3

Working through in the counter-transference

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This is a revised version of a paper first published in 1985 in the *International Journal of Psycho-Analysis*, 66: 157–66.

In this paper I hope to explore something about the complex interaction that takes place between analyst and analysand in our everyday work. Bion made the succinct remark that when two people get together they make a relationship whether they like it or not; this applies to all encounters including psychoanalysis.

Strachey (1934), in his now classic paper, spoke of a true transference interpretation being that which the analyst most feared and most wished to avoid, yet later went on to say that in receiving a transference interpretation, the patient has the experience of expressing murderous impulses toward the analyst and of the analyst interpreting these without anxiety or fear. Strachey is clearly implying that the full or deep transference experience is disturbing to the analyst; that which the analyst most fears and most wishes to avoid. He also says that conveying an interpretation in a calm way to the patient is necessary. The area I wish to address is this ambiguous problem, this walking the tightrope between experiencing disturbance and responding with interpretation that does not convey disturbing anxiety.

Whilst earlier understanding regarded counter-transference as something extraneous rather that integral, Heimann (1950) showed the use of the counter-transference as an important tool for psychoanalysis and differentiated this from the pathological counter-transference response. Whilst this differentiation is an essential part of our psychoanalytic endeavour, I wish to show how problematic the clinical reality is. For there is no such absolute separation, only a relative movement within that orbit.

It was Money-Kyrle (1956) who considerably furthered our understanding of this issue by showing how closely the analyst's experience of the patient's projections may be linked with the analyst's own internal reactions to the material. For example, he showed that in a difficult phase of an analysis the projection by the patient into the analyst of his incompetent self became mixed up with the analyst's own feelings of professional incompetence in not understanding the material quickly enough, and these issues had to be disentangled.

Money-Kyrle, investigating this problem in its more ordinary manifestations, said:

> 'If the analyst is in fact disturbed [and here it is implied that the analyst is inevitably disturbed in the sense of affected], it is also likely that the patient has unconsciously contributed to this result, and is in turn disturbed by this. So we have three factors to consider: first, the analyst's emotional disturbance, for he may have to deal with this silently in himself before he can disengage himself sufficiently to understand the other two; then the patient's part in bringing it about; and finally, its effect on him. Of course, all three factors may be sorted out in a matter of seconds, and then indeed the counter-transference is functioning as a delicate receiving apparatus.' (p. 361)

Indeed, in so far as we take in the experience of the patient, we cannot do so without also having an experience. If there is a mouth that seeks a breast as an inborn potential, there is, I believe, a psychological equivalent, i.e. a state of mind which seeks another state of mind.

The child's or patient's projective identifications are actions in part intended to produce reactions; the first thing that happens inside a living object into whom a projection takes place is a reaction. The analyst may deal with this so quickly as not to become aware of it: yet it is a crucial factor. The encounter is an interaction and, indeed, if it is being dealt with that quickly, we may have to ask whether the deeper experience is in fact being avoided.

A patient reported the following: when she was born, mother was advised to send away her 18-month-old brother, in the event, to relatives far distant, so that mother would be free to take proper care of the new baby. When the boy returned home six weeks later, mother was horrified to find that he did not recognize his parents, and mother said that after that 'wild horses would not keep them apart'.

I am struck by the metaphor and its relation to psychoanalytic practice. I think that the advice contained in Freud's metaphor of the mirror, or the analyst as surgeon, implicitly suggests that in order to take proper care of the patient's unconscious, the analyst's emotionality should be sent as far away as possible. The consequences of this attitude do result

in the non-recognition of essential areas and the danger that when the split-off emotionality returns, 'wild horses won't keep it apart' – with all the dangers of acting-out. To imagine that this split-off emotionality won't return is contrary to the very theories we hold in relation to mental life.

