A Woman’s Unconscious Use of Her Body: A Psychoanalytical Perspective

With a foreword by Susie Orbach
A Woman’s Unconscious Use of Her Body

Drawing on Dinora Pines’ lifetime of clinical experience this classic book provides a psychoanalytic understanding of women’s relationships with their bodies, focusing on key moments in women’s lives. It also considers the relationship between female patient and female analyst as expressed in transference and countertransference.

With chapters organised to follow the female life-cycle, topics covered include:

- the turbulence of adolescence
- pregnancy and childbirth
- infertility and abortion
- menopause and old age
- the traumatic effects of surviving the Holocaust.

With a foreword from Susie Orbach, this book will be of interest to mental health professionals including counsellors, psychotherapists and psychoanalysts.

**Dinora Pines**, who originally trained as a medical practitioner, was an eminent psychoanalyst in the British Society of Psycho-Analysis and lectured throughout the world. She died in 2002.
A Woman’s Unconscious Use of Her Body

A Psychoanalytical Perspective

Dinora Pines
To my husband, my children and grandchildren, who have been my beloved companions through my own phases of the life cycle.
<table>
<thead>
<tr>
<th>Acknowledgements</th>
<th>ix</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>Foreword: Holding, feeling, thinking</strong>&lt;br&gt;<em>Susie Orbach</em></td>
<td>xi</td>
</tr>
<tr>
<td>1 Introduction</td>
<td>1</td>
</tr>
<tr>
<td>2 Skin communication: early skin disorders and their effect on transference and countertransference</td>
<td>7</td>
</tr>
<tr>
<td>3 The psychoanalytic dialogue: transference and countertransference</td>
<td>22</td>
</tr>
<tr>
<td>4 Adolescent promiscuity: a clinical presentation</td>
<td>35</td>
</tr>
<tr>
<td>5 Pregnancy and motherhood: interaction between fantasy and reality</td>
<td>49</td>
</tr>
<tr>
<td>6 Adolescent pregnancy and motherhood</td>
<td>65</td>
</tr>
<tr>
<td>7 The relevance of early psychic development to pregnancy and abortion</td>
<td>81</td>
</tr>
<tr>
<td>8 Pregnancy, miscarriage and abortion</td>
<td>97</td>
</tr>
<tr>
<td>9 Emotional aspects of infertility and its remedies</td>
<td>112</td>
</tr>
</tbody>
</table>
10 The menopause 126
11 Old age 139
12 Working with women survivors of the Holocaust: affective experiences in transference and countertransference 148
13 The impact of the Holocaust on the second generation 171

Bibliography 188
Glossary 193
Index 195
I am grateful to my husband Anthony for his encouragement, to my colleague Marion Burgner who has so often been a most helpful critic and discussant, to Julia Vellacott for her sensitive editing and to Dorothy Unwin for her patient secretarial help. Above all I am grateful to the many patients who have shared their deepest feelings with me. To them I owe the ideas in this book.
Dinora Pines’ collection of papers republished now remains as refreshing, moving and profound as when they first came out. When she wrote, there was probably no psychoanalyst in the UK writing with such compassion. Her dedication to understand the dilemmas of the women who sought therapy with her, led her to extend the conventions of both psychoanalytic understandings and practice in deeply sensitive and useful ways.

Dinora Pines listened to her patients and she felt with them. Long before it became second nature to explore the analyst’s countertransference, not just for what the patient was conveying, but for its impact on the analyst’s own subjectivity, Dinora was making sense of the clinical encounter with reference to the profound impact it had on her as an individual woman sitting with other women.

She felt their suffering and she experienced her own. She felt their despair and she felt her own. She felt their loss and she felt her own. She made sense of the powerful emotions in play and has conveyed to us through her writings the intimate encounter that is the analytic relationship.

Dinora Pines was a humane analyst. There is none of the dissecting or distancing from the patient which is so frequently heard today in seminars and lectures when analysts talk about their work. The cost of absorbing the pain in our consulting rooms is not trivial. When we stay open to bear
witness and enter the inner world of the other, we inevitably hurt deeply. It is easier to diagnose, to objectify the patient, to see their struggles in terms of illness and pathology. But not for Dinora Pines. She stayed open and honourable to the very impulses that brought her to this delicate and meaningful work with people.

