5

Listening from an interactional viewpoint: a clinical presentation

In the last chapter I gave an example of a therapist re-enacting a traumatic element of the patient's childhood experience (Miss G. in example 4.6), where it was possible that this re-enactment grew out of the therapist's unconscious response to unconscious cues from the patient. I shall give here a more detailed illustration from an analysis in which, during the reported sequence, similar dynamics gradually emerged.

I also use this clinical sequence as a further illustration of learning to use internal supervision. I therefore follow the analytic process at three levels: (1) the analytical dialogue – what the patient and I said, in sequence, in each session; (2) internal supervision – what I was thinking, in the session, and how I arrived at each intervention; (3) hindsight – a commentary on some of what I later realized I had missed at each point in the session. Much of this hindsight occurred to me when writing notes after each session. I selected this particular week for making fuller notes than usual because I knew I was currently having difficulties in this analysis, and I was trying to sort out what was happening.

We will see that I made a number of mistakes in this sequence, which at the time seemed quite inexplicable. Gradually I began to recognize, and to respond to, the patient's unconscious cues which helped me to recover an analytic holding in the analysis. The following day, the patient made a surprising use of this recovery, re-experiencing in the session a very early trauma. With hindsight, some of those 'mistakes'

could then be understood from a dynamically different perspective.

Background to the week of sessions to be presented[1]

Mrs B. was in the third year of her analysis. (This patient has been referred to already in Chapter One, example 1.5.) She was about thirty when she started treatment, at which time she had not been long married. She had given birth to a son, here called Peter, six months prior to the week that follows. Before her pregnancy with Peter, the analysis had focused mainly on an accident that had occurred when Mrs B. was eleven months old. She had pulled boiling water onto herself, while her mother was busy elsewhere, and had been severely burned. This experience was worked over repeatedly during the analysis, in dreams and in many sessions, but it had remained as a memory never to be consciously remembered.

After her son's birth Mrs B. became healthily preoccupied with being a mother, the accident shifting largely into the background of the analysis; and having begun to feel much better, she suggested dropping her Friday sessions. Peter was beginning to wean himself, and (as it seemed) so was she. Mrs B. also told me she was offering flexibility to Peter, for him to be able to move away from her – with her still there when he needed her. Therefore, when she showed anxiety about losing her fifth session permanently, I wondered if she had been prompting me to offer her a similar flexibility. As a result I offered her a compromise arrangement. I agreed to keep her usual Friday time available for a month or two, during which period she ould see how it felt to be coming only four times per week. Then, when Mrs B. showed concern about my wanting to use that time for another patient, I told her I would be using it for myself, for reading. She seemed pleased and grateful for this offer; but, as soon as she began coming less frequently, her anxiety mounted. The week I shall now present is the fourth week with this reduced frequency of sessions.

Hindsight: We can see that I have interrupted the analytic process in a number of ways. Rather than analysing the

un-resolved anxiety about dropping this session, I have presented myself in the role of a good mother, offering a flexible weaning. This appears to gratify the patient but it more clearly meets a need of my own. The patient prompts me to re-consider my offer. She could be indicating the inappropriateness of the flexible arrangement, but I fail to recognize her cue. Instead I rationalize my offer by telling her how I plan to use the Friday time. I thereby give her valid grounds for perceiving me as wanting a rest from seeing her so often.

The clinical sequence

Monday

The patient began the session by saying she had had a mixed weekend. She felt it was possible she was not yet ready to drop her Friday sessions. (Pause.) She had had two dreams. In the first: *a girl was looking after a cat that had had a kitten. She had helped this cat deliver the kitten, which was lying in a pool of blood. The kitten was too weak to survive and died.* In her associations Mrs B. told me she had a friend whose daughter had the same name as the girl in the dream. (I shall call her Emma.) 'Emma has a white kitten. This kitten has a scratch that won't heal.' On saying this, Mrs B. became very distressed. (Pause.)

Internal supervision: The patient seems to identify herself with the kitten in the dream. I note the references to 'too weak to survive' and 'a scratch that won't heal'. I also note that the primary concern seems to have been announced at the beginning of the session when she said she was not yet ready to drop the Friday sessions. I therefore choose to interpret with this issue as my focus.

I said I had the impression she was anxious about dropping the fifth session, partly because she was afraid she might not be inwardly strong enough to cope with the change, and she might be afraid I would assume from such a change that the emotional scars had healed more than perhaps

they had. The patient agreed with this interpretation and told me the other dream. *She had been swimming very slowly in a pool.* She had no associations.

Internal supervision: I believe this dream is offered as confirmation of her need to go slowly, and I prepare to acknowledge that I have heard this.

Hindsight: I am intervening prematurely; it would have been better to formulate a silent hypothesis at this point and to wait for the patient's further thoughts before intervening. I had been selective in my playback of the patient's own words, avoiding any reference to the pool of blood or to there having been a birth and a death in the first dream. The patient now offers a second dream, in which she was swimming in a pool. We cannot be sure whether this is a confirmation of the interpretation offered, as I am assuming in the session, or whether it is an indication by the patient that I have been going too fast. She again gives no associations, as if to highlight the fact that I had interpreted the earlier dream almost on my own. I had responded too quickly and with few associations from her.