Unless we are to say that psychoanalytic function takes place in a conflict-free autonomous zone of the ego, we have to allow for the problems involved not only in digesting the patient's projections, but also in assimilating our own responses so that they can be subjected to scrutiny. The analyst, like the patient, desires to eliminate discomfort as well as to communicate and share experience; ordinary human reactions. In part, the patient seeks an enacting response, and in part, the analyst has an impulse to enact, and some of this will be expressed in the interpretation. This may range from an implicit indulgence, caressing the patient with words, to responses so hostile or distant or frozen that they seem to imply that the deprivation of the experience the patient yearns for is of no matter; a contention that a part-object mechanical experience is all that is necessary.

Yet an interpretation, and the act of giving an interpretation, is not a part-object selection of a number of words, but an integrative creative act on the part of the analyst. It will include unspoken and, in part, unconscious communication about what has been taken in, and how it has been taken in, as well as information about what has not been taken in.

The patient receiving an interpretation will 'hear' not only words or their consciously intended meaning. Some patients indeed only listen to the 'mood' and do not seem to hear the words at all. Joseph (1975) has shown vividly that we may be misled by the patient's words; the mood and atmosphere of the communication may be more important. The patient may operate with the same accent, listen to the analyst's speech in the same manner. His perceptions may be considerably dominated by his internal configurations and phantasies, but, I believe, following Klein's account in 1952, that: 'In the young infant's mind every external experience is interwoven with his phantasies and ... every phantasy contains elements of actual experience, and it is only by analysing the transference situation to its depth that we are able to discover the past both in its realistic and phantastic aspects' (p. 437).

Inevitably, the patient too will take in, consciously and unconsciously, some idea of the analyst as a real person. When we speak of a mother *giving the baby the nipple, we do not consider a simple nipple-mouth* relationship; we recognize that the baby takes in a penumbra of experience. There is always something in excess of the actual process. We see reported: 'The patient said ... and the analyst interpreted', yet the

complexities are enormous. To address the question of how the analyst features in the internal world of the patient, we need not only to move into the paranoid/schizoid internal world of the patient; we also require some flexibility in tolerating and working through the tensions between our own conscious and unconscious impulses and feelings toward the patient.

Constant projecting by the patient into the analyst is the essence of analysis; every interpretation aims at a move from the paranoid/schizoid to the depressive position. This is true not only for the patient, but for the analyst who needs again and again to regress and work through. I wonder whether the real issue of truly deep versus superficial interpretation resides not so much in terms of which level has been addressed, but to what extent the analyst has worked the process through internally in the act of giving the interpretation.

A patient, Mr A, had recently come to live in London, his first analysis had taken place abroad. He arrived for his session a few hours after having been involved in a car accident in which his stationary car was hit and badly damaged; he himself just missed being severely injured. He was clearly still in a state of some shock, yet he did not speak of shock or fear. Instead he explained with excessive care what had taken place, and the correct steps taken by him before and after the collision. He went on to say that by chance his mother (who lives in the same country as the previous analyst) phoned soon after the accident, and when told about it responded with 'I wouldn't have phoned if I'd known you'd have such awful news. I don't want to hear about it'. He said that thanks to his previous analysis, he knew that he needed to understand that his mother could not do otherwise, and he accepted that. He was, however, very angry with the other driver, and was belligerent in his contention that he would pursue, if necessary to court, his conviction that he would have to pay for the damage.

I believe that he conveyed very vividly his belief that he would have to bear alone or be above the immediate shock, fear and rage generated both by the accident and the mother's response to it. Not only did he believe that his mother did not want to hear the awful news, but that the analyst did not want to hear the awful news of there being a mother-analyst who does not listen to or share pain with him. Instead, he felt he had been taught to 'understand' the mother or listen to the analyst with an angry underlying conviction that the mother/analyst will not listen to his distress. He went along with this, pulled himself together, made a display of behaving correctly, became a so-called 'understanding' person. He replaced the distress of bearing pain with competence in doing the right thing, but let us know that unconsciously he will pursue his grievances to the bitter end.

Although he moved quickly from vulnerable victim to perpetrator of competent cruelty (consciously against the other driver, unconsciously against the mother and previous, and current, analyst), I also experienced an atmosphere that led me to believe that there was space for a more genuinely creative relationship to develop. In the counter-transference I felt that what I was asked to bear was not excessive, and that whilst there was a patient who does not want to know, I might also rely on there being a patient who shared wanting to know with me.

