in this chapter referred to as ‘Stage 3’)** is a re-creation, re-spatialisation of the original **Stage 2** room as replacement for her mother. My formulation of the Room-object Spatialisation Matrix, was informed by previous material from working with patient Miss C. She talked about her relationship with her bedroom as a child, where she spent a lot of time and where she felt safe. She would rub her cheeks against the wall paper which she experienced as comforting and said that she was conscious that this was because her mother

ignored her the majority of the time (**Stage 2**). Another way of thinking about this, in relation to **Stage 3**, was that the consulting room had been a physically safe room space that she had not had in her home (apart from her bedroom of which the consulting room was a secondary spatialisation of her original Stage 2 spatialising). She has experienced this as a detoxifying space and hopes to carry it over into the home with father (**Operationalisation determinant definition of Stage 5**) - *Tertiary Spatialised Room-object, Object and Consulting Room outside the Consulting Room (from now on in this chapter referred to as ‘Stage 5’)*. In transference terms (**the operationalisation determinant definition of Stage 4**) - *Secondary Spatialised Room-object and transference of Object in the Consulting Room (from now on in this chapter referred to as ‘Stage 4’)*, I was a detoxifying object which she hopes to re-project in Father. Counter-transference wise, I felt sad and left for the idealised Father, which she had felt with her mother in relation to her mother’s boyfriend.

The second last session before the move from consulting Room 1, (lines 20-25):

The second last session before the move from consulting Room 1, (lines 20-25):

In this session Miss C, after talking about it being the last session in the consulting room that she had been in for 6 years, and about the ending of the work after getting into the new room suddenly, as if she had not thought about it up till then, she talked about the patient chair, in which she was sitting. I had had the patient chair since before the first consulting room in this study, in a previous consulting room 6 years earlier, in which Miss C had been. The chair was a large shell-like shape in beige fabric. Although the new room was smaller, I was considering keeping it so as to least unsettle the patients.

Miss C said, “This is a great chair it’s the kind of chair you could curl up and go to sleep if

you wanted; you don't want to lose the chair; this is a special chair. We've had this chair since the old room [the consulting room I was in prior to consulting room 1 in this study]”, she thinks, “eight years? So, the chair has already done a move, so it's important to keep the chair”, she strokes the chair arm and turns and strokes the back of the chair.

In her unexpectedly focussing on the chair and stroking it, she had unexpected feelings about the chair (her first reaction to the move that was not the positive defence discussed above). Faced with the loss of an important spatialising part object item, through the stroking of it, she suddenly became emotional: tearful, seemed quite lost, confused, muddled and a bit angry – This is **Operationalisation determinants definition of Stage 1- *Primal Spatialisation* (from now on in this chapter referred to as ‘Stage 1’)** the creation of the object from parts of mother - which underlies all spatialisation activity as well as **stages 2 and 3**, where her re-creation of the first room (where she stroked the wall paper) in the consulting room utilising objects there (chair) to stand in for the original room spatialising. This could be seen in the spatialising activity of stroking the chair. My counter-transference feelings would include that Miss C's feelings about the chair are separate, nothing to do with me, as if it is hers and need to be kept for her and her use of it (as spatialising object or part object of mother **Stage 1 pre transferential**).

She then said, “When I was young, I had nothing, no space, no things, nothing allowed in the lounge, here I am allowed in the lounge”

Then here this feels like **Stage 4**, referring to having nothing in child hood where mother threw things away (including her bedroom furniture). There is a pressure in the countertransference to be unlike mother and keep the chair for her usage (spatialising) and also a counter-transference feeling of inadequacy (**stage 4**) that she needs the chair as a top up to my functioning (**stage 3**).

However, another way of thinking about this would be that her sudden realisation of the possibility of losing the chair, (representing parts of mother **Stage 1 pre-transferential**) brought a disturbing concern about also losing the room and its function (**stage 3**), and me (**stage 4**) and so the stoking the chair was a spatialising attempt (**stage 1**) and keeping the object going as well as asking me to keep it (as a defence against losing the object and for continued spatialising the object in the next room in it).

In the following session – The first session in the interim temporary consulting room 2 after Easter break (lines 1-6):

Miss C entered the temporary consulting room 2 and she said, “there are a lot of chairs”, and looked around again “there are a lot of chairs to put things on, I’m not coming for the next two weeks it’s too much – there’s a tube strike scheduled for the next two weeks and on the following one after bank holiday Monday, it’s too much to come back after a break. It’s been really awful.” She started crying then said “I just need to cry, the room stinks of damp,” She looked around and said, “it looks like being in the 70’s”, then she cried really hard.

On entering the interim temporary room Miss C had experienced strong sensory memory associations. The smell and look of the room and objects in it reminded her of nineteen seventies interiors, a period when she suffered a lot of abuse in different interiors. The physicality of the space triggered sensory memories of that and she felt disturbed and frightened. This is in stark contrast to **the fourth last session before the move from consulting Room 1, (lines 3-4)**, above where she said, “I’ve been thinking about it; the church centre is a bit of an adventure so it’s one sort of interim period. But that’s where I am in my life”. It is feelings of lack of safety and containment that she defended against with her expected act of entering the new room being an action related to her experience at fathers being good (**stage 1, pre-transferential**).

The reference to, a lot of chairs, may relate to the fact that none of them are her chair (**Stage 1-pre-transferential**) which she thinks about utilising “to put things on” them (**stage 3**) but is reminded of the reality of feeling out of control of the practice chair (utilised for spatialising) (**stage 2**) and the 1970’s interiors where her mother’s abusive boyfriend stopped any closeness with mother. This interim room brought up horrific fears of losing the object (stage 1) and the consulting room (Stages 3&4). She defends against this by not coming again to the interim temporary room to remove herself from the dangerous feeling (in itself a spatialising act, stage 1 as well as defending against the threat of losing the object- so here spatialising defends against losing the object so it is an origin spatialising enactment.)

In this example it can be seen that the Matrix Stages in the material are moved in and out of quickly. The pre-transferential **Stage 1** material is evident in two instances where unexpected events; focussing on the chair and entering the interim temporary room, break through the conscious defences of the constructed positive spatialising phantasy about the move being part of the creation of a good home with father. This led to horrific feelings defended against, of the loss of the object, which in turn needs re-spatialising to keep it going.

6.2 (ii) Example 2: Mr B - Last session in consulting room 1 (and before the Easter break) (lines 1-20) and Second and last Session in the interim temporary Consulting Room 5 (lines 1-25)

Background to the session:

Mr B, in his mid-forties, had been in psychotherapy for six months prior to the move from consulting room 1. He was unhappy about the consulting room move because he liked the existing consulting room. Mr B was building a room of his own in the form of a log cabin in the

garden, and furnishing it. This relates to **Stage 5** and, as he began the work on it around the time of the announcement of the room move, it was a spatialisation project. This involved taking control of the room move process, by taking all the spatialising out of the consulting room either to temporarily hold it there, to defend against the breaking down of the spatialising of the object or perhaps keep it there if he felt the new room was really not good enough for the role of top-up container.

Mr B. - Last session in consulting room 1 (and before the Easter break) (lines 1-20):

He said, “It is my birthday on Monday and my wife and the boys are getting me a desk for my new room from Argos. Also, my son is getting me something himself as well. I asked for lightbulbs from the internet which are coloured green or blue”. He was smiling a secret smile and looking to one side. My brother is giving me an angle poise lamp. It is worth £150.00” he smiles again.

I said, “Everyone is supporting you; that feels unusual”.

He smiled and said, “There is a shop that does offcuts of carpet I’m going to get some. I’m going to paint a chair which I’ve had stored in the shed, I want to give it a distressed look, I’m copying that off the internet. I wanted to get a desk with locked drawers. My wife said we do not lock things in this house. She said that she has a rule that there are no secrets.”