But to say that she was a humane psychoanalyst is not to underestimate her considerable theoretical and clinical advances and innovations. A dermatologist by training, Dinora was acutely tuned to bodily distress that involved emotional components. She saw skin that wept and did not heal. She turned her attention to the weeping heart and mind and the intricacies between the inside and outside of the individual. Through her physical care of her patients, she understood the healing nature of both containment and attention to detail. And out of that attention, which led her to train as a psychoanalyst, she began to think deeply about women’s experience and the construction of femininity. She recognised early on that the constraints of the analytic relationship needed rethinking so that she could meet her patients’ dilemmas and longings where they were, not from a perspective that said where they should be.

She opened up a dialogue for my generation of analysts to accept the likelihood that women who came to see us had enormous conflicts around issues of identity and merger. By understanding the difficulties in the mother–daughter relationship, she prefigured the concerns of the feminist reworkings of psychoanalytic theory and practice. She looked at the life cycle, at pregnancy, motherhood, menopause and infertility and at women’s sexuality. She looked at women’s relationships in the therapy. When we encountered merged attachments\(^1\) as we did in our practices we knew we were seeing something that had not been written about much, so in finding Dinora Pines’ papers and her discussion of the fear of merger we felt reassured and on track.

There is much in this wonderful collection that repays reading and discussing more than once. Her elegant discus-

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\(^1\) See *Understanding Women* (1983), Luise Eichenbaum & Susie Orbach, Penguin, Harmondsworth, Middx.
sion and interest in Second Generation and women survivors of the Holocaust opened up a taboo that existed not just in the psyches of survivors but in the consciousness of psychoanalysts too. In breaking open silences about the war, about survival anxieties, about women’s experience about the body, about women’s need to be related to within the therapy relationship, Dinora Pines gave us a new place to stand as psychoanalysts.

Rereading this book brings Dinora and her compassion and intelligence alive once again. While it made me wish she were still with us, I was comforted by the experience of her lively and empathic presence coming through the words that she wrote.
Introduction

My professional life as a psychoanalyst has involved me in working with both men and women patients, sharing their deepest experiences, conscious and unconscious. Love, joy and pleasure in living both for oneself and for other people are aspects of human experience which are easily expressed. What may remain secret and unknown, in order to avoid shame and guilt, is the child’s fear of abandonment, of being unlovable, the fear of loneliness, and the lifelong struggle to come to terms with one’s own mortality. These anxieties are common to patient and analyst, to men and women alike, for we share a common humanity. There are, however, certain major events, such as pregnancy, that only women experience. Over time I have become especially interested in these aspects of a woman’s life cycle, both from my own experience and from observing the reactions of women in my care.

After my early education at a girls’ school, I obtained a degree in modern languages at a mixed university. By the time I was considering further studies, a war was raging that threatened England’s very existence, and it felt inappropriate to begin research into medieval languages and literature. I therefore decided to study medicine, perhaps unconsciously striving to find a way of repairing, rescuing and healing human beings who were being so horribly destroyed in the outside world.

My parents were both doctors, and had always wanted me to study medicine. My arts degree was perhaps symbolic of an adolescent rebellion against them, but it was one that opened the doors to an appreciation of literature and
language that has never failed to delight me. The study of great novels, with their intense human relationships and feelings, formed an appropriate foundation for the close study of feelings and relationships that every patient brings to the consulting room. Sensitive listening to language, the choice of words and their meaning, is as important in psychoanalysis as in literature.

During the war, in 1940, very few medical schools accepted women. So I enrolled at the London School of Medicine for Women, where clinical studies were conducted at the Royal Free Hospital. All the students were women, as were most of the staff, since the men were in the forces. Air raids were frequent. A V-2 destroyed the casualty department just after we students on duty had left. After that we became evacuees, unwelcome guests of the families with whom we were billeted and a long way from our own families, from whom we were frequently cut off as telephone lines came down. Very early on in our lives we experienced in reality the powerful forces of life and death, our own vulnerability and that of those around us. Of course this was as nothing compared with the rest of Europe, whose countries were invaded, many of their citizens imprisoned or murdered for racial or political reasons.