Now let us consider what took place in the session. The patient made an impact in his 'competent' way of dealing with his feelings, yet he also conveyed a wish for there to be an analyst/mother who would take in his fear and his rage. I interpreted the yearning for someone who will not put down the phone, but instead will take in and understand what this unexpected impact feels like; this supposes the transference on to the analyst of a more understanding maternal figure. I believe, though, that this 'mates' with some part of the analyst that may wish to 'mother' the patient in such a situation. If we cannot take in and think about such a reaction in ourselves, we either act out by indulging the patient with actual mothering (this may be done in verbal or other sympathetic gestures) or we may become so frightened of doing this, that we freeze and do not reach the patient's wish to be mothered.

Yet already I had been lured into either admiring the sensible, competent approach, or appearing to condemn it. I found that I was having the experience of feeling superior to and judging the mother, previous analyst and his own 'competence'. Was I being party to taking them all to court? I then needed to reflect about the parts of himself and his internal objects that did not want to know. These too were projected into the analyst, and also, in my view, 'mated' with parts of the analyst that might not wish to know about human vulnerability (ultimately death) either in external reality, or currently in feeling 'tossed about' by the patient in the session.

I then needed to show him that he believed that in presenting me with such an awful picture of mother/analyst, he persuaded me to believe that I was different from and better than them. Yet he also believed (and that was how he had behaved toward me at the beginning of the session) that I too did not want to know about the fear engendered either by unexpected accidents or by the impact which he believed he had upon me.

If we feel at the mercy of an analytic superego that does not support us in knowing about these internal buffetings, we are, like the patient, in danger of 'wrapping it all up' competently. We may act out by becoming excessively sympathetic to the patient, taking the others to court in a superior or angry way, or becoming excessively sympathetic to the others, taking the patient to court in a superior or angry way.

The process of meeting and working through our own experience of both wanting to know and fearing knowing (in Bion's terms +K and −K) facilitates, I believe, a deeper and more empathic contact with these parts of the patient and his internal objects. If we fail to take into account *in statu nascendi* our own conflictual responses, we risk enacting that which we should be interpreting, i.e. the hijacking of all the good propensities and the projection into the other 'driver' of all the evil; we may behave as though we could meet with accidents or the vicissitudes of life with impunity.

In taking the case to court, the patient's belief in the superiority of competently keeping out passions and ostensibly pursuing 'pure' truth, needs to be examined. What looks like truth-seeking is suffused with hatred. There is an underlying menace that if I make a wrong move, my name will be blackened, as he has already blackened the other driver, mother and the previous analyst. My experience leads me to believe in the patient's terror that if he makes a wrong move, he will be taken to court, judged by a merciless superego.

I think that this raises a question for the analyst. If we keep emotions out, are we in danger of keeping out the love which mitigates the hatred, thus allowing the so-called pursuit of truth to be governed by hatred? What appears as dispassionate, may contain the murder of love and concern.

Bion (1962), referring to psychotically disturbed patients, writes

> 'The attempts to evade experience with *live objects* [my italics] by destroying alpha function leaves the personality unable to have a relationship with any aspect of itself that does not resemble an automaton'. Later he says: 'The scientist whose investigations include the stuff of life itself finds himself in a situation that has a parallel in that of the patients . . . Confronted with the complexities of the human mind the analyst must be circumspect in following even accepted scientific method; its weakness may be closer to the weakness of psychotic thinking than superficial scrutiny would admit.'

One great difficulty in our work is in this dual area of remaining in contact with the importance of our own experience as well as our allegiance to the profound value of our technique; this forms part of the impossibility and the value of our endeavours. I think that this problem applies, for instance, to the controversial issue of interpretation versus response; in a way a false argument and in a way a very real one. Yet the issue becomes polarized, as though one was all good, the other all bad. Consider a patient bringing particularly good or particularly bad news; say, the birth of a new baby or a death in the family. Whilst such

an event may raise complex issues requiring careful analysis, in the first instance the patient may not want an interpretation, but a response; the sharing of pleasure or of grief. And this may be what the analyst intuitively wishes for too. Unless we can properly acknowledge this *in* our interpretation, interpretation itself either becomes a frozen rejection, or is abandoned and we feel compelled to act non-interpretively and be 'human'. We then do not help the patient to share with the analyst the experience that interpretation itself is not an ideal object, i.e. a depressive position sharing within the analytic framework, rather than a frozen response or non-interpretive aside.