Here we see the chair which he upcycles and creates to be his own, is something like a creation of parts of mother spatialised (**Stage 1**) but here in **stage 5**, is a spatialising of a spatialising – a replacement of the function of the consulting room chair which stands in for the function of the original room, which is a spatialising of parts of mother. Interestingly, he plans to ‘distress’ the chair, representing his distressed object (mother) as well as an auxiliary container for his own distress.

He then talked about our coming Easter break, “We are back on the 24th, it’s 17 days, it’s a long time. It’s the longest time, 9 days is the longest so far on the Christmas break. “

Stage 4 - there is a lot there about secrecy in the transference, telling me choice things with a secret smile, so that I, like mother, can’t take them away (unlike the consulting room) (**Stage5**). There is also secrecy about lockable drawers in his replacement log cabin room. The countertransference feelings are of being left out (perhaps a reflection on his feelings about the new consulting room 2 being nearer the front door and therefore further from the centre of my home as consulting room 1 had been- so he was pushed to the outside). The spatialising defends against his anger at mother /me and out potential destruction by it. Spatialisation in the room at home keeps the object going safe from destruction. Then he suddenly switches to thinking about the length of break being the longest time apart (transferential).

He talked at length about the room

I said, “Perhaps, although you might miss this space here, perhaps by planning the space of your room at home, you are extending the space in here a bit by extending it to your space and by describing to me exactly what you are going to do you are putting some of that into my mind so I can think about it and picture it.”

I made a transferential interpretation relating to the room.

He said, “I agree with that. My bedroom at home was not my own; mum came into it all the time and touched my things, moved things, read my bank statements and things. I owned nothing. I only remember a Womble pillow case and I didn’t own anything in or out of the room. I never had music or books. I just spent time there. Mum would get rid of things”.

In return his answer directly relates to the transference. I am the mother who got rid of the consulting room. He is also saying I've not allowed him to own the consulting room or anything in it or be attached to it. He had so little as a child and very little room to spatialise into "**I only remember a Womble pillow case and I didn't own anything in or out of the room. I never had music or books. I just spent time there. Mum would get rid of things**", he was very attached to the original consulting room 1.

Second and last Session in the interim temporary Consulting Room 5 (lines 1-25)

Background to the session:

The previous session had been the first in the interim temporary consulting room. He was anxious because there had been a break-in to the building where, at the front there was a boarded window and police tape. In addition, during his session, someone had attempted to enter the room (I later found out that it was the cleaner), the door handle had rattled and turned a few times as they had tried to get in. I had gotten up and held the door handle and the person had moved away. Mr B was very upset afterwards. In the next session, after me letting him in the front door, he looked very nervous and waited for me to lead the way.

Second and last Session in the interim temporary Consulting Room 5 (lines 1-25):

He said, "I'm not sure where the room is."

He was looking around and seemed on edge and looked worried. He shut the door behind him firmly checking it was shut by pulling at the door handle.

This shows (**Stage 1 pre-transferential**) In the material: he looked very worried, he was holding and checking the door handle, physically pulling it (spatialising) to check it was secure and my countertransference feeling were of being totally separate from this experience, confirming that we were not connected, not in the transference relationship: he is in a world of

his own. Also, since I got up and held the handle, then he holds the handle, one could say that he was not just imitating me, he was regressing from a failed transference mother to spatialisation.

(Stage 4 to Stage 1 non-transferential)

He said, “I wrote some things down that I had thought about last session. The flip chart in the corner was in the group room I was in at the room at the library when I did the group therapy. I was also referred to it by the GP but it was in a different building from where I went from the one to one work. There was not a flip chart in the one to one room. The one to one room was in an older building; the one to one therapist did CBT. She didn’t write on a flip chart: she wrote on a white board. There was a white board in that room”

Again, **Stage 4** transference (me also as unreliable mother for removing him from the room that he loved – the first consulting room). My counter-transference feelings were; guilt for bringing him to such a rubbish room and putting him through the experience and residual guilt about the person trying to get into the room the previous week , which along with the signs of the break in had really upset him.

I said, “It seems to be a merging of two memories it’s reminding you of”

He said, “Yes, the 1:1 therapist drew a circle on the white board with words ‘happiness’ ‘sadness’ it felt like uncomfortable. I just felt uncomfortable. Not right. Something was not right. She was like a school teacher I was thinking. The [therapy] group room had the flip chart I remember in the therapy group that I talked about my friend’s death and she [the group therapist/facilitator] wrote down words about it on the flip chart like a class and a school teacher”

Stage 4 - similar to above – this time it is an unreliable/ untrustworthy/ therapist who he was with in individual work and the room they were in. Again it relates to my unreliability and possible harmful actions by bringing him to this unreliable interim temporary consulting room

I asked, “how did you feel about that?”

He said, “I was worried about her writing my thoughts onto the chart and then it was to be kept till the following week and brought back out again and then I realised after that the room wasn’t locked up and that anyone could walk in and look at the flip chart and the writing about the things I was saying about the death of my friend. It was horrible.”

After a pause he said, “I don’t like this room it reminds me of that feeling in the group therapy room”.

This is **stage 4 - (transference)** it seems to contain previous bad rooms which are a re-projection of his original, unreliable bedroom and mother.

Again, a range of stages were moved in and out of, here, the **pre-transferential Stage 1** showing in the door handle holding and an example of **Stage 5** – the creation of a room outside the consulting room as a re-spatialisation of all the other stages, to defend against the loss of the consulting room, other spatialising rooms, object. Mr B paid great attention to the creation of his top-up to the function of the consulting room, room, and its contents, including his own chair (line 8) and secret drawers, parts of mother spatialised.

6.2 (iii) Example 4: Miss A - Third Session in the New Consulting Room 3 (lines 1– 10) and Fourth Session in the New Consulting Room 3 (lines 1 – 8)

Background to the session:

This comment relates to **(Stage 4, Transference)**, she also gained from the idea of being away from family shared space into a room, just she and I, transferentially relating to never getting enough special time with her mother, wanting to go on holiday with just mother and upset that grandad comes and going into mother's bedroom but her father arriving. The new consulting room is made special by transferentially placing me, through splitting, into the role of an ideal mother. However, the room itself -a just us space- feels much more primitive. This is a special room for her and mother like a **Stage 1 (pre-transferential)** primitive spatialising creating the object.

I said, "but you could feel like my family and me are in a special room from which you are excluded"

She said, "yes I could feel like that. I am glad that I was on the first stage of the work when I was in a total mess, I couldn't think straight. I'm very glad to be in the next room, the next stage, it's a more grown up thinking space, I'm already used to this room, and I think about this room now, like when I'm not here when I thinks of the room, I don't think about the old one."

She ignores my comment completely about any idea that she is excluded, she feels the room for just her and I is all that matters, as well as bringing in again, her phantasy about how she split the rooms to her advantage. She also speaks of stages of work and of rooms where stages take place. Although interestingly, her idea of stages seems like a regressive one of getting back to just her and mum despite her calling it grown up.

Miss A - Fourth Session in the New Consulting Room 3 (lines 1 – 8):

In the following session she said, "Before I started here, I had a referral made by the GP to youth counselling services. The referral has now gone through and I've been offered eight

CBT sessions of youth counselling. It won't be like this. I don't have to move, I don't have to do it, it's like I said about the room move, I left all the bad stuff in the other room [consulting room 1] I don't even want to think about that again, I'd have to start again with someone else. I'd have to explain it all and to think about it again."

She is talking about her original phantasy, developed immediately as a defence to see her through the room move, which she is saying she must maintain. There is a **Stage 3&4**, spatialising the consulting room to keep the object intact here. She is also talking transferentially about my role within this process and that she is not ready to move away from me physically, especially as having the special new room with me.

I said "it's all in the other room and in my mind safely stored. You don't want to think about that stuff at the moment but it's important I know it and it's in my mind and also safe".

The other room in fact, all be it 'bad', is actually containing a lot of bad stuff that she projected into it (**Stage 3&4**), which has to be kept physically shut away from her and yet still exist next door. Perhaps like dad shut away next door, while she now has mother for herself in the new room in the room. Her room at home either gets invaded (by Father or Mother) or abandoned by Mother. She is creating a room with mum and creating mum (spatially) and the more 'grown up bit' is that she creates a room where things don't get abandoned or intruded on and invaded, and she can feel individually intact, physically and psychologically.