On our qualification in 1945 most of us were eager to take an active part in the war, but by then there were enough doctors in the forces and we were deployed to various hospitals where we cared for the civilian population. By this time rumours had begun to emerge as to what had taken place in the concentration camps. I was secretly recruited to head a relief team that would be sent to Auschwitz, but mysteriously, the group was disbanded and no reason was ever given. It was a great disappointment to me, as by then I suspected that members of my family whom I had known as a child had been murdered. My interest in the Holocaust at that time stood me in good stead when I later began to work with victims of those years.

When I began clinical practice as a doctor, I gradually learnt to listen very carefully to what my patients were telling me or – even more important – not telling me as I examined their bodies. The relationship between body and
mind impressed itself more and more on me through my work. I have described in my paper ‘Skin Communication’ (see Chapter 2 below) how vividly the women patients’ bodies expressed pain that was unbearable and unthinkable about. Because words were unavailable to them, their emotions had to be expressed somatically and understood by a woman doctor who could think about each patient’s predicament as if she were a mother, and try to bring relief. In this way the phenomena of transference and countertransference between patient and doctor began to impinge upon my medical training, and made me seek to understand more. I was very fortunate in meeting a colleague in my own hospital, Hilda Abraham, who was an analyst – the daughter of Karl Abraham, one of the first disciples of Sigmund Freud. She encouraged me to discuss my cases with her and to try to work on similar analytic lines. The insights she gave me were my first experience of the existence and power of the unconscious. None of this knowledge was at that time part of our medical studies. Fortunately, this is no longer the case.

For a time I went into general practice, and saw even more aspects of men’s and women’s lives. Adolescent girls experiencing the inevitable bodily changes of puberty and the emotional impact of powerful sexual urges could either accept such changes in their bodies, or deny the move to adult femininity by becoming amenorrhoeic or anorexic, thereby avoiding the secondary sexual characteristics of an adult feminine body, such as breasts. Young women marrying, becoming pregnant, giving birth to babies and mothering them, expressed their joy, but also their emotional difficulties. They could be heard and helped by an attentive practitioner who saw them in their own homes, knew their husbands and their mothers and their other children. Husbands, and their problems in becoming fathers and heads of families, were another part of the picture. Thus the family crisis that inevitably follows the birth of a new baby could be observed in reality by the doctor rather than seen through the eyes of the mother alone.

When I trained as a psychoanalyst between 1959 and 1964 and began to practise, these same problems appeared
in the patient’s narrative, but my deeper understanding of myself gained through my own analysis now enabled me to listen better, to try to understand the patient’s pain and enter into a psychoanalytic dialogue. Part of this dialogue consisted of listening to what the patient was not saying, and noting how the body was forced to act out feelings that could not be consciously known or transmitted. I saw that many patients somatized rather than spoke. They would frequently develop a transient rash at moments of stress, or abdominal pains would interrupt their narrative at a point where painful feelings might otherwise have to be acknowledged. In several patients with a history of asthma, feelings of aggression expressed in the transference were accompanied by loud wheezing in their breathing, though a full asthmatic attack was avoided by verbalization and making the unconscious conscious in the session.

It seemed to me that these bodily expressions of unbearable feelings were more common in women patients. In thinking about this observation I came to realize that a mature woman’s body offers her a means of avoiding conscious thought and facing psychic conflict. For example, my patients gradually taught me to be sensitive to the uses and abuses of pregnancy. Consciously a woman might become pregnant in order to have a baby, but unconsciously her ambivalence to her pregnancy might be acted out in miscarriage or abortion. Pregnancy may also be used to solve unconscious conflicts concerning sexual identity, or other psychic difficulties such as unconscious rage against the mother.

Even if a woman does not use her body to avoid the knowledge of conflict, she is nevertheless deeply influenced by bodily changes throughout life, and different women cope with these events in line with their own ability to manage life problems and their own previous histories. The finality of the ending of the child-bearing years is frequently accompanied by the painful death of so many fantasied future babies in a woman’s mind, babies who will never now be conceived and born in reality. The pain of remaining barren when all around her are fertile is devastating and difficult to bear. A woman’s ageing body and the loss of her fertility may be a severe blow to her self-esteem, as if it were the death of a
part of herself that was attractive to men. Yet it may force her to find a new solution to her life, and new areas of living once the mourning for this part of her life cycle has been achieved.