I said I thought this second dream stressed her need to go at her own pace. She replied that she was actually 'crawling' (doing the crawl) in the dream, and she added that Peter was now experimenting with crawling.

Internal supervision: I feel these comments are further confirmation of my interpretation that she needed to go at her own pace.

Hindsight: I am too quick to hear confirmation of this interpretation. The concern about the flexible arrangement is not being confronted directly in this session, and I fail to notice the omission. I am still assuming this flexibility to be what the patient needs, so I am deaf to any indications to the contrary.

Mrs B.then told me she wanted to explore the question of the Friday sessions further. I suggested to her she could do

one of two things, with regard to Fridays: either she could use her Friday time on a demand-feeding basis, asking for the extra session during those weeks when she felt a need for it, or she could go back to five sessions for as long as needed. I suggested she let me know which way she would like to arrange the Friday sessions when she felt ready to decide.

Hindsight: There has been a further shift away from an analytic approach to the unresolved problem of the Friday sessions. Instead, alternate arrangements are being suggested to her. We also need to note that I have shifted into a manipulative mode. I am directive, making suggestions, and offering solutions to the patient rather than allowing her to be free to find her own. By intervening prematurely, I cut across the patient saying whatever she had just started to say, deflecting her onto the alternative arrangements I am now suggesting to her.

Towards the end of this session, I introduced a new topic, saying I felt it might be related to the matter at hand but I was not certain. I wondered aloud to the patient whether she had needed to emphasize the importance for her of being allowed to go at her own pace. She had, for instance, made sure she did not direct my attention from the baby part of herself either by bringing her actual baby to show me or by bringing a photograph of him.

Hindsight: The possibility that there might be some significance in Mrs B.'s never having volunteered to bring her baby to a session had been suggested to me some months earlier, when I had attended a clinical presentation by a female analyst who was talking specifically about her experience with patients who had been pregnant during analysis. She had quoted several such cases, in all of which the mother had at some stage brought the baby to a session. When I mentioned I had a patient who had never brought her baby to a session, the patient having been pregnant while in analysis with me, I was told that I may have been blocking her from feeling able to

show me her baby; perhaps I had been communicating some jealousy of her relationship with her baby, from which I was excluded. I had not thought so at the time, and I had felt no need to bring this issue up with her until now. For some reason I chose to mention this now, even though it was manifestly quite irrelevant and far removed from the issues that were much more in evidence in this session.

I am still blocking the analytic process by remaining in a manipulative mode of functioning. I say I am not sure whether this new topic relates to the matter at hand. My introduction of this here suggests some unrecognized need (of mine) to direct the patient away from what is disturbing the present state of the analytic relationship. Indications of countertransference are present in the manipulative quality of my intervention and in the implied pressure upon the patient to feel that she 'should' bring her baby, or a photograph of him, to show me.

Mrs B. replied to this by saying she hadn't felt I needed to see the baby, or a photograph of him, because she had assumed I already knew him so well through her. (This was the end of the session.)

Internal supervision: I feel reprimanded by the patient. In her response she points out that I should not need to see her baby, or a photograph of him, at least not for the purposes of the analysis. She indicates that she had assumed I knew him well through her, but now she may be wondering whether I do. Her use of the word 'need' alerts me to the fact that she is picking up some countertransference interest expressed by me. However, because it is the end of the session, this is not dealt with. Having allowed my internal supervision to lapse in this session, I shall have to be more alert in the future. The unresolved issues are likely to appear as a continuing concern in the next session(s).

Tuesday

The patient arrived six minutes late. This was most unusual for her. She started the session standing, and offered two photographs to me while I was also still standing.

Internal supervision: The patient prompts me to see that there is something amiss, by coming unusually late. She also demonstrates, by standing, that the photographs do not belong in the analysis.

Hindsight: We can see a silent protest here along with the patient's compliance, but I fail to use my awareness of this in the current session.

> One photograph was of Mrs B. with her baby when he was a few weeks old, and the other was a more recent photograph of him with both parents. I responded to these by saying 'They are lovely', and handed the photos back to her. She lay down on the couch.
>
> After a pause, Mrs B. repeated what she had said at the end of the previous day's session, that she had felt I already knew her baby and her husband intimately without seeing the photographs; but, outwardly, she seemed pleased I had seen what they look like.

Hindsight: We can note her repetition that I should not have needed to see the photographs. Even though initially I had been alert to this as a break in the normal analytic boundary I fail to deal with it in this session, possibly because there are now several framework issues to be dealt with.

> The patient continued by saying she was still not sure about the fifth sessions. She didn't know whether it should be on a demand-feeding basis or not, as she might end up wanting her session on every Friday.

Internal supervision: This question of the flexible arrangement remains unresolved, and the patient continues to be anxious about it. The idea of demand-feeding had been introduced by me, not by her. The effect of this is to make her feel she would be greedy if she were to ask for a full return to five sessions per week.

