or collapse mentally, as she felt her second analyst had done. Any sign of weakness in me terrifies her.

There is also a change in the transference/counter-transference interplay. In the early years there was a lot of acting in and out, and communication therefore was predominantly by projective identification. Hence a highly-charged counter-transference reaction. I experienced depression, hopelessness, a great deal of irritation when she was manic and flippant, and a constant experience of an all-pervasive seductiveness. Now the counter-transference is mostly a fleeting indication of what goes on, and the communication by dream and association is clearer.

Postscript 2005

In this presentation I have tried to show how the patient has a psychotic identification with a depressed mother underlining her various pathologies. This was an identification which she maintained because it served her own narcissistic needs. I wanted to show the audience how important such a nexus is and how it can be relived and mobilised in the transference. I did not take up another theme that was becoming evident, that of the patient's hidden compliance. She did not overtly comply but she always provided extremely helpful associations or further developments to what I was talking about. It is often difficult to differentiate what is actual co-operation and what is another kind of process. Whilst being genuinely co-operative on the one hand the patient also adopted my interpretations in order to make us be of one mind and thus regain another kind of narcissistic union with her mother.

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What is therapeutic and counter therapeutic in psychoanalysis?[148]

This paper was given at a British Psychoanalytical Society conference on Saturday, 14 November 1987.

This Symposium has for me a *déjà vu* feeling. In 1961 I took part in the International Congress Symposium on Therapeutic Factors in Psychoanalysis. At that time I contended that Freud's basic proposition that insight is the specific therapeutic factor in psychoanalysis still holds true. The paper was controversial in that other views were represented, such as, that it is the relationship that is therapeutic or the love of the analyst, as expounded by Nacht.[149] My view was that all those factors are inter-related in that insight develops in a relationship and in turn affects the nature of the relationship.

Basically I still hold this view. It is insight that enables the analysand to regain parts of himself lost by projections, to integrate what has been fragmented or split, and this in turn alters his perceptions and object relationships. Insight is also of importance for lessening omnipotence and allowing a non-pathological introjection of the functions of the analyst. However, when one speaks of insight, even if one clarifies that insight can only be gained by experience, the impression is always left that insight is something predominantly intellectual. So in this contribution I would like primarily to expand

148 *The Bulletin of the British Psychoanalytical Society*, 1987, Number 9.
149 Nacht, S. 1962.

what I meant by meaningful insight. Such insight can only be achieved through emotional experience. The patient experiences different states of mind and through that experience he becomes familiar with and tolerant of various aspects of his personality. In particular, he experiences states of mind which hitherto he has warded off. And experiencing those states of mind he begins to know, not only his impulses and the nature of his relation to objects, but also the kind of characteristic defences he uses which contribute to making him the individual he is. Through his transference experience, he begins to know his own psychic history and how it affects him in the present. Insight is not something achieved once and for all. It is a capacity to recognise and tolerate different mental states. And it keeps shifting and evolving with the evolution of the analytic relationship. Such experiences lead to an increasing integration.

Insight is never static and once and for all. I think after the conclusion of a reasonably successful analysis the patient not only acquires some understanding of himself, his ways of functioning, etc. but even more importantly, he acquires the capacity to recognise, and to be more understanding of, his own mental states. And understanding is of importance. When people say, 'Oh, I understand it all but it doesn't make any difference', it is not in fact true. Understanding is a new factor which brings about change. For instance, the moment the patient experiences how split he is, he is already on the way to integration. If he understands what he has projected into another person, it alters his perception and his state of mind.

In this Symposium our concern is with what is therapeutic and what is anti-therapeutic in the analytical process. If I say that the potent therapeutic factor in an analysis is insight, I have to address myself to what it is in the psychoanalytic situation and interaction that favours the development of this insight. First of all, we must provide a setting which is stable, not intruded upon, etc. And an important part of this setting is a truly psychoanalytic attitude of the analyst. A person cannot allow himself to go through certain emotional experiences if he feels the analyst to be critical or rejecting of them. But equally, he may not allow himself certain experiences if he thinks the analyst can be upset or seduced by him. The stability of the setting allows the patient to gain a growing confidence in the ability of the analyst to tolerate the patient's experiences and attitudes and experiences which are projected into him without being unduly

affected. Such an attitude by itself tends to diminish the patient's belief in his omnipotence and lessens the anxiety deriving from it. And if omnipotence diminishes and he re-discovers, for instance, the warded off helplessness, he must have sufficient trust in the analyst based on good experiences not to dread excessively that situation.

I emphasise that trust is based on experience. Some American schools speak of the therapeutic alliance and mean by it that certain measures have to be taken by the analyst, such as fostering positive transference, to make this alliance. I think that there is always a part of the patient that is our ally, or the patient wouldn't be on our couch at all. But a true therapeutic alliance is forged as the analysis evolves and elements that interfere with the alliance, such as persecutory anxiety, are analysed. The alliance is not static but subject to fluctuations and the analysis of these fluctuations is an important part of the analytic work.