6.2 (iv) Example 4: **Example: Mr D - first Session in the interim temporary consulting room 2 (lines 5-15) and Mr D - Second Session in the New Consulting Room 3 (lines 1 – 30):**

Background to the session:

Mr D, in his mid-fifties, had been in therapy for a number of years at the time of the room move. He had done two previous consulting room moves, and had been in consulting room 1 for 6 years. Mr D's home situation mirrored the room move when he was moved out of his childhood bedroom, by his mother, to make way for his baby niece. He then moved into an interim room (where people walked through); then, just as we were in the interim consulting room, he moved into his new bed room. He struggled to settle there, but he was able to make something good of this and make it his own. He cleaned it, creating the fresh space with boundaries and a lock. This was **Stage 5**, as he created his room as the new consulting room was being created. When he knew that a new window was going into the new consulting room, he cleaned the windows of his new room. This, as with the case of Mr B, defended against anything getting lost in the move process, taking charge of the spatialising for safety, therefore allowing a room outside to have all those functions projected into it. There is also a defence against the loss of the consulting room as well as his own (**stage 2**) childhood bedroom which was the original site of spatialising to top-up the neglecting mother, and who had just taken his original bedroom from him.

Mr D- First Session in the new temporary consulting room 2 (lines 5-15):

Mr D said, "Because I've been doing something in my own new room, last week in the Easter break instead of being here I decided to clean my new room, or start the process anyway, I bought a small steam cleaner from T.V. I took down my wooden blind and cleaned all the mildew around the windows. My mum doesn't want them opened for security and it would make the room freezing. I cleaned each slat of the blind. The room feels so much better already, like the cleaner air I was reading up on mould spores. It's like I am taking over and owning the space. It's just the beginning. I'd never have done it in the past. Just like you are making a room. I'm making the room I want, to make it nice and

new and fresh. And keeping others out of the room, making it my own, this is just the beginning. I cleaned my room till 12.30am but I'm going to do the floor and ceiling.

He is not fixing a damaged mother, but he is inside a room space, mother as an object in space and with internal space, that was re-projected into his room to create this via spatialising (**stage 1**).

Mr D - Second Session in the New Consulting Room 3 (lines 1 – 30):

Background to the session:

Before the room move Mr B resorted to a defence that he had used with every previous consulting room move, where he considered the rooms were educational room stages from primary through to university. This had begun in the first room I had worked with him, which was in a building that reminded of him of his primary school and he used to use the toilets and go to the canteen as if at school. It was like starting education from scratch, with a fresh chance at it and the hope of a good educational outcome at the end. He had gone to university but dropped out after a year when his Father died. This was a positive and progressive phantasy, where each room is an improvement to the last and therefore defends against any sense of loss. However, when he got into the new room, for the first time, he had an unexpected sensory experience of being in the new space, which brought very disturbing feelings to the fore.

Second Session in the New Consulting Room 3 (lines 1 – 30):

Mr D said, “Last week I felt very stressed getting into the room and it'll take me a while to calm down”.

I said, “I thought about what you said about how you'd never see the old room next door again.”

He seemed angry, he said “it’s been very unsettling, it’s very hard to get used to it”.

This seems an unexpected reminder by me of something painful. I don’t know why I said that; it was rather like poking a wound and there is something provocative about it relating to my own feelings of guilt about depriving the patients of the room and the upset it had caused and I wanted to get it over with (transference). Then Mr B’s reaction seemed a very disturbed and distressed feeling of being separate from the old room (**Stage 1 pre-transferential**). My counter-transference feelings were that he was cut off in his own world.

I then made an interpretation which could be thought of as transferentially leaning at the beginning, in mentioning ‘my home’;

I said “perhaps it felt like you were angry that you were in the heart of my home for 6 years, in that other room and since we’ve moved it’s all very unsettled. As you said, everything was calm and settled for 6 years and then suddenly upheaval”,

“That’s exactly what happened,” he agreed.

He then said, “and now we are in a completely separate room. I still can’t help feeling that I am in the head teacher’s office and I’ve done something wrong.”

He then thought about how we are in a completely ‘separate room’ which seemed to cause him more distress. As we are now in the ‘separate room’ but he is not separated from me, as I am in the new room with him, I would suggest that it relates to (**Stage 3**) (**separate from transference to me**) and that it is in fact related to desperate feelings of separation from the old room, and the pain of that as a relationship reflected the separation from his childhood bedroom/original spatialising room.

He then retreated into the fantasies that he had constructed prior to the room move about the

new room being like the head teacher's office (that he has done such a good job of the psychotherapy process in the room for 6 years that he gets to go to the new room which is higher status, and then it will be like being praised for his work in the head teacher's office). However, here there is a negative spin on it, that he goes to the head teacher's office when he has done something wrong, this could be angry feelings towards me at having to leave the old room, like the head teacher, who will not praise him but tell him off (**stage 4**).

I said, "You said that you never had an experience of doing something wrong",

He said, "No, only the time I fought back the guy who'd been bullying me and then I got sent to the Head Teacher, yes there was the experience of going to the Principal's office for being very good',

He moderated this with it only happened once, and then went back to his former phantasy of being good in the Principal's office (**Stage 4**). I then made a transference interpretation:

I said, "Maybe you feel like you've been excluded from the family space, pushed outside, in to a special separate room and get less to see of me."

He said, "Yes that was temporary, and I still had to think of the other room. But last week, when I finally got in to the new room it was like Ah! Collapse, then, Ah! actually got here, then Oh NO actually I feel totally muddled and feel I miss the old room and I can't think about the new room yet. Well, I'll be used to it in a few weeks, hopefully before the summer break",

This interpretation (directly relating to the transference) seemed to bring him back to the desperate feelings being separated from the old room – **Stage 3 not transference** initially ignoring the transference but trying to rationalise that hopefully he'll be over this by the break.

Here he seemed irrationally disturbed and separate I felt very removed and bemused by his disturbance, as if he was in his own world. My countertransference feelings were that this was completely separate to me and unreachable (**Stage 1, pre-transferential**). Coming into the room was supposed to enact his educational stages spatialisation, but it failed and there was desperate feelings of loss and despair (and a feeling of desperation about how to proceed or indeed find a way to spatialise the object).

Then, in the discussion about the break, he moves to **Stage 3 & 4** regarding the idea of being without the old room.

Mr D then went on to say: “It would be very upsetting to see the old room next door now, I know it’s changed, it’s not the same. In my head the room next door still exists as it was that’s all I need to know. I don’t want to know what it’s like”.

He is saying he has introjected the old room and, just as he had already spatialised it in his room at home, he cannot see it changed or it will be ruined. It may also be the way he felt about his childhood bedroom that now had his niece in it, but in his mind is still the first site of room transference (**stage 2**), first room-object and he also needs that intact in his mind.

I said, “So perhaps it does just feel like being pushed in to a room that’s not your choice and massively inconvenienced in the process”

He said, “Yes well, when we had the building work done at home, I had to have the room I was given, I wasn’t given any choice at all (even though owning a share of that property)”.

This interpretation, although overtly relating to the transference, got a response of thinking

directly about his first Room-object (**stage 2**) and how he had no choice to leave it, by his own mother. This is a kind of disturbing triple whammy. His unreliable mother makes him leave his room where he might spatialise to top up her functioning. His anger at her disturbs him as it threatens to harm the object, so he needs to spatialise more (his new bedroom) (**stage 5**), to constitute the object, his Mother (**stage 1**), his spatialising childhood room (**stage 2**), and the consulting room he had been in for 6 years (**stage 3 and 4**). His anger at me presumably made his damage of me a concern, more like a quadruple whammy. Very disturbing for all of these factors.