On a later occasion, this hitherto rather propitiating patient began a session the day before a General Election, telling me with pleasure and excitement that he was thrilled at the prospect of the Tory victory. It then emerged that he had picked up either from my careful enquiry or from previous knowledge that I was probably a Labour supporter. I interpreted that I thought he was anticipating with triumphant excitement watching whether in the heat of the moment I would address myself to his reactions or mine.

He associated to a visit to a cousin with a new baby, and the story of his mother's labour with him. (He was not aware of the link labour/Labour Party.) As she was going into labour, she first offered to do all the family washing.

The patient not only reported a past family myth, but relived in the transference this relationship with an internal mother. My counter-transference problem was that either I was programmed to react angrily at this assault in the negation of my 'labour' pains or to be a saintly mother, who would selflessly deal with his 'dirty washing' without a thought for my disturbance.

But beyond that I believe the patient mocked me as a mother who he believed was above all concerned to keep her hands clean. Was I getting caught up with being technically correct, because I could not bear to take in how awful it feels to be a loser, and to be filled with hatred when someone else flaunts his or her success - the cousin with the new baby?

Like the young child, the patient, I believe, is consciously and unconsciously acutely sensitive to the way we interpret his difficulties in confronting the important issues, his labour in getting in touch with his infantile self – his propensities to become sadistic when he feels neglected or jealous or envious, when he feels mother/analyst is engaged with a new baby, and he feels himself to be the unwanted party. The patient raises very deep issues of rivalry between mother and child as to which 'party' is best equipped to deal with the issues, all of which may stir up reactions or excessive defensiveness on the part of analyst as well as patient. It is our professional task to subject these reactions to scrutiny.

I think that the extent to which we succeed or fail in this task will be reflected not only in the words we choose, but in our voice and other demeanour in the act of giving an interpretation; this will include the whole spectrum from frank self-righteous sadism to impeccable masochistic or hypocritical 'patience' in enduring the cruelties to which patients subject us. The point is that we have to cope with feelings, and subject them to thought; as Segal (1977) stresses, we are not neutral in the sense of having no reaction.

Money-Kyrle, in speaking of the analytic function, stresses not only sublimated curiosity on the part of the analyst, but the analyst's reparative and parental function. In his view, in the moment of the projective phase of the interpretation, the analyst is also taking care of an immature part of the self, which needs to be protected from the sadistic part. When we show the patient that he becomes sadistic when he feels neglected or that he identifies himself with the neglecting object and fails to take note of the needy infantile self, I think whether we know it or not, the interpretation will contain some projection of our own wish to protect the baby from the sadistic part. The maintenance of a careful setting is in some way a demonstration of this care.

In developmental terms the infant who is able to begin more genuinely to feel for the mother's hurt and wishes to protect her from it, is an infant who has taken in and identified with a mother who feels for his hurt and wishes to protect him from unnecessary hurt, as well as supporting him to bear pain. This experience does not come from a saintly mother, but a flesh and blood mother who knows about her own wishes to be rid of troublesome problems.

I have been trying to show that the issue is not a simple one; the patient does not just project into an analyst, but instead patients are quite skilled at projecting into particular aspects of the analyst. Thus, I have tried to show, for example, that the patient projects into the analyst's wish to be a mother, the wish to be all-knowing or to deny unpleasant knowledge, into the analyst's instinctual sadism, or into his defences against it. And above all, he projects into the analyst's guilt, or into the analyst's internal objects.

Thus, patients touch off in the analyst deep issues and anxieties related to the need to be loved and the fear of catastrophic consequence in the face of defects, i.e. primitive persecutory or superego anxiety. I shall try to show this with a final example from this patient.