Finally, I have been privileged to work with victims of the Holocaust and bear witness to some of their impressive ability to live their lives again after such massive traumatization, creating new life in themselves and in others. None the less, secrets about their past may be retained in their analyses, and in their families in a way which affects the next generation. Others are not so fortunate – despite the analyst’s strong wish to rescue them from somatizing unbearable emotional pain, they remain victims. Yet I am convinced that for all the patients I have worked with and described in this book, making the unconscious conscious in psychoanalysis leads to new and enriched life – secrets that are revealed allow room for the patient to think rather than to act out.

This collection of papers, written over the past twenty years, describes my psychoanalytic journey and some of the problems that I hope I have understood more clearly over time. Reading them over has made me aware of my own increasing emphasis on the importance of benevolent and compassionate listening, no matter what the analyst’s theoretical orientation. Such a stance is sometimes difficult to maintain in a psychoanalytic dialogue, as it is in any close relationship between two people where one’s own feelings of hatred and destructiveness towards the other may be unconsciously aroused, however strongly they are consciously defended against. For the analyst is human, not ideal. Benevolence does not imply that the analyst’s use of critical thought is suspended, but that the patient experiences in the psychoanalytic dialogue an atmosphere of compassion which enables him or her to expose the angry, hurt child inside and re-examine past solutions without shame.* In my view the past cannot be erased, but a more mature understanding of oneself and others may help to replace rage with compassion, and thus enable the patient to seize the opportunity for a new beginning and a greater pleasure in living.

Much still remains to be understood, not only by me but
by others working in the field – I look forward to learning from them now and in the future. I am grateful to my patients who have shared the analytic experience with me and taught me to understand more than I understood at the beginning.

Note

* To avoid the ungainliness of writing ‘he or she’ when referring to a psychoanalyst and to a patient, since this book is by a female analyst and is focused upon the problems of women patients, I have used the feminine gender only.
Skin communication
Early skin disorders and their effect on transference and countertransference*

Introduction
In this paper I shall describe and discuss the psychic predicament of female patients who have suffered from infantile eczema during the first year of life. After drawing on direct observations from my previous experience as a consultant dermatologist in a women’s hospital, I shall discuss the analysis of a patient with a history of this disease. I will concentrate on transference–countertransference problems, since in my view they highlight a basic disturbance in the earliest mother–infant relationship. This disturbance is renewed with every transitional phase of the life cycle, and exerts a subtle influence upon it.

The skin as a means of communication
I am focusing on the fundamental importance of the skin as a means of communication between mother and infant while she provides the holding environment, in which primary identification of the self is founded. In Leboyer’s (1974) film of the process of birth, we observe the immediate soothing effect of skin-to-skin contact between neonate and mother after the infant has abruptly emerged from the mother’s warm body into a cold and non-containing world.

Skin contact re-establishes the mother’s intimate feelings for her baby, as if they were once again merged, like they were in pregnancy, when the mother’s skin contained them both. The skin becomes a medium for physical contact, for the comfort of holding and of being held, and also for the transmission of smell, touch, taste and warmth, sensations which can be a source of pleasure and intimacy to mother and infant alike. The skin establishes the boundary of self and non-self, and represents the container of the self for each one of them. It is one of their most primitive channels for preverbal communication, where non-verbalized affects may be somatically experienced and observed.

Through her handling of the child the mother’s skin may convey the full range of emotions, from tenderness and warmth and love to disgust and hate. The infant may react through its skin to the mother’s positive feelings by a sense of well-being, and to her negative feelings by a skin disorder, which can take varying forms. The child’s non-verbalized affects may find expression through the skin. The skin may itch, the skin may weep, and the skin may rage. It will be dealt with by the mother according to her capacity to accept and soothe her blemished child. Such a situation may be internalized by the infant, as Bick’s (1968) paper has described. She shows how the containing object, the mother, is experienced concretely as a skin, and that her capacity to contain the infant’s anxiety is introjected by the infant. This function gives rise to the notion of internal and external space. Failure to introject the containing function and to accept the containment of self and object in separate skins leads to pseudo-independence, and to ‘adhesive identification’ and inability to recognize the separate existence of self and object.

Direct observation in the hospital setting

As a young dermatologist in a busy hospital, I observed that some patients with extensive skin disorders, who did not respond to medical treatment alone, would often be helped by my untrained attempts at therapy combined with sympathy and appropriate ointments. I noticed that some would