6.3 Summary and Conclusion of Analysis and Results of the Testing of the hypothesis with Data set 4-Clinical Data

Utilising Data set 4- Clinical Data, I have provided evidence of the Room-object Spatialisation Matrix stages in particular demonstrated the pre-transferential aspects. I can, therefore, conclude that I have established that there is a non-transferential component, which clears the way for presenting spatialisation as an ingredient of object relations. Possible reasons when and why it appears in the material are discussed in the next Chapter.

Chapter 7

Discussion of Findings and Implications for Practice

7.1 Introduction

In the last Chapter I have shown phenomena occurring in the consulting room that appear not to be transference, and that this component often has the characteristics that I call spatialisation, which occurs in stages and also occurs in a regression from a maternal transference. I shall be showing implications for psychotherapeutic, clinical practice, throughout this chapter highlighted in each section.

7.2 Spatialisation as a defence – controlling the spatial array in the environment and its implications for practice

In this section I will discuss spatialisation as a defence – how controlling the spatial array in the environment manifests itself in order to potentially defend against pre-object, pre-transferential feelings emerging. In the case of the consulting room moves, I, the therapist, had control over the organisational aspects of the room moves, as well as the building of the new room: the patients had no control over any of these processes. The patients believed consciously that they exerted control via the defensive phantasies about the rooms and what inhabiting these means including building rooms outside

I suggest that patients defend against primitive pre-object, pre-transferential, feelings, by employing the spatialising mechanisms. At times, these were broken through with unexpected feelings triggered by unexpected sensory memories (particularly seen in the interim temporary room and new room, but with Miss C and the chair; Mr B the door handle and the room outside

and it's chair and Mr D with his own room outside, creating a primal spatialising pre-transferential experience where there is a panic about spatialising space and its objects being inaccessible or removed.

By way of concluding, I want to return in more detail to Mr D. I describe the spatial array between the rooms 1 and 3 and the interim, temporary room 2 including the spatial array of location, spaces and objects within them and lay out around them. During the time in the interim room, Mr D demonstrated his worry about me and my ability to deal with the process (relating to his own anxiety and lack of control over the room move process), through asking a lot of questions about progress. There are several possible reasons for this, it was perhaps to do with a concern, that his job was to be responsible and somehow help me, the therapist who in the transference he perceived as struggling like his mother, and that he was needed as he had been by his mother to help. His worry may even have extended to mother's, and consequently his, survival. He worried intensely about paying his fee in cash, during the time in the interim room, for fear that it would get stolen by 'youths' hanging around in the park as I went home, (a five-minute walk). He had also reported being worried about me getting back home, where the old consulting room 1 and the new consulting room 3 were located. His worry was spatialised as danger, in this insecure interim period, projected into, the spatial array of the street (see fig. 41). The building work and changes were dangerous, moving from consulting room 1 was dangerous, the interim temporary room felt dangerous, even bearing the signs of danger in the break-in to the building, shown through the boarded window and police tape. But in this interim temporary room, even the prospect of the new consulting room also felt dangerous. He felt angry about the move and unconsciously experienced his own anger as dangerous. I think that the danger of his own anger, with no location, added to using spatialisation as a defence as a way of bringing some order and safety to it. So, the dangers and threats whether arising internally or externally, were

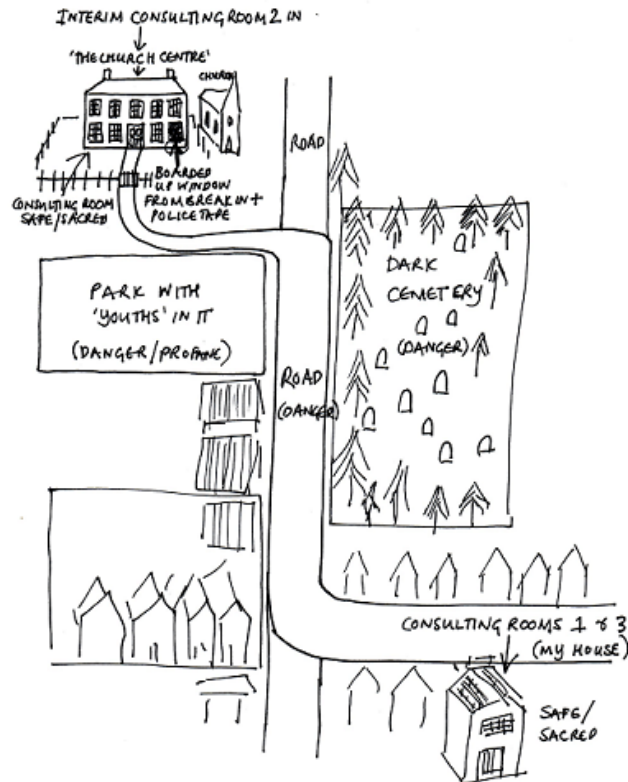


Figure 48: The spatial array of the street separating safety and danger, by D. Wright

projected in to the spatial array. This dividing up of the spatial array of the streets into safe and dangerous (see fig.48) is like the Westminster Abbey example (p30) as well as the Nigerian village model (p24) in Data set 1, in Chapter 1. In Westminster Abbey the space was used, and thought about, to control psychological space. There were clear signs and ritual related to the margins of the spatial array, in other words the parts in between – in this case that is the street, keeping the consulting rooms safe. As with Westminster Abbey, sacred and profane are kept apart to enable the safe functioning of the individual. In the case of Mr D, there was safety and danger in the spatial array of the rooms/ corridors/ buildings/ street in between. Referring to the stages of spatialization in this study, the danger comes from the primal, pre-object level; the defence comes from the projection of the spatialised mother. Mr D wanted to keep me safe, as I moved from consulting room 2 (the interim room) back to consulting room 1/3 (in my house). This involved passing the areas of danger on the road such as the park with ‘youths’ in it and the

cemetery. This is also reminiscent of the Nigerian village model where the danger was all around the village and negotiating the going in and out had to be done through spatialising – ritual and metamorphosis.

I have also suggested that psychotherapists can attempt to control the spatial array of their consulting rooms by copying items that Freud used in his consulting room, such as eastern rugs pinned to the wall and cushions, as if adhering to a magical spatial organisation designed for the spatial array of the room, by Freud himself. This might afford a smooth and successful passage through, and experiences in the consulting room, perhaps even creating the ability for the room to play an efficacious role in the therapeutic experience.

As we have seen, Freud created a spatial array with positive meaning relating to the potential for achieving success which involved the streets of Paris (p49), Notre Dame and Charcot all of which were re-projected onto the walls of the consulting room in the form of the Charcot lithograph alongside his other ‘Household gods’ (p42). Perhaps this defended against weakness and failure (of actual Father), by magically evoking the education and genius of Charcot in the consulting room perhaps ensuring success for his and his patients’ analysis. This could have been reinforced by the objects, such as antique figures, in the room. There was also projection shown in the dream (p45) onto the stair outside his consulting room. Here, as discussed in chapter 2, we can think of this as representing paternal or maternal projections onto the spatial array of the spaces around and within Freud’s consulting room. I will now go on to explore this further as I look further at the notion that Room-spatialising potentially relating to the spatial array of mother’s body.

7.3 The consulting room and the spatial array of the anatomy of mother’s body and implications for practice

I have suggested in Chapter 3 that Stage 2 *Primary Spatialised Room Transference (Room-*

object) as well as Stages 3 *Secondary Spatialised Room-object in the consulting room* can facilitate attempts to manufacture the holding and containing functions, through projections creating a rudimentary auxiliary mind and body space. In this section I am arguing the case that the consulting room can be spatialised as the spatial array of the anatomy of mother's body and discuss the implications for practice of this idea.

As we have seen in the pre-object, pre-transferential Stage 1, *Primary Spatialisation*, parts of mother, part objects, are spatialised to create the object. Stages 2, 3, 4 and 5 contain elements of this, where parts of the spatial array in and around rooms and the consulting room can become parts of mother. In relation to the anatomical elements within and surrounding the consulting rooms in this study, that can make up the anatomical spatial array; there are the consulting rooms and their contents, such as chairs and blinds and (in the case of Freud, pictures and objects and rugs etc.) toilets and hallways outside the consulting room, and the streets around the consulting room. These are all connected in a spatial connection of a spatial array of locations, objects and their meanings and also their relationship to each other – good or bad. Freud brings imagery such as box, lock and key, womb, wardrobes and cupboards representing the insides of mother, and the stairs, representing mother's body. He also showed items such as the picture of Charcot along with the pictures that are 'household gods' and the objects that can represent parts of the paternal body.