> Mrs B. went on to say she didn't want me to assume too many of the Friday times would be available to me for my reading.

Internal supervision: More errors come home to roost. Mrs B. specifically picks up the unconscious implications of my earlier self-exposure with regard to the reading. She shows here quite clearly how she is reacting to these implications; that she is anxious I might want the Friday time *for me* when she could be needing this same time for herself. The offer of a demand-feeding arrangement is not turning out to be as reassuring as it was meant to be. It is making the patient feel criticized, as being 'demanding' if she should need her Friday time back. In the guise of seeming to be generous to the patient over the Friday times, I have projected some unacknowledged greediness of my own into the patient.

> I said I felt it had been unhelpful telling her how I planned to use her time, while keeping it available to her. Knowing this, she now saw me as the mother who wanted to be allowed to get on with her own things once the child was beginning to grow up. I was aware of the implications of this for her, because her accident had occurred at a time when her mother was busy elsewhere – and at that time she herself had just recently begun to walk.

Hindsight: There is an attempt here to acknowledge the patient's reality perception before referring to any childhood precedent to it. But, I am still being too quick to pass on to the past from the uncomfortable reality in the present. In effect, I am deflecting the patient away from my own failure in attention to that of her mother. This could be seen by her as a further indication of my sense of discomfort at the recent lapses in the analysis. I do not leave her free to elaborate on this, in her own way or in her own time. I pre-empt her by doing this for her.

> Mrs B. replied to this by remembering in some detail how her mother always seemed to be putting housework and cooking before spending time with the children. Her mother always wanted to have the house cleaned, and a

good meal prepared, as if all they needed was to be housed and fed, whereas Mrs B. would have preferred a simple lunch and more time with her mother.

Internal supervision: The patient seems to be playing back her perception of me as having been preoccupied with getting the recent mess in the analysis cleaned up, and myself reinstated as the good mother ready with a good meal, whereas she would have preferred me to have allowed her to have had more time in the session for her to have used this in her own way.

Mrs B. went on to tell me about about her nephew (aged nine) and niece (aged seven) who were staying with them at this time. Her niece had been away for the weekend. She had a favourite cookery book that she had brought with her for her stay; and she had also taken this with her for the weekend, so her brother would not use it while she was away. Mrs B. had let her nephew use one of her own recipes for him to cook with her, which he wanted to do. Half way through making something in the kitchen with her, he complained that she was not really letting him do the cooking. She was doing too much of it for him.

Internal supervision: I regard this as unconscious supervision by the patient. I reflect on this and feel she is alerting me to my having done too much for her, in her recent sessions, in relation either to the frequency of the sessions or to the issue of the photographs or both. I prepare to explore each of these in turn.

Hindsight: What I do not recognize here is the theme of *two people wanting the same thing*. The niece wants to keep her cookery book for herself, to prevent her brother using it when she is away. The patient may be alluding to my telling her I would use her time on Fridays for myself when she is away. She could feel I am wanting the time for myself, not wanting her to have it.

I said I felt she needed to confirm that she was being allowed enough freedom for her decision about the Friday

sessions to be really her own. Mrs B. replied to this by saying she didn't feel I was interfering in any way with that. There was then a silence.

Internal supervision: I note the word 'interfering', and again I feel rebuked by the patient. I sense this might be related more directly to the photographs.

I said to Mrs B. I felt perhaps the missing freedom had more to do with the fact that I, and not she, had raised the issue of the photographs. Although she had complied with my comments, apparently happily, I felt she may have had more reservations about doing so than she had been showing. She picked this up quite readily and said that, although she was pleased I had seen the photographs, she was aware of being anxious I might assume from them that everything was now all right. Everyone looked so well and happy in the photos. She was afraid I might be unaware that, inside herself, she was still having to deal with more distress than she felt able to cope with in four sessions per week.

Internal supervision: I note the patient is elaborating on her anxiety related to showing me the photos, and she inserts a further reference to the still unresolved question of frequency. I see that I must attend to this now.

I said she was clearly still anxious about the question of the Friday sessions. She replied that she was, and asked if she could (at least) come this week on the Friday. This was agreed to.

Hindsight: The issue of the treatment structure is only partly resolved. It was not until after this week that Mrs B. made an unreserved request for a return to five times per week, on a regular basis, which was how the analysis continued.

Mrs B. continued by telling me a dream:
She was holding a container with something valuable in it. There were other people around and they seemed to want

their share of what was in the container. She felt as if they had robbed a bank, or something, and she was now carrying the loot for all of them. They were sent to prison, but there was a friendly prison officer who saw to it that she was put into a cell on her own for her protection. She finished her sentence before the others. She was being conducted across the yard towards the gate to freedom when the others set upon her and kicked her head in. She lay dead on the ground. Mrs B.'s subsequent associations referred to the analysis, but I could not recall these after the session had ended.

Internal supervision: I feel flooded by this dream and the associations. I am abstracting the themes in the dream while listening to what the patient is saying. I choose to play back those themes I can recognize as relating to the analysis, and to the current issues regarding it.

