Some thoughts on lying and pretending

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Introduction

Albert Camus was an inveterate lover of women who had many projects. He died in an accident, travelling back from holiday to several of each. Before leaving, he wrote to five women that they were the love of his life (Todd, 1996). Was this a lie (a conscious, cynical manipulation), or did he actually believe each letter as he wrote it (treating parallel fantasy worlds as real, which I will suggest involves splitting modes of psychic reality)? It is fitting to start with Camus, a great writer on the invention of social reality; I will suggest that some people who characteristically misrepresent the truth are not primarily trying to deceive, but defensively regressing to a split experience of subjectivity which obstructs emotional contact with ordinary (adult) reality.

Edna O’Shaughnessy in 1990 asked whether a habitual liar could be psychoanalysed. To do so involved a paradox: psychoanalysis is founded on truthfulness, yet for a liar to be himself he must lie in his analysis. Lying is a symptom, and psychoanalysis has always recognized the need for, and worked with, a variety of forms of untruth—denial, disavowal, misconception, distortion, delusion. So, she asked, “why not the lie?” (O’Shaughnessy, 1990, p.187). There is not much psychoanalytic literature on lying. Alessandra Lemma’s “Many Faces of Lying” (2005) clarifies a distinction between sadistic and self-preservative lying, and I am concerned with the latter defensive kind. I will explore whether we gain anything by drawing on a model of the evolution of psychic reality, or ‘internal truth’, described by Peter Fonagy and myself in a series called ‘Playing With Reality’ (e.g. Fonagy & Target, 1996; Target & Fonagy, 1996).

Before they can lie, small children learn to pretend to escape their own sense of fixed psychic reality. Later they realise that other people have different psychic realities, and that others do not know what they know. Being able to lie is thus a developmental achievement (the young child realising he can deceive his parents), a step towards mental privacy and ownership, not at first an assault on trust and intimacy. However, adults who habitually hide or misrepresent central facts to those affected by them damage any who get close to them. One extreme is psychopathic manipulation, but here I focus on falseness which can be as extreme but is the social face of a dangerous internal struggle for self-regulation and coherence. The patient is stuck in a pre-mentalizing, split mode of experiencing psychic reality which presses others similarly to split their knowledge of reality.

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1 Paper for the British Psycho-Analytical Society Scientific Meeting June 18th 2008. A version was previously given at the 2007 Berlin IPA Congress.
2 I am very grateful for the generosity of Prof Peter Fonagy in helping work out these ideas, and for the comments of several other friends.
Psychic development

The regressive state of mind which allows this pathological split comes from a normal stage in early childhood, and it partly involves a failure to move normally from play to games. Let me clarify this. Before the child learns, at 3-4 years, that people have different perspectives and no-one knows what others think or feel, he treats his mind as part of the world. If the small child believes the dressing gown behind the door is a burglar, this thought in itself frightens the child, the thought almost becomes the burglar. This is an aspect of what we have called ‘psychic equivalence’. It is no good for the parent to argue with it, she can only show by example that she thinks differently - she knows other things about the world, which eventually helps the child to take a third perspective. Before this, to maintain internal balance, the child develops a special state of mind which we have referred to as ‘pretend mode’, in which he can create things that he knows are not real, where there is no connection between pretence and reality. (He might for example pretend there is a burglar, whom he or Daddy will beat up.) This pretending is the seed of what around the oedipal stage becomes symbolic play, where reality constraints are infused with the imaginative flexibility of play, which in turn lays the groundwork for mature psychic reality and ultimately the capacity to love and work together.

Let me illustrate this developmental move:

James is four years old. He wakes early and enlists his two year old brother to play with him. Paul is to “drive the armoured car” [push a little roller skate], which takes one injured man at a time. “You have to take the soldiers to this base. You get across the river by a bridge. Look where I’ve marked them.” Paul, still sleepy, tries to please but sometimes puts all the wounded soldiers in the car at once, or “magics” it to fly across the river. Finally his car turns into a multipurpose tank/fighter bomber/submarine, which quickly wins the battle. Meanwhile, their parents hear James’s crescendo of frustration: “NO, Paul! You can’t DO that!! The car can’t fly! And it can only fit one man! You CAN’T go on the river or underwater… NO! Oh it’s no use! ….. You don’t know anything.”