In relation to my formulation of the Room-object Spatialisation Matrix, when a baby is born, the things around the baby are the first spaces, the body, breast, the first physical spatial experience. There is the space of the womb itself, but how does the baby know that it is a space? It is all the baby knows until there is something to contrast it with. It is not a space, rather *a site for spatialisation*. In Object-relations terms this is like part objects (such as breast, eyes or face).

The baby can cry desperately or furiously if the breast is taken away before the baby feels that its feed is at an end, and that the baby then loses control of that process (and experiences separation). This would be because mother has decided that it is over, not because the baby has finished the feed, therefore all volition (control) is removed from the baby, which is distressing, disturbing and disruptive to its continuity of being - the breast and the food are no longer available. But, in fact, the baby in its primitive thinking, does not understand the breast will come back next time. My understanding of this goes in underneath the premature finishing of the feeding, to a more primitive process going on – the spatialisation – that’s the aspect I am bringing out and show in sharper relief. Spatialisation is part of the formation of objects but also defensive reaction to maternal failure. In the case of the consulting room move, it was like too early finishing of a feed from that breast at that time (that consulting room) when the patient was not ready for it to finish (because I, the therapist, needed to finish in that room). Therefore, the patients felt they were losing control over the room process (in this analogy: feeding process). Mr B, Miss C and Mr D, when the room was removed, had no control over that. The unexpected unconscious sensory memories that emerged were of desperate anxiety, perhaps losing part of the self, with a threat of disintegration or lack of integration of self. What I have argued it that the disturbance was the loss of the site of the spatialising of the object. This spatialising is a defence against the loss of the object. When the spatialising site is removed then it can be disturbing that the object cannot be spatialised and in addition gets damaged by anger at me in the transference for being the withholding object.

Returning to the part object, breast analogy – leaving aside the chaotic ‘feeding’ arrangement in the interim room, which was highly unsatisfactory and disturbing for some patients - even though a new breast was presented for a new feed (and indeed for spatialising opportunity), in the form of the new consulting room, Mr B, Miss C and Mr D rejected the new ‘feed’ as not

‘good’ enough or not under their control. Mr B and Mr D put a defence in place, by making their own holding ‘breast’ elsewhere from introjected and re-projected elements, standing in for mother’s anatomy, in the form of the Stage 5 *Tertiary Spatialised Room-object, Object and Consulting Room Outside the Consulting Room*.

As discussed, in Chapter 3 (contributing to my formulation of The Room-object Matrix stages), see p74, Miss C had talked about her relationship with her bedroom as a child, saying that rubbing her cheeks against the wall paper and the walls comforted her. She had a sense, at the time, that it was to comfort herself because she felt distant and rejected by her mother. She felt alone and only felt comfortable in her room. Her mother’s boyfriend was frightening and she was not welcome in the rest of the house. She used the walls of her room to stand in for mother’s skin, hugging it as part of the anatomy of mother’s body. During the consulting room move, her initially positive response (defence) to the room move, changed in the second last session before the move (see p112), when, on stroking and looking at the patient chair, and saying, “This is a great chair it’s the kind of chair you could curl up and go to sleep on if you wanted, you don’t want to lose the chair. This is a special chair”, she experienced unexpected sensory feelings of anger about leaving the room. She seemed to experience the chair as part of the anatomy of mother’s body, (stage 1-*Primary Spatialisation*), telling me we must keep the chair, to retain consistency and continuity of the holding and feeding breast. In her anger she was talking about her mother taking things away and having no control over things. A lot of the patients, who are not part of this study, also asked me to keep the chair, I think for similar reasons.

Following this line of thinking, recall Freud’s room descriptions, which I suggest relate to his mother’s body, as well as his dream about the insides of his mother being represented by the wardrobe (p45). We also looked at this in relation to the Abbey shrine kneeling places (p30) and

the Chapel of Our Lady of Pew (p31) to get as close in to mother's body as possible and as Figlio wrote 'I have argued that we are driven to know mother from the outside and the inside' (Figlio, 2000, p21). I suggest that pre-transference elements of *Primary Spatialisation* are a precursor from which the transference to mother's body was composed. But this can be moved in and out of at any time as a replacement for inadequate mother functioning by actual mother.

Another example of the usage of the spatial array, as the anatomy of mother's body, can be seen in Mr D's relationship to the toilet outside the consulting room. In the past, use of and nearby access to a toilet was always very important in different consulting rooms in which I worked with him. It is, however, important to note that the toilet was the consistent element in the move as it (and the hall way) remained the same (which was reassuring for the patients). In the eleventh session in the new consulting room he said, "The toilet is so nice – a nice atmosphere, I like everything, [...] the towel is always clean, everything neat and tidy. The toilets at the gym are really disgusting, you wouldn't want to change in there. There is always a feminine soap smell here". He went on to talk about how his Mother's bathroom is always neat and clean and nice; and he's not really supposed to use it but sometimes he does. Perhaps the soap is a way of spatialising a touching and smelling of something 'feminine', mother like, like mother's bathroom. Perhaps the sacred part of mother can be got near to, with things that can be touched and held (the soap and towel) that are like mother. He experiences his mother's body as benign (sacred) but her mind dangerous (profane) as he talked about his phantasy of whether his Mother's mind can move through the walls of the house and in to his bedroom and into his mind and know what he is thinking. In Westminster Abbey there are niches in the walls for monks to wash their hands, which, (as with Mr D) was a spatialising ritual, before entering the refectory from the cloisters - a marginal transitory space, neither sacred or profane. Mr D prepares for the

session before entering the consulting room by washing his hands in the corridor, which, like the cloisters, is marginal - neither sacred nor profane.

7.4 The anatomy of mother's mind - thinking about thinking: Thinking and spatialisation - implications for practice

Freud's observation of monuments in the streets of London being invested with emotional meanings to 'Londoners' was a way of describing the spatialisation of feelings and ideas. I have argued that this dimension of 'controlling the world' is based on intertwining the physical and the psychological space, in which physical space can be used to harness and control psychological space. These manipulations and possessions of space are ambiguous: while they control forces in the psyche, they can also intensify the pressure for action against objects in other projected – locations. The less the occasions for and the more primitive the psychic level of thinking, the more there will be pressure to spatialize and the more immanent will be an acting out of the need to control the spatial array of the physical space and the objects in it. As discussed, this can also be witnessed in adult life, for example when under pressure. Karl Figlio and Barry Richards (2003) specify the scope and nature of the containing function of nonhuman environments: 'The role of the public utilities in the life of the mind must therefore be in an important way the creation *of* that mind, that is to say, their containing function must have been projectively invested in them.' (Figlio & Richards, 2003, p. 412). As I have formulated, in the Room-object Spatialisation Matrix, that the room can be utilised to afford a rudimentary thinking/containing mother function to provide a rudimentary containment of disturbing emotions.

When this is secondary spatialised (Stages 3 & 4) then the consulting room can also be utilised for this purpose as a replacement or top up function (to be gone in and out of utilising, depending

on need) to the therapist's functioning as the containing function. This is why the pre-transferential elements feels separate and cut off in the counter-transference, as, at that moment the patient is in their own relationship to the room and the room function. This was shown at the points of unexpected, unconscious feelings emerging, which were experienced as panic at the separation from this functioning. The sudden reminder of this function of the consulting room being removed, resulted in temporary inability to think and process the strong emotions/instincts which can normally be dealt with, in an auxiliary way, by the room, as a top up to the containing function of the therapist. I suggest that this is a role taken up by the consulting room at times when this is required by the patient – as a replacement of, in the role of Stages 3 *Secondary Spatialised Room-object in the Consulting room* or an addition to Stages 4 *Secondary Spatialised Room-object, Transference of Object and in the Consulting room* the therapist's function, as an auxiliary container .