This patient began a Friday session, a week before the holidays, announcing that he felt ill. He did not know what it was; he had the same symptoms as his little girl. But, said fiercely, 'I was determined to come, even if that risks you [the analyst] getting my illness'.

He was clearly frightened by illness and its potential threat. In the

counter-transference I found I was worrying about being infected and becoming unable to cope with work next week, i.e. having his symptoms. I interpreted his fear and referred to the part of him that wished me to 'catch the illness' of that fear.

He then told me about his small child's school play the day before. His wife had had a pressing work commitment and could not attend. He had given up his session to be there. He described the delight of watching the children; they would recognize parents and relatives and interrupt the performance to call, 'Hello Mummy', etc. He was hurt and angry that his wife was not present: it was plain that he felt lonely, unsupported by a family. I interpreted the loneliness; the wish for me to have been there as a 'family'. I related this to anger with *my* work commitments (I had not been able to change his hour), as well as my weekend and holiday commitments.

He acknowledged this, then remembered an occasion when he had seen me at a public lecture where psychoanalysis was under attack for not providing patients with sufficient support. He said that he had observed how well I had dealt with this.

I felt flattered and then needed to think about this. I interpreted that I was being flattered into a belief about how well I coped with this charge, whilst in fact I was being watched to see how I manage when I feel alone, unsupported and assailed by persecutors, external or internal.

He said he had woken in the night with a fear that he could die; previously with such a feeling he had experienced utter panic; now it was more with a feeling of terrible sadness to take in that one day he just won't be there. He had had a dream.

In the dream Freud was undergoing an operation for shoulder lesions. There was a worry that the operation was not fully successful; when Freud tried to lift his arm he could not do so. A group of people, including the patient, were trying to protect Freud in various ways, including sedation, so that he would not have to bear the pain.

He told me that I, and indeed Freud, the father of all psychoanalysts, needed group support; part of this support lies in sedation. Whilst he claimed to be part of a group supporting Freud, he had also said at the beginning of the session, that he needed my help even if that meant not protecting me.

There was a seductive, spurious quality to the sedative support. I thought of the operations on Freud, not for shoulder lesions, but for cancer associated with smoking. My patient had seen me smoking at that meeting. I felt a strong urge to avoid this area.

I pointed out that he seemed to be protecting me from this issue; as though that would be too much to put on my shoulders. He admitted this and now said that in the dream the lesions seemed to be a

consequence of cancer. He spoke of his aged father and the fear of his death. Now he protected my by placing the problem with an aged father.

We could say that the patient projects into the analyst parts of himself and his internal objects, as indeed he does. He presents two models; the one copes impeccably, the other is broken down. In the course of such projection, he affects me. In the session I found that I was lured into having experiences in both directions. ('I'm terrific' or 'I'm awful'.) I have to remind myself that I was neither. In part, I do share, or am infected, by the child's symptoms, idealization or persecutory fear, in which the depressive position mother gets lost. This has to be recovered so that I and also the patient can be helped to realize that in assailing the mother or father with these pressures, including guilt (putting it all on Freud's shoulders), the child's need to be protected and cared for gets lost. In part the patient projects anxieties about, and rivalrous triumph over, unable parents; he also fears an analyst triumphant over a patient unable to cope with feeling ill or abandoned.

I believe that there is evidence of movement in the patient from the impeccable coping after the accident (as reported earlier) to something that feels more hopeful about anxieties about not coping (more feelings of sadness, rather than feeling overwhelmed by panic). Whilst there is pain and rage about missing parents, or what was missing in the parents, this is interrupted now by child parts delighted to recognize good aspects of parental and analytic support. The need for an impeccable performance has given way to the possibility of more spontaneous interaction.

My stress is that, within the analyst as well, spontaneous emotional interaction with the patient's projections takes place, and that if we fully respect this and are not too dominated by the demand for impeccable neutrality, we can make better use of the experience for interpretation.

The patient's projection of his experience into the analyst may be felt by both as an unwarranted intrusion and touches on issues in mental life where boundaries between internal and external, phantasy and reality, self and object become problematic in various ways. I shall give a brief illustration.