James returns to playing alone until his parents are available. They will play by the rules because they understand that you can play the game, but you cannot play with the game. Just because the “car” could be a large amphibious ambulance, that doesn’t mean you can turn it into one. (But the trouble is, you can…)

When James protests “You can’t DO that!!”, he is defending symbolic play against the potential anarchy of the ‘pretend mode’, in which you can do that… because you can. The car can fly, you can invent a move in chess, you can not pay tax, and so on. Paul’s freedom spoiled James’s game, which equally spoiled Paul’s play. James was not ready to provide a ‘zone of proximal development’ for Paul, having himself only recently integrated ‘psychic equivalence’ and ‘pretend mode’ thinking.
Our model brings together clinical and research evidence and aims to continue the work of Winnicott and Bion, on how people learn to think about and find meaning in our inner worlds. Language, play and oedipal triangulation facilitate integration of the split modes. Paul, when serious (in "psychic equivalence mode"), expects his feelings and thoughts to match external reality, but this makes him feel rocked by the fear that what is in his mind must be concretely real. He develops an escape-route of conscious, playful fantasy (our "pretend mode"). Then he knows that internal experiences do not map onto external reality, they are disconnected from it and occlude it, they have no consequences. At the oedipal stage, children normally integrate these two modes so that states of mind in both self and other can be symbolized - as representations of subjectivity. Inner and outer reality can then be seen as linked, yet different; they no longer have to be either equated or dissociated. The parent gives the child's ideas and feelings (whether serious, or "only pretending") a bridge between reality and fantasy, by showing an alternative perspective outside the child's mind. The parent also shows that perspectives may be acted on in playful ways, creating new, imaginative, malleable yet real mental experiences. This integrated psychic reality allows the understanding that even if a thought is untrue, it can be represented and communicated. It may then be a lie, a pretence, a joke, a mistake, and so on. The integration of modes of subjectivity is never complete, it continues to be tested or lost throughout life, in fear, pain or pleasure.

**Truth, illusion and psychoanalysis**

For the early latency child like James, play is serious, systematised as a 'proper' game. He hangs rigidly onto his arbitrary symbols, the rules which flimsily connect inner and outer reality, wish and truth, lateral and linear. The logic of symbolic games, the frame of social reality, will go on to pervade James's adult life, all of our lives and the frame of psychoanalysis itself. In our virtual 'battleground', or playground of the analytic relationship, we know that we need a strong frame. Psychoanalysis can be thought of as a 'game', the relationship 'played' by rules which mobilise the unconscious - a catalyst to potential anarchy, within a setting that helps this to be safe and creative.

The analytic process can be thought to involve a dis-integration of psychic equivalence and pretend modes. The setting (including the internal setting, Parsons, 2006), the fundamental rule and regression create a strange but benign, 'pretend' atmosphere in which fantasy is given free play and normal social rules are suspended. The analyst then listens for what is experienced with the concreteness of 'psychic equivalence', especially within the transference. For example, fury or depression about the analyst's slight lateness, or about the existence of other patients, are not necessarily heard as bizarre or psychotic complaints, but as familiar, passionate, childish

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3 The work of Ron Britton has points of contact with this description, within a Kleinian developmental framework.

4 Winnicott wrote that: "Games and their organisation must be looked at as part of an attempt to forestall the frightening aspect of playing... The precariousness of play belongs to the fact that it is always on the theoretical line between the subjective and that which is objectively perceived." (Winnicott, 1971, p. 58-59).
feelings with the concrete, unmediated impact of psychic equivalent mode. What makes this intensity and vulnerability tolerable is the frame (analytic theory and stance) allowing the analyst intuitively to titrate painful experiences of psychic equivalence within the background safety of pretend mode, in which anything can be said because it is true but not real, thought but (mostly) not enacted. The analyst minimises reminders of normal reality to create space for both early modes of self-experience; fantasies, feelings and thoughts can be played out, felt as real without becoming so in adult reality. Once these experiences have emerged in this split mode, they can be worked through, symbolised and reintegrated. Without the emotional immediacy and conviction, starting with the rawness of psychic equivalence, reflection would be sterile intellectualisation.