The mechanism of spatialising, where thinking is replaced by action, is utilised to manage mounting instinctual pressure - the more developed the thinking, following Wollheim (1969), the more integrated processes of thinking and feeling will become. Wollheim wrote that:

‘All such conceptions derive ultimately from an assimilation of the mind to the body, of mental activity to bodily functioning, of mental contents to the parts of the body. [...] It is not merely that we are at home in our body: we are at home in our mind somewhat as in a body. This, we may say, is the mind's image of itself.’ (Wollheim, 1969, p219).

Wollheim is writing about the antithesis of Freud's idea of mnemonic symbols, of the body, or indeed other's bodies - an assimilation of 'mind and body' and being at home in the mind. This is like the 'integration' versus 'localisation' that Freud argued for in his theory of Aphasia (p60). I argue that the more thinking takes place, the less there is spatialising (see fig.42). As Wollheim writes, 'we should have some specific view about the relation in which objects of

Diagram of Spatialising: The more thinking the less spatialising

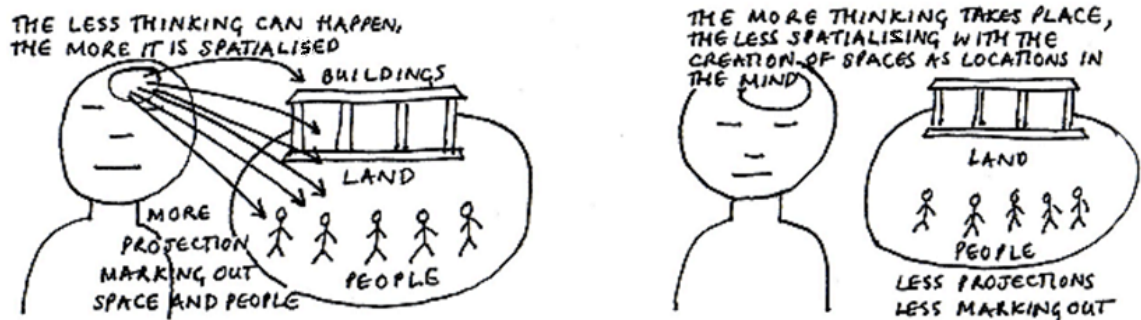


Figure 49: Spatialising into spaces, buildings and people: the more thinking the less spatialising by Wright, D.

mental states stand to the mind, assigning to this a positional character. Here we have something like a disjunctive criterion for spatiality.’ (Wollheim, 1969, p216). This involves creation of spaces, as locations in the mind for thinking. This is to accommodate ambivalent thoughts and feelings without having to split them, project them out and act them out in the space outside the self onto objects projected into and onto (see fig. 49). Bollas writes:

As the analysand develops the capacity to think, [...] we may say that psychoanalysis assists in the growth of the patients’ mind.’ (Bollas, 2009, p.39)

The psychotherapist may assist in the growth of the patient’s mind, through their mind, being an auxiliary mind, and feeding back raw material; thoughts and feeling, digested by the therapist in their mind. This demonstrates thinking and assists in developing the patient’s thinking capacity, as an auxiliary mind. However, what if the patient cannot yet use the therapist in the transference, has not had a good enough mother/ primary care function to transfer, and has in fact functioned by creating *Primary Spatialised Room Transference (Room-object)*, as discussed in chapters 1 and 3, where they have projected the holding containing functions of mother on to a room space? I suggest therefore that the role of the consulting room can be, as an initial one to the work, or top-up function to the function of the therapist, as an auxiliary mind space.

7.5 Thinking About Transference and Implications for Practice

I am suggesting that the Room-object Spatialisation Matrix stages have, like transference, an important role in psychoanalytic work. As shown in the chapter 2, Freud transferred maternal and paternal projections in to rooms, but he did not theorise it. Freud believed transference was essential to the therapeutic process:

the patient sees in his analyst the return – the reincarnation – of some important figures out of his childhood or past, and consequently transfers onto him feelings and reactions which undoubtedly applied to this model. It soon becomes evident that this fact of transference is a factor of undreamt-of importance (Freud, 1940, p52).

I am putting forward an argument for the importance of the awareness of the role of the physical space of the consulting room when this can be experienced as pre-transferential, spatialised and therefore, have its own function separate to the therapist in the therapeutic process. It can also function as a separate or top-up container to the role of the therapist, as seen in Stage 3, *Secondary Spatialised Room-object in the Consulting Room*. Therefore, thinking about working with this is also important.

Working with the transference can be very useful for:

- The therapeutic understanding of the patient in order to work better with them (when interpreted)
- The patient's potential greater understanding of their relationship with an important inner figure (inner object world) such as father or mother

Jane Milton, Caroline Polmear and Julia Fabricius write that:

‘[T]ransference to the analyst and the whole analytic situation, [...] give[s] valuable insight into each individual’s unique way of seeing and relating. There are always little hooks to hang transference on, real features of the analyst’s appearance, tastes and personality [...]. The patient’s particular expectations in relationships, based on personality and previous life experiences, quickly begin to emerge. [...] The analytic setting is unique in deliberately existing to concentrate, observe and make sense of transference, rather than modify and dispel it. The analyst’s position and function mean that he or she quickly tends to become clothed with maternal and paternal transference. (Milton, Polmear and Fabricius, 2004, pp.8-9)

I am suggesting that all of these ideas about transference can also be applied to the thinking about the Stage 3 *Secondary Spatialised Room-object in the Consulting Room*. Thinking about this is a tool for use of understanding the patient’s inner worlds, and if interpreted, the patient’s potential understanding, as much as transference to the therapist. It was shown in the clinical

Diagram showing where transference to the therapist and transference to the room in the Room-object spatialisation stages are related and where they are separate in the consulting room

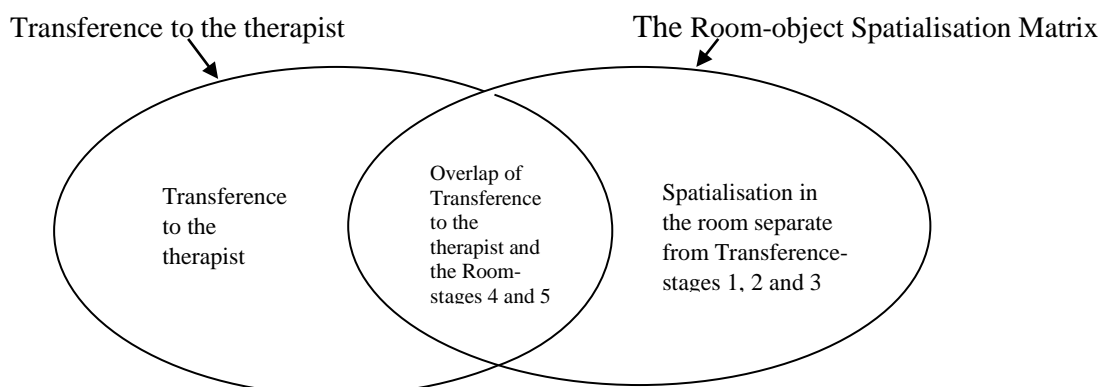


Figure 50: Diagram showing where transference and the Room-object Spatialisation stages are related and where they are separate by Wright. D.

data that, at times, patients move in and out of different ways of relating to the room and to the therapist, some of which is transference and some of which is non-transference. Figure 50 is a diagram showing where transference and Room-object Spatialisation are related and where they are separate.