In order to provide this kind of setting, which primarily is the mental setting in the analyst's mind, the analyst must have what I would call a good counter-transference disposition. Nacht's view,[150] that the analyst's love is therapeutic, could be right in the sense that the good counter-transference disposition is one in which the analyst's unconscious, in his relation to the patient, is predisposed to receptivity and understanding. That I think is the expression of 'love' appropriate in a psychoanalytic treatment. It's easiest for me to think of this good counter-transference predisposition in Bion's terms of the 'container' and the 'contained'.[151] The analyst is identified with the containing capacities of parental objects and his own analyst. It means the analyst is able to contain his own infantile experience, and those that resonate with what is projected by the patient, without it leading to a disruption of his containing capacities. In other words, the analyst's state of mind corresponds to what Bion called 'reverie'.[152] If this is the basic unconscious stance of the analyst, then the patient's projections can be understood and elaborated. However, this containment is frequently breached by the concreteness or violence of the patient's projections and it leads to the analyst acting out, however discreetly. By discreet acting out I mean such manifestations as: a

150 Nacht, S. 1962.
151 Bion, W.R. 1962b.
152 Bion, W.R. 1962a.

change of voice we may not even be aware of, formulations too harsh or too caressing, interpretations which are wrong or at the wrong level etc. These occur in all analyses, however strict the psychoanalytical attitude and avoidance of more obvious acting out.

And it is essential that the analyst recognises such situations in which his containment was breached and uses that in turn for understanding the interaction with the patient.

But the analyst's receptivity and containment are only the first step in the analytical process, the ultimate aim being the patient's increased understanding. The patient himself cannot reach his warded off experience without the help of the analyst and in the psychoanalytic interaction a crucial role is also played by interpretations. One can think of it as the breast being the container and the nipple the instrument of feeding, or as the maternal and paternal function of the analyst.

Being receptive and silent is not always containing. The containment is in the understanding. I once had in analysis a mildly borderline patient who was in treatment with a totally silent analyst. In this situation, inviting regression and projection, she started hallucinating on the consulting room's wall. Fortunately, she was strong enough to interrupt the treatment before a complete psychotic breakdown occurred. In her later treatment with me she did well, as her projections into the analyst found a response which was not a blank wall. At some point the containing parent takes appropriate action to communicate her or his understanding. The appropriate action for the analyst is the interpretation. Whether to be silent, when to interpret, at what level, are decisions that have to be constantly made, and to make them the analyst is guided by his intuition based on knowledge and experience.

A crucial role in psychoanalysis is played by psychoanalytic intuition. A creative scientist must be capable of an intuitive leap which then has to be tested by experience. But a less creative scientist can work by pure deduction. This is not so in the case of the practitioner of psychoanalysis. The psychoanalytic process is always creative and always a process of discovery in which intuitive capacities are central. These capacities must depend on many factors, such as, the good counter-transference disposition, which goes also with the good internalisation of psychoanalysis, the analyst's experience and whatever it is that makes for psychoanalytic gifts.

These emotional factors are *sine qua non*. There are however also intellectual necessities. I think that one's conceptual armoury plays an important role. I have seen gifted, well-disposed analysts completely missing the right level of communication through lack of adequate concepts. A typical example is what used to happen in the past to patients with acute erotic transferences. If the analyst took up the obvious oedipal material in the best possible way, it was experienced by the patient as a sexual seduction or assault and sometimes led to acute psychotic breakdowns. This was so because there was no conceptual apparatus to understand part-object relationships and psychotic projections by the patient which made them experience interpretations in a concrete way.

Case material

I shall give you two brief examples of the importance of interpretation, or even of commenting at the right level. The first comes from work of a candidate. He was confronted by a patient starting his analysis in an acute homosexual panic of a psychotic kind. He objected to using the couch because he was tired of being a faggot and lying down for men, etc. He was clearly dreading the analysis as being forced into a homosexual submission by the analyst. The candidate interpreted, 'You are afraid that I am not able to distinguish between the psychoanalytical situation and a homosexual assault'. The patient immediately relaxed, staying on the couch, and started associating in a less psychotic way. I think the candidate got absolutely onto the right level of experience. He did not take up the patient's fears, didn't interpret at that point projections, but contacted the patient's fear of concrete thinking in the analyst. It was only later that he could address himself to the patient's own concrete thinking and the projection of that into himself. This patient reminded me of Schreber[153] explaining that God was unable to understand symbolism and metaphoric thinking. The opposite happened to me, making a comment which proved counter therapeutic. A patient on the brink of a severe manic breakdown rang me in the evening to reassure me that he was all right. I felt it necessary to communicate to the patient that I didn't treat his ringing me as an intrusion, but rather as a positive

153 Freud, S. 1911b.

step. So, in a comment, I used the expression 'that he wished to maintain contact with me'. My use of the word contact turned out to be most unfortunate. The next day when the patient had broken down he was persecuted by electric wires driving through his brain, producing short cuts, etc. I obviously hadn't realised how concretely the word contact could be experienced. I was very well aware that I must never with this patient use the expression 'get in touch', as it is immediately erotised and experienced as a seduction. But the possibilities of the word contact had escaped me. Probably I should have spoken of communication. It seems to me that both the candidate and I had a sufficient conceptual apparatus to understand the problems and pitfalls in the choice of language in talking to our patients, but his psychoanalytic intuition led him to a correct formulation and mine let me down.