Within this model, psychoanalysts spend the day in a succession of ‘pretend’ worlds of transference / countertransference ‘play with reality’, a different world with each patient. We could not learn to do this without first having made the journey of integration (as children, and again in analysis), that James has made and Paul will soon make, on the road marked out, no longer flying the car across the river on a whim. As analysts we know that some things can only be realized within the analytic session, they are not real outside. As adults we know that we can only live one life, played out within social codes. Some people, though, come to us not having made the journey, not accepting that the car can’t fly, living their lives as though everything were still possible.

Living in this way requires either openly rejecting ordinary constraints or presenting false pictures of oneself. I will contrast two patients whose lives were full of falseness, and try to sketch a dimension of untruth from ‘ordinary’ lies, to survival through pathologically split psychic reality - living out omnipotent, insulated, alternative fantasies which feel externally real.

**The first case: Dr P**
Dr P was a 45 year old senior civil servant, a gifted and likeable man, brought up in a former British colony where his father had been a judge. As a baby, my patient had had a nurse, a local woman whose village hut had been his second home. His parents had travelled extensively, and lived in a separate house because of rebel attacks. When he was two years old he had a serious fall, and was sent far away to hospital, expected to die or be disabled. When discharged many months later his nurse had disappeared, then at four the little boy was again sent far away, to boarding school. From 8 he was sent “home” (to Britain, where he had never been). He saw his parents once a year, but wrote cheerful letters to them weekly as required, and got similar letters in return. That chatty quality is familiar from the transference – a bright, friendly veneer covering the conviction that no real contact is possible.

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5 Perhaps we need our long summers to regain a sense of ordinary integrated psychic reality, not having it continually pulled apart in different ways. And to provide a frame of reality for the analytic process as a whole, punctuation between phases of the analytic relationship, as each session is framed by a beginning and end outside which the patient must reintegrate his divided psychic reality as best as he can until next time.
Dr P was referred when his third marriage was ending. He had four children whom he loved. He had carried on various parallel affairs for decades. He made quite lasting, intense relationships with strong and talented women, to whom he lied automatically. There was a similar pattern with work in that he took on conflicting responsibilities, and was always trying to soothe people with charm, excuses and promises. The trail of disappointed and angry people saddened and puzzled him, as he felt he tried always to please everyone.

Dr P came into treatment smarting from recent collisions. One day, he had had two important conference presentations to give in different places, and the following weekend he had arranged with two girlfriends to go for a romantic break at the same hotel. Until shortly before each event, he had not really been anxious - it would work out somehow. But really he did not accept that he could not please both conferences, both women. He wanted both, they wanted him, why should it not work? He had not even lied this time, “there was no actual dishonesty”, and he felt that somehow the ensuing confrontations were not fair – but he could see something was not right and he needed help. The thing he could not see was that help was possible.

Of course he did his best to play the therapy game well, and he increased from two to four sessions weekly after two years. Four excuses weekly, at first. Below is a session after that change, when he missed many sessions and we sometimes spoke on the phone in his times.\(^6\) I will show how I tried, like James, to play the game and not to let him fly, winningly like Paul, over the inconvenient rivers of reality. This involved being more concrete and focussed than usual (reducing the permissive ‘pretend’ atmosphere) for several months.

**Session**

{Dr P begins by talking about Karen, his current mistress (he also has girlfriends A and B and is living with his wife who believes he has stopped seeing Karen). He and Karen had agreed to buy some land in Ireland, to build a home for holidays and eventual retirement.}

**Dr P:** Karen wanted to buy the property next week. There is a cash-flow problem: I can’t get the money this month for my share, Karen has got all upset that I won’t get it in time. This comes at an awkward moment because she is angry with me for going off to the policy think-tank next week. It feels a little hurtful after I have turned my life upside down for her! Next week is complicated: the think-tank organisers changed the date to suit the Americans who recently decided to join. I know the people involved and have been trying to mediate, but tempers have got rather frayed. {He describes prominent politicians, their rows and his peace-making.} It’s as much as I can do to get them to be in the same place at the same time, there is no way I can go to Ireland right now! I understand it is frustrating for her, but there is really nothing I can do!

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\(^6\) I have found with several patients like this, that such flexibility helped them to settle into attending well through their own wish, as they discovered the difference it makes.
[I think about his ‘cash-flow problem’ of not paying two analytic bills recently, and missing some sessions. I also reflect that surely he won’t have the money for Ireland for a long time, if ever – he has not sold his marital home because he has not talked to his wife about separating. Having the ‘think-tank’ next week not only gets him out of being with Karen, but also out of the family holiday which is still planned.]