As with transference, the hook to hang the projection on is related to aspects of the room which may remind the patient in a positive or negative way of other rooms. The hooks are not just about the peculiarities of the consulting room that evoke reactions to other rooms, but that also evoke something of the original transference meaning of the room, that is, features of the original room that stand out because they stand in for features of the mother as well as of the room of the earliest experiences. Take the case of Miss C, who strokes the chair. You take chair to be skin, as an early transference from mother. Then maybe there is something about the chair itself. There must be a whole range of substitutions, from both mother and other rooms, other arrays of space and objects. As I have speculated Freud's regular changing of the prominent figure on his desk, his showing patients such as Hilda Doolittle (p53) figures from his cabinet, his invention of the couch as an item to support the body of his patients as well as covering it with cushions and rugs for additional comfort, indicates different sorts of items for usage by the patient. This could range from the stage 1- *Primal Spatialisation* level of constituting parts of mother (couch cushions blanket for holding and containing the self) – a re-construction re-enactment of the most primitive pre-object levels of creating the object from part objects, to a much more advanced transference use of objects in the form of figures (potentially maternal and paternal figures) on the desk and in the cabinets. We do not know Freud's intention with any of these objects in terms of hooks to hang spatialised room transferences on, but if therapists mindlessly copy the actual items that Freud was utilising, it no longer becomes conscious at all (if indeed it

ever was) in relation to the meaning of the actual items for the patient, but instead becomes a spatial ritual form the therapist, meaningless.

7.6 What can be learned from the differing cases chosen for this study in relation to spatialising- implications for practice

Of the cases utilised in this study, Miss C and Mr D had been in several consulting rooms with me over years (and so had done moves before). Miss A and Mr B had only been there a year. Over all, I would say there was little discernible difference in reaction regarding the different stages on the Room-object Spatialisation Matrix- I would have hypothesised, that the two who had done room moves with me, would have dealt with the move more easily, as they were used to it and would have defences in place. To an extent this is true, in that, when they were told about the room moves, they were both readily prepared, defended, based on prior experience, with ready formulated metaphors (used before) for their relationship with the room, which afforded a defence against any unexpected feelings. These defences were concrete or hardened, having been, previously formulated by them. I was, therefore, surprised to find that Miss A, who had been working with me less than a year, also did this by – creating a projected story in the moment that the old room would have all the bad thoughts and feelings locked into it and there would be a fresh start in the new room. So, the very action of entering the new room spatialised this phantasy of being with just her and good mother with all the bad locked away, (stage 3) which continued to hold up throughout the material analysed.

Not only did the long-standing patients (Miss C and Mr D) build defences, just as did the recent patients (Miss A and Mr B), but also these long-standing patients were sensitive to the breaking through of moments of unexpected memories, when unconscious feelings of disturbance behind the defence came through. They had both been in the room with me for 6 years, and one might

have expected a greater attachment to the room and use of it for Stage 3 *Secondary Spatialised Room -object in the Consulting Room*. Also, both struggled to tolerate the new room. Mr B, however, acted as if defence from an entrenched defence. He did not want to leave the room at all and, in fact, made all things relating to the old room 'good' and all things to do with the new room 'bad', a situation that did not change as he continued to despair at the loss of the old room throughout the material. It reinforces the idea that spatialisation is there from the outset, a constituent of object relations and therefore also a retreat to which one can return as a defence. As such, both new and old patients already have their developmental and defensive use of spatialisation in place.

Chapter 8

Conclusions and Future Research Work

8.1 Introduction- Summary of Thesis

This study originated from my observation of phenomena relating to patients' relationships with the consulting room, where they project onto the room, at times seemingly unrelated to the transference to me. I utilised Freud's theory of instinct, as well as three data sets (1- Historical and Cultural, 2- Sigmund Freud's Writings, 3- Object Relations and Winnicottian theories) to formulate my hypothesis to explain the phenomena better: The Room-object Spatialisation Matrix. Spatialisation simultaneously involves a psychological projection of meaning and physically acting upon the environment, utilised to master the undifferentiated, relentless, internal pressure of instinct. I suggested that this can take place within a matrix of stages, the first of which - *Primal Spatialisation*, takes place into mother/parts of mother to create the object, this is pre-object and therefore pre-transferential. I suggested that a difficulty in utilising mother as the first object of spatialisation, can lead to Stage 2 of the Matrix - *Primary Spatialised Room Transference (Room-Object)*, where spatialising into the spatial array of room spaces and the objects within them replaces or supplements the mother function. Stage 3 - *Secondary Spatialised Room-object in the Consulting Room*, is where the consulting room is used as other rooms were used before as a direct displacement from one room to the other, separate from transference to the therapist. Stage 4 - *Secondary Spatialised Room-object and transference of Object in the Consulting Room*, is like Stage 3 but includes the transference to the therapist. Stage 5 - *Tertiary Spatialised Room-object, Object and Consulting Room outside the Consulting Room* includes the spatialising of the original spatialised room, the object, the therapist in the transference and the therapist's consulting room. These stages represent a

regressive, defensive function as well as a maturational one as a form of rudimentary containing mind. I tested this hypothesis utilising Data set 4- Clinical Data, to demonstrate the hypothetical Room-spatialisation Matrix stage in particular the pre-transferential aspects. This non-transferential domain opens the possibility of the transference to the consulting room , separate from the transference to the therapist..

8.2 Strengths and Limitations of the Study (leading on to future study)

8.2 (i) Strengths of the Study

The strengths of utilising the room-moves for the study and the four case studies, is that there was increased focus on the room in the material and case studies covering that period give an opportunity that is ideally suited to psychoanalytic research. Jochem Willemsen, Elena Della Rosa and Sue Kegerreis (2017) write ‘The clinical case study is clinical research *par excellence*’ (p6). The four cases gave an opportunity of diverse reactions and relationships to the room and to think about the meaning of the different room moves, to yield enough data to test, specifically, the spatial dimension of object formulation and defence against threats to object relations. More precisely, it also enabled me to test my model of the stages of the Room-object Spatialisation Matrix in terms of its precursors in early development of Stage 2, *Primary Spatialised Room Transference (Room-object)*, which I observed in analytic cases.

Common precursors to the emergence of Stage 2, *Primary Spatialised Room Transference (Room-object)* that I have observed in patients;

- 1.All four of the patients in this study had experienced during childhood a depressed mother, who was partially, or occasionally available, sometimes intrusive, this being out of the control of them as a child and therefore evidence could be seen of the defensive spatialisation

accompanying maternal failure.

2. Additional concerning, frightening or actual abusive factors meant that certain rooms outside of the child's bedroom are unsafe (Miss C) or the child's bedroom is perceived to be potentially invaded (Mr D, Mr B, Miss A).

3. Until being in the consulting room no room has felt safe (Mr B and Miss A), this is then a precursor to the creation of a *Primary Spatialised Room Transference (Room-object)*, where the experience of some introjection enables some thinking such as parallel room making in a room space outside the consulting room.

Another strong point of my thesis is that the range of stage in the Matrix, whilst being in and moved out of by the patients, shows its regressive defensive qualities and its maturational ones as well. Patients who are unable to utilise the therapist in the transference, much or very little, but have some spatialising abilities and some experience of spatialising into rooms can utilise the room. This therefore shows the importance of the role that the consulting room, in that it can fulfil, until patients are more enabled to utilise the therapist in the transference (therefore a maturational tool) a continuing top up function. This makes the role of the consulting room particularly important, for some patients, particularly at the beginning of the work, enabling them to engage with the process.

8.2 (ii) Limitations of the study (leading on to future study)

In relation to the limitations of the study, although I have gained insight into the precursors of early Stage 2, *Primary Spatialised Room Transference (Room-object)*, I cannot see the patients, as children, and observe the actual relationship with rooms that they had in childhood, despite Abram and Hinshelwood writing that: 'clinical listening to conscious and unconscious expression of experience is the primary source for understanding the issues and puzzles arising in infancy.' (Abram & Hinshelwood, 2018, p 42). Charles Rycroft wrote:

I should like to open by asserting dogmatically that we *inevitably* use metaphor when talking about mental activity. Thoughts and feelings, the raw material of psychology, or at least subjective psychologies, such as psychoanalysis, are experiences which people have, not phenomena which people observe, but when we try to describe them we are compelled to use analogies derived from phenomena which we do observe.’ (Rycroft, 1969, p.52).