Hindsight: There is a further reference to the theme of *other people wanting what she has,* what she is holding in the container, but I miss this and therefore still do not deal with the issue of the Friday time being no longer clearly hers. Also, my not being able to recall the patient's associations indicates a difficulty in following, rather than leading, her in this session.

I said the patient was trying to preserve her analysis, as the container with something valuable in it, from whatever was threatening to take it from her. She needed me to be a protector of it, allowing her to have space to herself, particularly as she may have felt I intruded on her space by my reference to her bringing her baby or a photograph of him. Maybe she saw me as being jealous of her special relationship with her baby, wanting some of it for me too.

Hindsight: This attempt at interpretation is too long. Also I refer ambiguously to two kinds of intrusion by me: (1) into the analytic space, and (2) into her space with her baby. The reference to jealousy is a further carry-over from the comments made by my senior colleague about babies born during an analysis.

Mrs B. agreed with what I had said (an agreement too easy to be convincing) and added that she thought her reason for not bringing her baby to show me was that she wanted to be allowed to have something all to herself.

Internal supervision: She picks up what makes most sense to her from what I have been saying, and she adopts the same ambiguity in her response 'something all to herself', as I had used. This phrase can refer either to the analytic relationship which she does not want shared with any third party, or to her relationship with her baby which she does not want me to intrude on. I choose to pick up first the matter of the analytic frame.

I replied that this comment is particularly true of her wish to have her analysis to herself, without having other people intrude upon her being allowed to use her sessions in her own way.

Hindsight: I have stopped hiding behind the ambiguity and have acknowledged that the analytic frame requires privacy, not being subjected to suggestion or directives from the analyst. Had I responded to the earlier cues, with regard to the Friday time, I could have been more specific here. She is also wanting the Friday time to be 'all to herself'.

She said that this was true, and she began to relax in the session for the first time, having been noticeably tense. She remained calm until the end of the session, a few minutes later, without talking.

Internal supervision: During the silence I begin to realize that the attack upon the patient, in the dream, has not been referred to by me or by her. I have selected only those themes in which I can see myself reflected in a positive light. Because I have ducked the negative references, she could see me as not yet ready to tolerate the more painful perceptions of me.

Wednesday

Mrs B. arrived eight minutes late. Still standing (again), before moving to the couch, she asked me if she had left the

smaller photograph anywhere in my room the previous day. I told her I had not seen it.

Internal supervision: She is using the same defence of isolation as before (i.e. standing rather than using the couch). She is also late again. I recognize that something is still interfering with the analytic space.

Mrs B. told me she was late because the car wouldn't start. 'There was no light in the battery', and it was only the second time that this had happened with this car. She had then taken her husband's car. She hadn't looked in her own car for the missing photo.

Internal supervision: I hear of something that has been lost, something to do with her having brought the photographs the previous day. I listen to this, around the current framework issue related to the photos. I try to find a bridge towards dealing with this.

Hindsight: 'No light in the battery' is a strange way of referring to a flat battery. English is not the patient's original language, but as she is fluent this expression stands out as unusual for her. There may be a reference to my not having been more enlightened in my recent handling of her sessions. I have become like the car – not working properly.

I said she may have needed to feel that the photo had been lost, for the purpose of this session, so we could look at the implications of this for her. For instance, she could feel (with some justification) that she would not have lost this photo if I hadn't mentioned she might show it to me. She agreed. She then wanted to refer back to the previous day's dream.

Internal supervision: Again her agreement is too quick. I am left feeling unsure whether this is confirmation. I note, however, the patient's indication that there is something we have not looked at left over from the previous day's dream.

Mrs B. pointed out to me her passivity in relation to the people threatening her in the dream. She saw them as people from her past. She commented that she could not gain anything if she merely sought protection from them rather than facing them.

Internal supervision: The patient picks up one of the aspects of the dream I had bypassed in my selective play-back of themes from the dream. She also offers a deflection from me onto people from her past. She may have registered that I had previously avoided the negative references to me in the dream. I think she could be expressing a perception of me as needing to be protected from her more negative feelings. I also note her passivity in relation to my comment about the photographs.

Hindsight: We can see how the patient parallels my own defensive manoeuvre in the previous session, when I deflected her too quickly from my own failure onto the failure of her mother. This could be seen as a further indication to her that I might have been feeling unable to cope with the critical allusions to me in her dream.

I said it seemed to me that I appeared in two forms in her dream: as the prison officer, who is seen as friendly and who is putting her into protective custody, and I might also be represented in the dream by the people threatening her.

Internal supervision: This is a clumsy attempt to bring the patient back to the present reality, rather than collude with a possible flight to the past.

Hindsight: I am interpreting without giving the patient time to present me with the material for an interpretation. I am therefore still acting upon my countertransference anxiety at having made so many mistakes recently, one leading to another.

Mrs B. seemed puzzled by the second part of my interpretation and asked me how I had arrived at it.