**MT:** You are also letting me know that you won’t be coming to your sessions next week. (And that there is really nothing you - or I - can do).

**Dr P** (edgy): it’s pretty much a write-off, though I really regret it because we have got into some very helpful things recently. {Silence. He then describes with detail and absorption how the VIPs can only do that week, need to meet out of London and are insisting that he is there ...} It will be like old times going back to X {where the summit will be held}. I remember that awful occasion when I had to make a speech in their Parliament on behalf of {a statesman whose speech he had drafted}! I clean forgot what I had been going to say – or (quickly correcting himself) what **he** had been going to say, rather!

**MT:** do you think you have been needing to make a speech for someone else here too?

**Dr P:** uh ...?

**MT:**: when you told me about Karen getting annoyed about the cash-flow, going away and so on, I think in the back of your mind alarm bells went off, and you needed to go off into a speech about important people and events. You started speaking as someone else, the man who is too important to be here with me.

**Dr P:** Hmm. (Long pause; he seems rather crestfallen but thoughtful.) So, it is like before…. I put up a smokescreen ...

**MT:** we know that next week really is complicated. As you say, - you meant to turn your life upside down for Karen, but in reality it was not so easy...

**Dr P:** yes. I suppose it is that thing again - because I did it in my mind, it has happened in reality (and she should be grateful!)

**MT:** and so should I... (pause) Easier to create world peace...

**Dr P:** (laughs) thank God you are not giving me a hard time about it! (continues warmly, smiling) I will miss seeing you next week. I wondered whether in fact we could have our sessions over the phone, some of them at least. I would be happy to get out of those talking-shop sessions!

**MT:** I think you like it when we are in a benign little world, our own “talking-shop sessions”, a refuge where you feel accepted. But when you are away, you may worry that you have spoiled this refuge too.

**Dr P:** that’s true. I get anxious that you will be angry with me for not being here. (silence)

**MT:** then you want to reassure yourself that I still like you, by talking to me on the phone. You talk to Karen, your wife, A and B, and me, so none of us will be angry with you.
Dr P (looks tense then falsely bright): Hmm! My colleagues do give me
grief about my ‘telephone dance-card’… (silence)
MT: you want to make sure everyone still wants to dance with you, you
have enough refuges.
Dr P: yes. (pause. Laughs ruefully and sounds anxious) – you must be
so fed up with me, I don’t know why any of you put up with me really.
MT: My guess is that when you felt anxious about that, a few minutes
ago, you needed to run away into your bubble about the VIP think-tank
and world peace.
Dr P: hmm.
MT: Now you feel in need of the ‘lovable rogue routine’ {his description
for disarming his interchangeable women}
Dr P: yes (serious, longer pause)
MT: I think you really do feel worried about whether I still like you, or
whether I just put up with you and go through the motions.
Dr P: yes. I do feel that. (pause) I don’t know why I have to antagonise
everyone. (silence)
MT: When you try to please everyone with heroics, you realise it is not
going to work, you can’t fit everything into the same space. The fear
that you have antagonised them makes you shift, I think, into a ‘dance’
where we have roles you feel in control of: I am cross; you are sorry; I
forgive you. This stops anything unexpected from happening and we
feel close. But then you worry I am just going through the motions and
inside I don’t really like you. As you felt about your mother, who wrote
you travelogues but did not come to see you when you were so lonely.

(he nodded. We were both silent for the remaining minutes, in which
he was tearful. On leaving he said that he was not sure whether he
could phone me at the usual session times. I said I would be here in
his times, and hoped he could come, or he might phone me. But he
might feel too important. Or too afraid about me being angry. He came
for the first session, and phoned in two of his other times.)

Discussion of Dr P
Dr P invited an over-close erotised relationship. He erotised all relationships
with women, and in the transference I felt the pull of collusive intimacy: a
subtly sweet identification and pleasurable timelessness. This seductiveness
made me focus on the actual realities of his life and what he was ashamed of,
behind his ‘smokescreen’, rather than getting entangled in his ‘pretend mode’
of psychic reality. I found that he generally glossed over a deceitful aspect of
his life until he had been able to have the pleasure of it, after which he would
‘confess’ to me.