A young married woman had been exposed to a series of unpleasant burglaries. Now their apartment is secured like a fortress. She arrives on a Monday saying that the weekend has been awful, taken over by an event on the Friday night, a burglary, not to their apartment (which is now so well secured), but to the apartment above where the people are always away. 'We were just going to sleep. We could hear the footsteps because the partitions are so thin. We called the police but by the time they got there, the bastards had got away.' Meanwhile they tried to reach the owners at their country house. First they got the Ansafone, and when eventually they reached them, they explained they'd been in the garden

clearing up the aftermath of a huge party – 'the discrepancy of our experience and theirs seemed crazy'. The rest of the weekend she felt depressed, upset, exposed and vulnerable and in no state to look after her baby.

The patient reports an actual event at the weekend; an intrusion into her home. In the transference there are already hints linking the 'upstairs owners' with me (I have an Ansafone; I work in an upstairs room in a tall house, and I am also 'always unavailable' at the weekend). She tells me that the discrepancy between the experience of those people who are away having a party and her experience is enormous, implying that I will be distanced from taking in her experience. But am I? On the contrary, as she continues to describe the detail of how the burglars climbed up the drainpipe to the third floor, and says that what was so specially disturbing is that 'we really thought we had got the apartment secured; whilst it's happening, it feels so sinister'. I find that my thoughts have turned, naturally enough, to my house, to thinking with some anxiety – 'a burglary like this could happen to me; I'm not so secure either'.

The patient continues – 'in fact, when the police arrived, they came with vicious sniffer dogs – as I opened the door – the dogs – although held on a tight rein, jumped! I felt terrified and for a moment I felt sorry for the burglar'.

In my view this patient was not only describing the events of the weekend; she was also engaged in intruding into me certain sinister fears, both of being intruded into in reality, but also about being 'sniffed out' and 'jumped on'. She alerts me to her fear of being intruded into and sniffed out and jumped on (suggesting also certain sexual anxieties in the face of a frightening superego). But I would suggest that I am also being sniffed out as to how I take in her experience, and that secretly she will be ready to 'jump on' me.

I would suggest that one view she holds of me as the mother in the transference, is that I so fear being intruded into by a burglar/husband or by the patient/child's projections that I secure or defend myself as though I were living in an analytic fortress. In that way I would be impenetrable by a partner at the weekend, but would also then be impenetrable to the patient's experience. An interpretation of the patient's experience of robbery at the weekend, or the internal experience of feeling robbed of the analyst/mother by the intrusive 'bastard' of a father would be experienced as given by impenetrable or unreachable parents – those parents whose experience is so discrepant from hers, engaged as they are in clearing up the aftermath of their sexual party.

Yet the patient has also intruded into me a wish not to be distanced in that way. On the contrary, I believe that I was invited to feel that I was in the same 'boat' or the same exposed house as the patient. Thus

I am invited to feel that the 'partitions are so thin' that there is no separateness. Then she is the sniffer dog, not only sniffing the parents out at the weekend, but entering my mind as though we were 'one'. What I wish to convey is that the 'partition' between what we tend to call normal projective identification (or empathic sharing) and intrusion is very fine.

In the counter-transference in such situations we may find that we either become 'lulled' into such states of mind by the patient, or so sensitized to that danger that we behave like an impersonation of the police sniffer dogs, ready to pounce the moment the door is opened.

Thus one gains access to the patient's view of her internal objects, felt to be either overidentified with her or so distant and harsh that they are not able to take in her experience.

These issues are very real and we may become particularly vulnerable to them in these areas where the patient touches on our 'shared' external or internal world. Making space to work through these issues internally will much affect the way in which we give our interpretations in both taking care of the exposed baby in the patient, and 'sniffing out' and dealing with the nasty intrusive parts as well.