Internal supervision: The patient points out that I have picked my interpretation out of thin air. Certainly, she has not given me the grounds for this intervention, in the course of this session, so naturally she cannot see where I have got it from. I am in too much hurry to correct my recent errors. I therefore try to remedy this situation by playing back some of the missing ingredients from the dream, hoping to provide a bridge from that to my interpretation.

Hindsight: It would have been better to remain silent and let the patient lead.

I said I felt we should see how the dream had started. She had been carrying something valuable in a container, which she was trying to protect from the other people in the dream who were seen as wanting to have their share of it. She had also told me she had had some reluctance about showing me her baby. Nevertheless, she had brought the photos and she had had this dream the following night. At the end of the dream her head is kicked in, possibly a reference to her feeling she had not been allowed to think for herself. She reflected on this and partly agreed with it. She added that she hadn't been conscious of any wish not to bring the photographs; it had merely not crossed her mind to do so.

Internal supervision: I note that it had 'not crossed her mind', in other words it was not her own thinking. I see this as some degree of confirmation, and I feel that perhaps we can now look at the transference elaboration of this experience.

Hindsight: It is evident I remain impatient to move away from the present reality. By not giving her time to continue from here on her own, I am still threatening her space while acknowledging her need for me not to do so.

I said it was possible I had come to represent a bit of her past experience with her mother, in which she had not felt

able to stand up to her, or in this instance to me. Instead, it appeared that she had felt a need to please me by bringing the photographs; but this apparent need may have been caused by her seeing me, at the time, as the mother who needed to be pleased. Mrs B. was nodding as I was making the last part of this interpretation. She went on to tell me about something that happened 'on Friday – no, Thursday night' of the previous week.

Internal supervision: The slip seems obvious. I see this as a reference to the missing Friday sessions.

Hindsight: The Friday issue is dealt with only temporarily here. It is not until after this week that the Friday sessions are reinstated on a regular basis, so in this sense the Fridays are still missing.

Mrs B. continued by saying that on Thursday evening her husband had been away, so she had invited herself to supper with friends. She told me in detail about a rich sweet dish that she took with her to the supper, how she had eaten too much and had then felt sick. In the night she had been afraid she might be ill the following day and unable to feed Peter, who was still being breast-fed. She therefore made herself vomit; and by the morning she was feeling better and more able to cope.

Internal supervision: I note the themes: husband absent; feeding herself; making herself feel sick by eating too much; fear of having to interrupt her baby's feeding. I decide to offer a bridge towards dealing with some of this.

I pointed out to Mrs B. the timing of this experience, prior to the Friday morning when she would not be having her usual session. She agreed it was probably because she was feeling deprived of the Friday session that she had allowed herself to eat too much.

Internal supervision: She gets to this on her own. I do not need to over-feed her.

She also pointed out that she was aware of having had a choice: either to remain feeling ill and helpless, or to do something about it in order not to have to interrupt her present feeding pattern with her baby.

Internal supervision: She indicates the theme of interruption, which I see as alluding to interruptions of various kinds. I decide not to interrupt here.

She went on to say it would not necessarily have meant having to wean Peter abruptly; but certainly she thought it would have meant an unwarranted interruption of the feeding pattern.

Internal supervision: I note the words 'unwarranted interruption'. The issue I feel she is highlighting, with her reference to feeding, is that of the Friday sessions – one of which was the previous Friday just referred to.

I said to her she had come to experience the recent interruption of her Friday sessions as unwarranted. On the Monday, in her first session after the sequence she had just described, she had indicated that she wanted to review the decision to drop Friday sessions. She agreed. It was by this time the end of the session.

Internal supervision: I think it only became possible for Mrs B. to refer to the dropping of her Friday sessions as an unwarranted interruption once it had been agreed that she could come back to her Friday session, at least for this week. The long-term arrangement has still not been settled.

Thursday

Mrs B. started the session by telling me about Emma's mother. This mother had said that Emma should stay the night with Mrs B. and her niece. She had also said in front of

Emma: 'It would be so nice for me.' Mrs B. felt terrible about this, feeling very sorry for the child and feeling she should have been given a chance to say what *she* wanted. Mrs B. went on to say it seemed wrong to push Emma out of her own home in this way, to please her mother.

Internal supervision: I seem to be hearing about a self-interested mother. Listening first for the external realities being alluded to here, I wondered if that incident were being told to me as a further unconscious prompt from the patient. I decide to start with this as a bridge-comment towards exploring the patient's internal reality, which I believe is being indirectly referred to here.

I said to Mrs B. that here we have an example of a child being separated from her mother, because of wishes of the mother rather than of the child, and the child had not been given a chance to say what she felt about it. Mrs B. agreed and fell into a distressed silence. After a while she told me that, during the previous night, she had awakened thinking she heard a child calling 'Mummy'. The older children were both soundly asleep. She went to see Peter but realized (of course) he could not talk yet. She then noticed that the voice had been saying 'Mummee', which was how a child would call for a mother in her own childhood language. She relapsed into silence and was noticeably more distressed.

Internal supervision: There is ample confirmation here of the theme of an *absent mother*. I feel she needs some acknowledgement by me, that I am aware of the meaning of her distress, rather than having me leave her too long in a silence in which I also could be seen as the mother who cannot hear.