He used charm and apparent appreciation to hide his omnipotence and the
damage he was actually causing, the daily fact that each time he ‘had to’ do
something new, he was spoiling something with meaning, that he and others
had invested in. Unconsciously, he punished himself for his greed by being
unable to enjoy anything fully or even know what he wanted. He ended up
constantly managing conflict; instead of developing his artistic talent, enjoying
his children and pursuing work projects he cared about, he agreed to do
everything he was asked by others, and then frustrated them. More became less.

Two things seemed to help me avoid functioning too much as another deceived but hopefully forgiving mistress. One was, early on in the analytic phase as above, to adopt a degree of irony towards the ‘lovable rogue routine’. The serious work of making his traumatic early life something he could think about, and have feelings about (rather than manically dumping pain, loss and confusion into his disposable objects), seemed to follow if a light touch partly deflated the narcissistic bubble first. The second thing was to have a way of understanding the point of his game, and why it had become overwhelming. A striking aspect was his difficulty in really understanding why the plates were spinning out of control, and why others were angry with him. I thought about this in terms multiple, dissociated realities which were not felt to be incompatible, the quality of a ‘pretend’ world. His many refuges made him feel powerful, almost immune to other people’s reality. Manic omnipotence made him too ‘high’ to remember his miserable history of traumatic separations, only bearable perhaps by precocious coping, white lies and secret consolations.

Dr P’s fear of further loss and isolation was felt concretely (in psychic equivalence) as a existing fact, that forced him to generate multiple realities: safety in numbers. Through development, other motivations had come in, including triumph over ordinary reality found inescapable by others. He could switch magically from feeling forgotten about to being in everyone’s minds, the one everyone wanted. Of course, he feared that analysis would take away his pleasure. Finding that I could sympathetically hold his pretend worlds in mind enabled him gradually to see them as expressions of feeling, which could either be secretly enacted (split off from, and threatening, ordinary reality), or become represented as desire, fantasy, and integrated into a more transparent life.

Dr P became increasingly open and painfully honest about what he really wanted, needed and felt in the closest of relationships, including the analytic relationship. He could emotionally connect the fracturing of his experience of mothering (mother/nurse with completely different cultures and ways of relating), with the current questions “Why only one lover? Why only one career? I can have lots! (I had lots of mothers)”. Behind the temporary thrill of getting away with excess was the fear of facing an unbearable repetition of being left with nothing and no-one: “What happens if they are all gone? Who will love me? Who will know me?” He began to feel the fear, confusion, anger and emptiness of his nurse disappearing, his parents being away for months, and having made no childhood friends, only alliances. This began to make sense of current ‘strange’ feelings - of being sent away as a punishment, of being unlovable, learning not to trust anyone. His unconscious hatred and fear of women, and his wish to hurt them, were explored in many contexts including powerfully in the transference. What had felt like a callous game had unconsciously seemed life-saving. Perhaps in his infancy he had had stable but divided attachments, after that trauma had left ‘holes’ in his integration of
the two modes of inner reality, and over those holes he tried to erect fantastic
defences against his fears.

I was aware that my patient would surely lie to me, or hide some important
secret. After another year, I found myself thinking about his nurse, with whom
he had talked basic Swahili but I imagined most communication was through
action such as carrying, washing and singing. I asked him whether he had
some close relationship where words were not so important. He then told me,
intensely emotional and inarticulate, about his 20 year relationship with C,
with whom he felt absolutely accepted and did not need to talk. He seemed to
use a parallel currency of primitive, wordless, deep intimacy in this most
‘addictive’ and lasting relationship of his life. His visits to C were the most and
least “real” thing he did, seemingly in an almost dissociated state, and he had
never discussed them with anyone including her. She was not on his
‘telephone dance-card’. She was so inconceivable she was not truly secret,
yet she was fundamental. It was a relief to talk about her at last. His
interaction with me seemed to deepen after I opened this up, of implicit
understanding, with gesture, expressions, tones of voice and the rhythm of
sessions in themselves carrying a more real and continuous intimacy.