I am compelled to use metaphor to describe these hypothetical formulations based on what I have observed and tested with the clinical data from the consulting room- however, this is the beginning of a process of study of spatialisation and Room-object Spatialisation. I have shown that my formulations can sit alongside the metaphors of Freud, Winnicott and Object-relations but have observed behaviour in my patients that cannot be explained entirely by existing ‘metaphors’ alone. I have tried to find a language and metaphors to describe what I have observed and to make sense of the client’s experiences.

However, as my observations are to do with relationships with rooms and that the formulation of the theory arose from my experience of working in residential care, observing residents’ relationships with their bedrooms over many years and observing the reactions, conscious and unconscious, in the clinical setting of many different room moves, which I am relating to the individuals’ early rooms, my formulation of the Room-object Spatialisation Matrix, has the input of these phenomena observed (Data set 1) as well as evidence from the data testing of Data set 4. The limitation remains that the actual observation of children and their relationships to bedrooms has not been included in this study, and therefore opens up the idea for the next study which could address this limitation, which I discuss below.

8.3 Future research work that would further develop the line of my research

In relation to future research work which may answer or fill a gap left in the limitations of the current study, I propose two areas for further investigation by future study.

8.3 (i) Future study idea I - investigation of early *Primary Spatialised Room Transference (Room-object)* (Stage 2 of the Room-object Spatialisation Matrix)

In relation to the limitations discussed in the last section, regarding the capacity to demonstrate more immediately the existence of *Primary Spatialised Room Transference (Room-object)*, in early years, I propose a future psychosocial study of children's relationship with the space of their bedrooms.

- **Proposed Rationale for study-** To further investigate my formulation of *Primary Spatialised Room Transference (Room-object)*
- **Proposed setting** – Residential home(s) for children
- **Proposed Research participants** – The children and staff in the home
- **Proposed collection of data** –
 - 1) Interviews with the children
 - 2) Observation of children in relation to the space of their bedrooms. For the methodology for observation I would utilise methodology outlined in Hinshelwood and Skogstad (2000, p.17)
 - 3) Interviews with staff regarding the children's relationships with their bedrooms
- **Proposed methodology** –

Qualitative study. Thematic analysis, possible narrative analysis to see changes of emotional emphasis, triangulated with my own countertransference feelings and the material.

8.3 (ii) Future study idea II - Further investigation of *Secondary Spatialised Room-object in the Consulting Room* (Stage 3 of the Room-object Spatialisation Matrix)

Utilising two case studies of two patients in depth over a longer period, to track and investigate the *Secondary Spatialised Room-object in the Consulting Room*

- **Proposed Research participants 1** – Research participant in this study patient Miss C
- **Proposed setting re Research participants 1** - Miss C has done several moves over years- look in more depth at sessions spanning years in different consulting rooms
- **Proposed Research participants 2-** a patient who I have worked with for several years, whom I will call Mr E. I began working with Mr E. soon after starting work in the new consulting room 3.
- **Background of participants 2**

Mr E's relationship with the consulting room was a fractious one. Nothing was satisfactory, the chair was uncomfortable on his back and he asked to bring his own folding chair. His mother was distant and narcissistic and he spent a lot of time in his bedroom. His Father died when he was in his thirties, whilst he still lived at home, and he continued to live at home to look after his mother. When he began work with me, he was in his mid-forties and still living with his mother and felt 'dead' inside, feeling he had no life, no career and no friends. During the course of the work, he moved out of his mother's house, an excruciatingly difficult experience, involving going back to his old bedroom at the weekends. With my formulation of the Room-object Spatialisation Matrix clearly in mind, I could begin to use it in a way I was not able to do while the concept was germinating. Thinking about his spatial usage and possible meanings has

assisted me with thinking and has also assisted conscious thinking through interpretation. Further clinical work should allow me both to refine the theory and to consider its usefulness as a clinically-close, practice-close concept, in the spirit of Freud's distinction between metapsychology and psychology. I have found using my conceptualisation of the Room-object Spatialisation Matrix extremely helpful in thinking whilst working with this patient. The sessions are often silent. He has difficulty with thinking and functioning and meaning gets destroyed a lot. Thinking about his spatial usage and possible meanings in relation to the stages of the matrix, has assisted me with thinking and has also assisted conscious thinking through interpretation. I have utilised in my most recent work with him, my formulations of the Room-object Spatialisation Matrix, in the work through interpretation, which opens the possibility of a utilising the 'hypothetico-deductive' (Hinshelwood, 2013, p.103) method, proposed by Hinshelwood, used for comparing conceptual frameworks. by tracking the changes in the work post interpretation (and making comparisons).

- **Proposed setting re Research participants 2-** Mr E. has not worked with me in any other consulting room so the setting will be my current consulting room.
- **Proposed collection of data of both Research participant 1 and 2,** process notes of the session taken at the time going back several years, specifically focussing on material involving/relating to the consulting room. In the case of Miss C this would involve going back many years and several different consulting room settings.

Proposed methodology for testing the data- I propose using the 'hypothetico-deductive' (Hinshelwood, 2013, p.103) model for further testing my formulation of Room-object Spatialisation Matrix utilising the clinical material.

8.4 General Conclusions of the Study

At the end of his first book, *Aphasia a Critical Study*, Freud (1891) concludes:

I have endeavoured to demolish a convenient and attractive theory of the aphasias, and having succeeded in this, I have been able to put into its place something less obvious and less complete. I only hope that the theory I have proposed will do more justice to the facts and will expose the real difficulties better than the one I have rejected. It is with a clear exposition of the problems that the elucidation of a scientific subject begins. (Freud, 1953 [1891], p104)

Freud is highlighting the attractiveness of concepts that conceal a lack of knowledge. Sweeping statements sometimes don't fit the phenomena and the evidence. In the case of Aphasia, it was localization. In the case I have explored, it is that everything in the room is transference. Utilising Data set 4- Clinical Data, I have provided evidence of my formulation of the Room-object Spatialisation Matrix stages, in particular demonstrating the pre-transferential aspects. I can, therefore, conclude that I have established that there is a non-transferential component, which clears the way for presenting spatialisation as an ingredient of object relations. In addition, the evidence of the pre-object, pre-transferential, aspects, makes way for the existence of the stage 3 *Secondary Spatialised Room-object in the Consulting Room*. This is because the Stage 1 *Primal Spatialisation* pre-object stage, can be spatialised into rooms (stage 2 *Primary Spatialised Room Transference (Room-Object)* and secondary spatialised into the consulting room (Stage 3), where at times, the consulting room functions as the stage 2, original spatialising room did, separate from any transference to the therapist. I am suggesting that there is a projection on to the room, not via the therapist, which is separate.

I suggest that evidence of spatialisation (where instead of thinking actions occur in space) into

rooms by Freud has not been taken up in psychoanalytic theory, perhaps because it was so personal and habitual for Freud and perhaps not entirely conscious. Then later generations, in identification with Freud, repeat his retaining of spatialisation in an unconscious or minimally conscious state. However, Freud's fascination with the development of the mind included his attempt to find the original spatialisation, which creates the object world and is retained in transferences. I suggest that the stages 2-5 of the Room Spatialisation Matrix, are a defence against the feelings of the original *Primal Spatialising* (Stage 1) experience where spatialisation creates the original object through spatialising parts of mother. I suggest that this spatialising can be a life time pursuit (to be retreated in to as a defence) of re-constituting /re-creating/ rebuilding the object mother to defend against the object's loss, or its getting damaged by anger /rage at its inadequacy. My formulations open up this subject for more investigation. I hope this does more justice to the phenomena in the physical space of the consulting room than the view that everything in the room is transference.

Just as the original spatialised room (Stage 2, *Primary Spatialised Room Transference (Room-Object)*) offered top-up/replacement of the object/mother function, the role of the consulting room can be to provide top-up/replacement of the therapist function (separate to the transference to the therapist), depending on need and ability to utilise the therapist in the transference, through an auxiliary containing space that can be related to by the patient transferentially, and pre-object, pre-transferentially.

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