I said: 'So it was the child in you calling out for your childhood mother.' She agreed and heaved a sigh of relief. She added that she could not count on her mother to hear. She went on to ask why it was she still went on and on with the same problems, and again became silent.

Internal supervision: I reflect that the patient is needing help to deal with feelings about her absent mother, and I feel she is also alerting me to my recent absences (my lapses of analytic attention), which triggered this material. I look for a current focus to this theme of inattention, where I could have been failing her in ways like the mothers she is criticizing (Emma's mother and her own).

> After a fairly long silence, I said that what set this off again in her might have been her uncertainty about whether I had been offering her flexibility, with regard to the sessions, to meet *her* needs or whether I was really wanting to get on with my own business. (I was silently bearing in mind that I had told her I would be using her time for myself.) Mrs B. said that consciously she had been glad I had explained to her about the reading.

Internal supervision: I note her emphasis on 'consciously', so I wonder about the unconscious aspect.

> I said I felt that to her unconscious, my having told her about my wish to have time for reading had given her occasion to develop a perception of me as being too much like her mother, wanting to have time to get on with her own things, and like Emma's mother who had behaved in a similar way. Mrs B. said the child part of her would probably latch onto anything like that to feel anxious about. She said she was wondering whether her need to go back to five times per week had stemmed from a need to be sure that her Friday times would still really be there for her.

Internal supervision: I see some of this as a confirmatory response, but I find myself wondering about the original dropping of the Friday sessions, whether the arrangement had been such as to allow this to happen too readily.

> I said I felt perhaps she had become unsure where she stood with me, once I had offered to let the structure of her sessions become flexible. She might have accepted this change partly because it had been made to appear seductively easy rather than her having been given a chance to work this through, to have her own say on it, to the point of being sufficiently clear in herself to take this step on her own.

Internal supervision: I am beginning to get hold of the point I had missed until now; it could have been the *flexibility* that had made things so difficult for the patient. The analytic framework had begun to suffer further breaks from that point on.

> Mrs B. replied she didn't know about this; but shortly afterwards she said that she had suddenly developed a splitting headache, and she said it was most unlike her to have headaches.

Internal supervision: She is telling me there is still a painful conflict around here. I listen for further cues.

> After a silence, Mrs B. began to tell me about feeding Peter. He had a great appetite and at this time happily ate solids during the day, but he continued to be breast-fed in the mornings and the evenings. Until recently she had felt she needed to be very careful about what she herself ate, in order to be sure she had an adequate supply of milk and a proper balance in her milk for the baby. She had since discovered that she really didn't need to be so 'ultra careful', and her baby had continued to be perfectly all right.

Internal supervision: I hear further unconscious prompting here. I have been too careful with Mrs B., in thinking she needs flexibility; so my attempts to hold her particularly carefully around the time of 'weaning' in the analysis have made her more anxious and insecure, not less so. As a result, I have lost my balance as analyst and I am still in the process of having to recover this.

> I said perhaps she had experienced me as being overly careful with her, offering her such a gradual change from

five-times-per-week to four-times, that she felt I was thinking of her as more fragile in this respect than she actually was. Mrs B. replied with surprise saying her headache had gone now.

Internal supervision: I take this as confirmation of my interpretation, and so does she. I then reflect upon this theme of my trying to be the over-protective mother, in preparation for my next interpretation.

I said there had been a painful conflict in her. She had been anxious for me to be sensitive to her child needs, in order that my behaviour did not appear too similar to the insensitivities she had experienced in her mother; but she also needed me to acknowledge her adult strengths. She agreed that she would feel I was letting her down either way: if I responded only to the child in her or only to the adult.

As the session was ending, and she was about to leave, the patient added that she wondered whether she had pointed out to me she still had the negative of the lost photograph. She had noted to herself that still having the negative meant she could re-create the positive. I said I felt she had needed me to learn from her, in order to recognize what had been a negative experience in the past few sessions, so we could re-establish the positive which had been lost. She nodded and smiled her agreement as she left.

Internal supervision: The analytic holding seems to have been recovered. The patient has found her own symbolic way of letting me know this.

Comment: It should be noted that my preoccupation with the recent mistakes (although necessary as a step towards resuming the analytic process) was also presenting a degree of interference. This concern over errors is always a hazard if the work of the internal supervisor is allowed to become too active and conscious during a session. It then functions instead as an internalized supervisor, which at times can even become

persecutory to the therapist. (This is especially true if the clinical material in question is going to be presented to scrutiny by others, as in a clinical seminar, which was the case here.)

My recent high level of concern is being pointed out by the patient as being 'ultra careful'. I had been giving her a pain in the head. Even though I do not recognize this particular contribution to her headache, in the current session, her headache lifts when I show that I acknowledge there had been too much carefulness somewhere and, by implication, that I am ready to relax and to allow the analytic process to be resumed.

Friday

The patient arrived slightly late. She referred to the previous Wednesday night, when she had had a dream she had forgotten until that morning.