The second case: Mr A
I will now briefly contrast Dr P with Mr A, whose behaviour had some
superficial similarities but who was much more ill, almost unable to represent
his experience, his multiple realities more uncontrollable, with potentially life-
threatening psychosomatic symptoms when his pattern of living was
disrupted. In the model I am using I would say that his psychic reality was not
even partly integrated; the appearance of being able to represent his thoughts
was entirely false.

Mr A grew up as a treasured only child. He described being idealised and
overprotected, with a mother who hysterically over-reacted to everything and
often lied, so he lived in uncontained anxiety about what was really going on.
He suffered from anorexia and depression as a young adult, then a
hypomanic period in which his multiple fantasy lives got out into reality. Like
Dr P, Mr A came to see me after the collapse of several incompatible parallel
lives precariously held together by deceit. He had moved to Britain and
arranged for his wife and mistress both to come to live with him, at the last
moment fobbing off his mistress who then conclusively rejected him. He was
shocked into utter despair. When I first saw him, he was distraught and
suicidal, unable to accept the loss of his mistress, of his illusory omnipotent
control. He was also developing a rare auto-immune disorder, which
threatened permanent disability and early death.

Starting analysis seemed to stabilise him physically, but uncovered a pattern
of indiscriminate sexual and professional deceits, together with compulsive
spending, and heavy absorption in virtual reality internet Role-Playing games
and dating sites. His sessions felt equally unreal, he spoke in the most
abstract, repetitive terms about himself as though he were describing a
fictional character, or an ‘avatar’ in one of the virtual game worlds.
Mr A seemed to operate in split pretend/psychic equivalence mode, with the pretend state of mind dominating (feeling nothing to be real and fearing any intrusion from reality), while actual loss or change felt fatal (in psychic equivalence) and could at best be dealt with omnipotently. For example, when two of his girlfriends got pregnant at the same time, each assuming he was committed to her, he changed his phone number and email account and felt that the problem was solved – not just for him but for them.

I needed to confront his deadening style of meaningless abstraction (he much later described it as word-salad, then word-shit), for example asking him specific questions about his external life, and what his vague allusions referred to. I would try to help him work out what his state of mind had been when he had lost contact with reality demands, for example by missing work (and sessions) to play an online game for several days. He was lost in fantasy, and I would say he was not well enough actually to lie. Unlike Dr P, he had no sense of someone real behind the falseness. He was fascinated by himself as a hypothetical or fantasy figure, and talked in those terms. ‘Collapsing the compartments’ of his pretend world had to be done much more slowly and he had to keep recreating them for much longer.

The virtualness of his life could take over completely, especially when he imagined any change. He thought of this as a fear of loss, e.g. of the death of someone he loved, or his own decline. However, unconsciously he had already killed his objects (at least poisoned them with his magic ‘word-shit’). For example he said he feared his parents dying, yet he had cut off contact with them, and might not have heard if they had died. They were dead to him already, absorbed into the waxwork world of his objects with whom he played, or imagined playing. This sort of dehumanising, paralysing way of being in his world only felt fully described by those writers who have written in the starkest terms of psychic life and death (Rey, Joseph), about keeping oneself psychically barely alive, and bringing half-dead objects to analysis in the unconscious hope that they might be restored.

In his mind nobody lived except under his control, and his own capacity actually to grow and develop (having children or developing his career) had been cancelled by him (for example he said he had refused sex with his wife since their marriage 10 years earlier). Mr A imagined he maintained a chosen image of himself, through controlling the minds of those he needed. He did this literally through manipulating his photo and description online as he ‘worked up’ a new partner, only meeting her finally when he thought she had ‘bought’ the image he had designed for her. Keeping that image alive in her eyes then made him feel half-real while with her.

In working with Mr A, I first needed to help him recognise his distinct modes of experience: the dominant pretend state of mind (everything is possible and nothing is real), and the more hidden experience of psychic equivalence (I can make everything or nothing happen, I really control everyone with my mind). I showed him how he tried to straitjacket my mind along with everyone else’s, that there was enjoyment in ‘working me up’, for example by lying that he was
sick, abroad or in need of a reduced fee, the lies obvious from his eagerness for my reaction.