So, to summarise what would I consider therapeutic in the analytical situation: it is everything in the setting and the work which helps the patient to feel, to express himself freely, and to become more self-aware and everything that promotes the analyst's understanding and meaningful communication. It is fashionable nowadays to speak disparagingly of 'clever interpretations'. If the 'clever interpretation' is out of touch with the atmosphere of the session and the patient's feelings, then it is not clever, it is merely a bad interpretation. An intelligent interpretation, however, which shows understanding of the patient's feelings and defences, is not to be dismissed as clever clever. An interpretation of the right content and at the right level is the central therapeutic factor. It is the very basis of the psychoanalytic method.

What then would be counter therapeutic? I think the way the title of our Symposium is formulated invites us to consider not only the analyst's countertherapeutic attitudes or interventions, but the whole question of whether the psychoanalytic situation and process by themselves could be counter therapeutic. I think it is the same factors which are at the crux of a potentially therapeutic situation, which also have the potential to make a counter therapeutic one. It is the interrelated factors of the regression produced by the psychoanalytical treatment and the effects of the transference. If regressive phenomena are not understood and well handled, they can lead, for instance, to a decompensation of the mechanisms of defence and possibly irreversible disintegrations.

Transference is a danger in that it confers enormous powers on the analyst and the patient is vulnerable to the analyst's wrong responses just as he was to the responses of his parents. The powers and weaknesses of the patient and the analyst interact. The power of the patient's projections may affect the analyst and, as the patient is dependent on him, he becomes the victim of the analyst's response.

The regression to dependence and the transference of infantile attitudes to the analyst cannot be avoided as they are the fulcrum of the analytical therapy. For the therapeutic use of the situation, there is a need of at least some co-operation on the patient's part, but the major onus is on the analyst's work because the patient only partly wants to get better. The forces in him which led to his illness are still active and he needs the analyst's understanding to enable him to face them. The analyst's counter-transference is always under strain. The patient unconsciously always pushes the analyst to act out a role in the patient's internal drama. For instance, he may be pushed to act out a punitive superego. This can lead to prolonged sado-masochistic ties. On the other hand, the analyst sometimes cannot help sounding to the patient like a superego when he interprets to the patient the existence of negative feelings or his acting out of these feelings, or generally interprets what the patient, for good reasons of his own, does not want to know about. Some patients, some of the time, experience such interpretations with relief. Other patients always, or some patients some of the time, can only experience such interpretations as an attack by the superego. And this too must be carefully followed and interpreted to diminish this superego effect.

Case material

One of my patients came to understand that as far back as he could remember, and probably long before, he experienced all reality as a vicious vengeful attack on his omnipotence – his comeuppance. This truly-felt understanding enabled him to tolerate and accept what had been earlier experienced as cruel and attacking interpretations and to spot himself how he turned them into persecutions. Another patient for many years could turn anything or nothing into a persecution, and any interpretation of her denied or projected good feelings was treated as a sign of weakness, stupidity, wish to placate her, etc. She made very, very slow

therapeutic progress which made her external life more liveable. But there was no lasting structural change and the psychoanalytic situation was stuck. I reached a point where I realised if the patient stayed in analysis it could prove counter therapeutic. Outside the analysis her relationships broke up and people avoided her. In analysis she found an object she could endlessly exploit and ill-treat without being left. The sadistic pleasure she derived from it gave her a kind of haven that she intended to keep forever. When this became crystal clear to both of us I decided to stop. That this situation could not be resolved shows the limit of an analysis. It could be my own limits, and another analyst might have done better (though she had seen three good analysts before me), or it could be the limits of our knowledge today.

Like all potent therapies, psychoanalysis has its dangers. There are some dangers in interpreting. There are also dangers in not interpreting which blocks the patient's development and leaves him alone with his despair. Under interpreting – pussy footing – also leaves the patient alone with his problems. If the analyst can't bear speaking clearly, it confirms the patient's feelings that his thoughts or feelings are unthinkable because they are unsayable. It also brings about an element of unconscious collusion, particularly in the erotic sphere – a kind of atmosphere which says – 'We both know what's going on but we shall not speak of it clearly so we can carry on pussy fooring' and this can also be very cruel. I once told a candidate a joke about a masochist and a sadist. The masochist was writhing on the floor saying, 'Beat me – beat me' and the sadist, his hands in his pockets, said, 'I won't'. I suggested that his pussy footing had the same effect.

I only touch on a few points on the therapeutic and counter therapeutic in analysis, focusing my comments on the problems of regression, transference, dependence and the analyst's reaction to projections. I would like to conclude on a simple remark Mrs Klein made in a discussion. She said mistakes are unavoidable. We all know that. But by and large, the more mistakes you make, the less good your analysis. And the fewer mistakes, the better your analysis. Psychoanalysis is a very potent treatment, involving a lot of responsibility. Too many or too great mistakes are dangerous to the patient. So both individually and collectively, we must always take very seriously the sources of our mistakes and try to understand and derive more insight from them.