Internal supervision: The patient had 'forgotten' this dream. Maybe she could not let herself remember it while we were still caught up in other matters. She is also late, so there may be something still holding her back.

In the dream *there was a river. She was lying beside this river, the sides of which were like springtime with new growth all around. She was either very small or was lying on her front as the water seemed to be at eye-level. It had then begun boiling and threatened to destroy everything around. She felt the boiling water was coming straight at her. She wanted to turn away, because she was so frightened, but instead she looked at the water and it became an ordinary river again.* The patient paused in her recounting of the dream and said with amazement: 'I was able to stop it boiling.'

Internal supervision: I note the themes in this dream: springtime and new growth; the patient is very small or lying on her front; there is eye-level water; the water begins to boil; it threatens to destroy; it seems to be coming straight at her. I sense that I am being presented with a traumatic memory, or a

dream-reconstruction, of the accident. The boiling water had been at eye-level, and it was the patient's front that had been so badly burned. She also seems to indicate a readiness to look at the water. Possibly she is letting me know that the 'memory', which had always been too terrible to remember, is close to being consciously re-called. Just possibly she is feeling more secure now we have worked all week on re-establishing the analytic framework. I decide to explore this with her, but being careful not to lead her towards my own thoughts about the dream. She needs to be ready to see the implications of this for herself.

> I commented that the river had stopped boiling once she was able to look at it. I also noted she had 'forgotten' this dream until she felt safe enough with me to look at it. She replied she hadn't realized until telling me the dream that it so clearly referred to the accident. She then became very distressed and began to experience the accident as happening to her in the session. It was as if the boiling water were pouring onto her and burning her. She cried out loudly in extreme pain and sat up, saying: 'When I was lying down it wouldn't stop coming at me.' She sobbed for a long time, holding her head in her hands.

Internal supervision: Her holding of her head in her hands prompts me to see that she needs to feel held. I recall that earlier in the analysis she had told me that, after the accident, the pain only ever felt tolerable when she was being carried by her mother. She had felt as if she had been able to 'put' her pain into her mother; but when her mother laid her down again it had been as if the pain were too much for her mother, so it seemed as if she were 'putting it back' into the patient.

I cannot but feel under enormous stress, being with the patient now in this session. It is excruciating. I feel a very powerful wish to stop this experience, in any way possible, by trying to reassure her or by trying to divert her: anything seems preferable to remaining witness to her pain. Alongside this impulse to protect myself is a realization that this had been Mrs B.'s perception of her mother's response. For the patient's sake, therefore, I know I must find some way of staying with her through what is happening, without trying to by-pass it.

> I said I felt she was holding her own head in her hands as a way of telling me that she needed to feel 'held' through this experience. Still crying, she replied: 'My mother couldn't face it – she had to turn away from it – I couldn't bear it alone.'

Internal supervision: I recall that her mother had in effect caused the accident by not being in the room, where this now mobile child was and where there was water boiling. After the accident her mother had not been able to look at the results of the accident. Mrs B. had a memory image of her mother dressing the wounds while trying to turn her face away from them. I feel I am being tested by the patient to see if I can bear to see her in such pain. She is telling me she cannot bear this alone.

> I said to her: 'You need me to be able to stay with you in your pain and not to have to turn away from it.' She looked me straight in the eyes (she was still sitting on the couch) and said: 'Can you?' I answered: 'I know you need me to bear it with you.' After this she lay down, saying: 'Let me see if it has stopped now. Before, the boiling water kept coming at me. I could not bear the pain. It is better now.' After a while she added: 'I never believed I could bear to remember it; but now I have.'

Internal supervision: This is a quite different level of experience from all the earlier allusions to the accident. Mrs B. had dreamed of the accident a number of times, but it was always more disguised. For instance, the boiling water had often been represented by its opposite, by ice. In one dream it was the movement of the water that was frozen, as it began to fall towards her like in a photograph. I note the progression.

> I said to Mrs B. that this was the first time she had let herself experience the accident undisguised. She replied: 'This

time I let it flow over me; and, even though it burned me, I now find that I am all right.' At the end of the session she again looked straight at me and said: 'Thank you for staying with me.'

Aftermath of the sequence

The following week Mrs B. told me she had realized that she had been singing to herself over the weekend. This was something quite new, and it reminded her of her mother singing to her. She recalled prodding her mother to get her to go on singing when she stopped. This was the first remembered link between a good mother from before the accident and a good mother still there after it.

What followed later was the patient's hating me most intensely, as the mother who had allowed the accident to happen to her and as the analyst who had allowed it to be repeated in the analysis. She also had to test me out extensively to discover whether I could continue to hold her analytically. She expected me to become the mother who could not bear remaining in touch with her pain, or who might retaliate if being in touch with this became unbearable to me. She expected to be left to fall for ever. (Part of that sequence is described in Chapter Seven.)

It took a further year before Mrs B. could begin to find real peace from the unspeakable dread of the anxieties which had come to be so closely associated with her experience of intense dependence on her mother after the accident, and on me as analyst after she had re-experienced the accident in the analysis. Much else, of course, occurred during the next year of treatment, but the experience of the week reported here remained a basic foundation to most of the subsequent progress made in the analysis.