As with Dr P, I found a particular hidden ‘pocket’: he was probably seeing other therapists, and some of his lying was about that. When I asked him he was quite moved to realise that I knew him enough to understand that he would spread his bets, showing both his desperation for help and his fear of actual dependence or exposure. And that I would still see him. I focused not so much on the facts of his other therapies (e.g. what the CBT psychologist did and which other analyst he claimed to be seeing), but on why he needed to split his dependence and the versions of himself, and to shift from one to another at particular times – defiance, contempt, feeling misunderstood, or understood, and so on. This gave a more immediate example of what he felt to be his uncontainable destructiveness.

A further break in what he called his repeating ‘loop’ came from helping him to see how in his fantasy he was the analyst and I was the slow student admiring and assisting him in menial ways. This was a variant of his collection of ‘nurses’. His wife was portrayed as staying in an empty marriage, existing merely to support and accompany him - on his non-journey through life. It struck him when I suggested that while he surrounded himself with many ‘nurses’ (mothers), he was afraid to have a doctor or surgeon (father) who could actually diagnose and change him, penetrate his unreal world. He behaved as though he were himself the great doctor, with no need of a patient (just as he could have no child). Perhaps a real doctor might have turned out in Ron Britton’s terms to be a malignantly misunderstanding third object.7

**Discussion of Mr A**

In our terms, Mr A may have suffered, even earlier than Dr P, from ‘unmarked’ mirroring of affects in early infancy, by a mother overwhelmed by her own somatised anxieties and perhaps a fear of her aggression, projected into the baby, giving him little chance to learn to recognise his own emotional states and build a true self (or even a functional false self). He instead developed an ‘alien self’, the residue of early mirroring which has failed systematically, for example not reflecting a core feeling such as anxiety or anger, leaving a blank, or a false substitute from the parent’s mind (her depression, excitement, disgust or whatever). In this case I suspect a self-disgust, and fear of aggression and damaging the baby might have left Mr A feeling like a damaging and sick person who consumes others in parasitic relationships. The sense of an intrusive, projected aspect of the mother could have become lodged in the baby’s self as part of it and yet not felt to be owned. His unprocessed feelings, not recognised as part of him yet pressing for expression, perhaps then needed him both to somatise dangerously, and to implant synthetic images of himself into as many minds as he could find. Thus

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7 He has described, in ‘The Missing Link’ and a recent lecture here (Britton, 2007), the way in which ‘thin-skinned’ narcissistic patients have a hyper-subjective relationship to the object, trying to prevent the risk of being seen as an object by them. Their transference operates through extrapolation rather than penetration, and this over-extension seems to me to capture the tendency of Mr A to multiply objects, with many ‘backup copies’ but no real thing, no feeling of there having been an original base for his mental world.
he was stuck with projective identification, unable to build on a recognition of his mental and physical states to think about his subsequent experiences symbolically, made meaningful by rooting in actual feelings.

Unlike Dr P - who protected his pleasure by taking holidays from the world of rules, but mostly knew what he was thinking and feeling, felt real and could lie - Mr A lacked the building-blocks of emotional subjectivity. He had the papier-mâché bricks of a stage set, which could not contain his real feelings. Unlike with Dr P, we could not dig down to find the foundations in real memory and experience, and any attempt to do so would be illusory. We have to create the foundations between us in his ongoing analysis. Mr A lived his life much more falsely than Dr P, even when he said the truth it was not real; to lie you need to know the truth. He did not so much lie as confabulate. In contrast (possibly like Camus in his letters), Dr P said many things that were psychically real but incompatible, when he told lies he knew it but did not want to accept having only one life.

Another difference between these patients is that for Dr P, his ‘games’ were still games - he could stand back, think and decide to change. He also did things, although many were distressing and destructive to others. He had been married three times, had had children with each wife and had strong, specific feelings about each wife and child, his colleagues, friends and his analyst. He cared very much about his work, while Mr A, also gifted, phobically avoided making anything and knowing anybody. Unlike Mr A, Dr P was not terrified of the idea of commitment, he liked it so much he wanted everything to happen and develop. Mr A was stuck in a nightmare pretend world in which nothing could grow in reality, solitary games had taken him over which were not symbolic but deepened the split in his mental world, so he felt they were killing him. The intolerable sense of himself as dead meant he felt he could only half-exist as a lie in someone else’s eyes.