These issues I have been trying to illustrate become more rather than less problematic when we are dealing with borderline and psychotic patients. These patients may become more or less impervious to ordinary analytic co-operation and may act out in ways that present the analyst with serious management problems. They may make demands, say for an extra session at the weekend, where, for the analyst to acquiesce, may be to feed and reinforce tyrannical narcissistic parts of the patient; to refuse may be to indulge and reinforce sometimes profound grievances. In cases of suicidal patients, anorexia, or malignant hysterics, for example, such management issues may carry life and death implications.

Of course in these situations the patient massively projects parts of the self and internal objects into the analyst; such patients also arouse in the analyst feelings of being helpless and at the mercy of vengeful exploitative behaviour whilst the patient indulges in imperviousness to the analyst's needs. The task of experiencing and bearing these feelings whilst at the same time not becoming alienated from those parts of the patient that are genuinely defective and in need of support is a considerable one. In those cases where the situation becomes unmanageable it is easy to feel that the patient is 'unanalysable' (and sometimes this may be so). The very intensity of how unmanageable the situation becomes, may be the evidence of how unmanageable the internal dilemma is for the patient. In these cases the patient actually makes the analyst feel helpless and at the mercy of a ruthless persecuting object that goes on relentlessly and will not be modified by human understanding – the archetypal primitive superego.

I wish to emphasize that faced with such serious managerial problems, the analyst is also involved in a massive effort not only to contain the patient's projections but to manage his or her own feelings, subjected as they are to such intense pressure. And even in the case of, or perhaps most especially in the case of, such disturbed patients, the patient, either consciously or unconsciously, makes enquiry into the question of how the analyst deals with such feelings.

When analysis proceeds well, the analyst has the luxury of being able to manage the combination of some involvement and some distance. In the case of these very ill patients the power of the patient's predicament, and the capacity to intrude into the analyst's mind and disturb him, may put the analyst in the position, at least for some time, of being taken over and unable to function as a separate thinking person.

The analyst needs to work through the experience of feeling like an overwhelmed mother threatened with disintegration by an interaction with the overwhelmed baby. The analyst may need to be able to turn to an outside person, a 'father' to provide support; for example, a hospital or colleague may be needed for support not only in the management of such a case, but also to encourage the analyst to have the strength to hold the feelings of hatred for the impervious, exploitative, parasitic patient/baby together with the love and concern for the needy or defective baby in the patient. This, in my view, enables the analyst to help the patient to feel that these intense, contradictory feelings can be endured, so that the patient may be helped to begin to meet the issues in relation to parts of the self and internal objects.

Whilst these patients intrude problems relating to actual management, my contention is that these problems form an essential part of the management of any analysis; were it not so, working through would be a smooth, uninterrupted process; it never is for the patient, and my stress is that it cannot be so for the analyst either. Analytic thinking must then include a recognition of, and a struggle with, our desire to enact, in order to be able to think about and decide what to do in the circumstances.

I have tried to show that the experience for the analyst is a powerful one. To suggest that we are not affected by the destructiveness of the patient or by the patient's painful efforts to reach us would represent not neutrality but falseness or imperviousness. It is the issue of how the analyst allows himself to have the experience, digest it, formulate it, and communicate it as an interpretation that I address.

Summary

This paper is intended as a development of Strachey's classic paper, 'The nature of the therapeutic action of psychoanalysis' (1934). Strachey states that the full or deep transference experience is disturbing to the analyst; that which the analyst most fears and most wishes to avoid. He also stresses that conveying an interpretation in a calm way is necessary. The area addressed is the task of coping with these strong counter-transference experiences and maintaining the analytic technique of interpretation. The clinical illustrations attempt to show something of the process of transformation or working through in the analyst, as well as showing that the patient is consciously or unconsciously mindful as to whether the analyst evades or meets the issues.

The contention that the analyst is not affected by these experiences is both false and would convey to the patient that his plight, pain and behaviour are emotionally ignored by the analyst. It is suggested that if we keep emotions out, we are in danger of keeping out the love which mitigates the hatred, allowing the so-called pursuit of truth to be governed by hatred. What appears as dispassionate may contain the murder of love and concern. How the analyst allows himself to have the experiences, work through and transform them into a useful interpretation is the issue studied in this paper.

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