A very striking difference for me between these two patients was that being with Dr P was rather like being with a narcissistically grandiose child, wanting to have, do and be everything, and needing to be supported in recognising reality. Being with Mr A was far more disturbing, like watching someone repeat a bizarre perversion, isolated, sterile and trapped. Winnicott (1935) wrote that he had come ‘to compare external reality not so much with fantasy as with an inner reality’. It is this sense of fantasy, as the enemy of creativity and of inner liveliness that I mean by pathological persistence of pretend mode split off from reality-sense. Mr A shows how destructive it is when this becomes a kind of lair for developing a perverse adult character. He unconsciously protected other people and their mental worlds from close contact with his sickness; his falseness allowed neither truth nor a true lie. I would think that unlike Dr P, while sometimes fascinating or pitiable to others, he was not lovable.

8 In ‘Playing and Reality’ he described that compulsive fantasying is: ‘fantasying remains an isolated phenomenon absorbing energy but not contributing—in to dreaming or to living’ (Winnicott 1971).
So what did I do with Mr A? I kept offering simple links between, in Winnicott’s terms, inner and external reality, sidestepping what Mr A called ‘mesmerising abstraction’. This included my often saying how he came across to me (e.g. bored, or anxious since the last thing one of us said) and asking him whether that corresponded to something he was thinking or feeling. This gradually led onto more solid ground of our immediate experience together, away from the ‘fantasying’ which stifled emotional life and made him feel that he and everything in his mind was dead and fake. He thought that he contaminated everything and this is why (I think) he avoided contact with his wife and parents. His games had become too frightening and he could not let another person see them any more. But he is letting me see much more. For example, his constantly wooden, guarded expression and repetitive, meaningless talk gives way to spontaneous emotional expressions (a real smile or look of contempt), and personally specific comments (e.g. a thing he has done or thought), particularly when I am relatively transparent and accessible to him in my moment-to-moment awareness of his states. We have a good way to go.

**Conclusion**

In different types of psychopathology there are persistent, characteristic distortions of the experience of psychic reality, which can be regarded as a hallmark. Here I have considered distortions in the experience of psychic reality in manipulative narcissistic patients, which may help us to understand their tendency to lie and deceive others including the analyst. I have used the idea of a stable dissociation between ‘pretend’ and ‘psychic equivalent’ modes, where the pretend mode is privileged and used to control the external social world through deception, defending against unbearable affects threatening to break through in psychic equivalent mode. Pretence then creates the illusion of coherent self-experience and becomes a secret, addictive source of pleasure. The dissociation of these modes of experience of subjectivity is however hard to sustain particularly because others are required to collude. The precariousness of the solution threatens overwhelming the self with feelings such as intense dread, despair, loneliness, hatred, self-hatred, loss of self cohesion, and in some cases psychosomatic collapse.

The dissociation between ‘pretend’ and ‘psychic equivalent’ modes can however serve benign and healthy purposes. I have suggested that the situation of analysis may be interestingly thought about in terms of such a creative dissociation. Thus, holes in the integration, or islands of unbearable experience (as with Dr P), may be identified through the analyst’s sensitivity to the rawness of psychic equivalence, and his maintenance of the safe ‘pretend’ frame. With Mr A there is a bigger task, more equivalent to the marked affect mirroring of infancy which enables a knowledge of one’s own mind to be built up, before perspectives can be developed and integrated.

I have suggested that technique needed to be modified in the early stages to enable these patients, already too loosely connected to reality, to engage more authentically. Consistent gentle confrontation, and little development of a shared pretend mode, helped to create traction. After that, a more usual analytic technique became effective; if used at the beginning it risked
bolstering the patient’s false way of living and relating to self and others. Both patients settled into reliable attendance and a more normal technique was then successful with Dr P.

The work involved noticing how the pull into ‘pretend’ strongly operated in the transference, blocking the experience of unbearable, traumatic feelings with the immediacy of psychic equivalence, and working against integration. Progress required finding where pleasure as well as the threat lay in that, and tracing how everything worked on would be privately cancelled out, especially by Mr A. He showed a pervasive, perverse and desperate gratification in negating change which confounded the problem but also made it possible to work on in the transference. Bridging of the two modes and working through the areas of psychic equivalence, in these patients as with others, brings confidence that the analyst can know, bear and even understand the patient’s frightening inner world. With such a road through the minefield, and bridges between realities analogous to those a parent offers a young child, the car need no longer be flown across the river.

References