Discussion

The interactional viewpoint

As in Chapter Three, this presentation illustrates a number of points that are most clearly observed when the clinical sequence is considered from an interactional viewpoint.

It shows once again how closely a patient monitors the analyst. Mrs B. not only noted my conscious interventions, and other expressions of myself, but she also monitored for the unconscious implications of my behaviour; my intrusions, my deflections, my timing of interventions or failures to intervene, my choice of what I referred to and what I had overlooked, and my capacity to cope with what she needed to be able to present to me or my unreadiness for this.

Also, by a series of cues offered to me, this patient was able to help considerably in the re-establishing of a more secure analytic framework – without which she could not have re-experienced in the analysis the memory which she had felt she might not survive remembering.

Evidence of indirect countertransference

One influence affecting this week's work with Mrs B. was my knowing that I had decided to present it to a clinical seminar, at which a number of senior colleagues would be present. The seminar leader was also known to be rigorous in his criticism.

Having chosen to present whatever happened in this week, with this particular patient, my listening was already less relaxed than I would wish. The work of my internal supervision became tilted away from the more sublimal way of working I wish to advocate, and at times it was more like that of a severe internalized supervisor. I was internalizing the anticipated critical attitude of the seminar leader – 'identifying with the aggressor'. This intrusive presence of an influence from outside the analytic situation is what has been described as 'indirect countertransference' (Racker 1968). To that extent, therefore, this work is not an illustration of how a more autonomous and relaxed process of internal supervision should be.

Countertransference and role-responsiveness

There is also evidence that I was responding to the patient with personal countertransference.

At some level, I must have known there was more to be dealt with in this (so far) quite short analysis. Mrs B's accident had been analytically encountered at various levels, all of them significantly less traumatic than the accident itself. The patient

had dreamed about this many times, always with a high degree of 'dream-work' disguise (Freud 1900:461n). But it had never been experienced in the session. I had assumed that so early a trauma could not be really remembered or re-lived in an analysis. I now recognize I must have hoped this, so that I would not have to be confronted by the impact of this trauma upon myself.

With hindsight, it is also possible to recognize there was a likelihood Mrs B. would become anxious at the time when she began to feel better because it had been when she was beginning to be a normal lively toddler, exploring the world around her, that the accident had occurred.[2] So, when she felt better and suggested she might be ready to drop one of her sessions, I should have been more alert to the possible significance of this for her. However, it must have suited me unconsciously to collude with the patient's confidence, I too wishing to think we had been through the worst of her analysis already.

When Mrs B. became anxious, immediately she had begun to do without her fifth session, I was getting early warning signals that all was not as well as it had appeared.

When I introduced the topic of her baby, that she had not brought him or a photograph of him to show me, this looks (at first sight) entirely unaccountable. On reflection, however, it begins to make more sense if we see this in terms of what it did to the analysis. It temporarily deflected the analysis onto the patient's *well baby*, and away from the *unwell baby* in her unconscious memory. She later pointed this out, when she explained her reservations about my seeing how well she looked in the photographs; that I might assume everything to be all right, and I might therefore overlook that there were very difficult things still to be dealt with.

In the process of this accumulation of errors, there began to be an uncanny parallel between how I was behaving with this patient and how her mother had been at the time of the accident. I was too quick to assume her readiness to cope more on her own, when she first said she was feeling much better. I agreed to drop the fifth session without a careful analysis of the implications. I compounded this by telling her how I would be using her time, that I would be using it for my own

business. So, by these several stages, I came to represent her mother who had been prematurely absent from her child at the time when she was at risk as a toddler needing more active attention rather than less.

Can this parallel be explained only in terms of personal countertransference? I think there must have been some unconscious role-responsiveness too, which contributed to my becoming so fully involved in this re-enactment of the mother who had failed this patient at the time of the original trauma.

The recovery of analytic holding

This patient could not dare to experience her original trauma while the state of the analytic framework and holding continued to be inadequate and therefore insecure.

An essential part of this sequence, in my opinion, emerges through the patient's tenacious cueing of me to see those things that were still not right. By listening to the sequence interactionally, and by gradually recognizing and attending to her anxiety concerning whether I could bear to stay with her pain in the analysis (rather than to divert her), she rediscovered that I could be responsive to her cues. The analytic hold thus came to be restored; and the patient was able to acknowledge this symbolically in the Thursday session.

Re-experiencing the original trauma

Before this week of analysis, I was not familiar with Winnicott's notion that the details from early traumatic events are 'catalogued' (Winnicott 1958:247). Elsewhere, in his paper 'Mind and its Relation to the Psycho-Soma', he writes:

> 'One has to include in one's theory of the development of a human being the idea that it is normal and healthy for the individual to be able to defend the self against specific environmental failure by a *freezing of the failure situation*. Along with this goes an unconscious assumption (which can become a conscious hope) that opportunity will occur at a later date for a renewed experience in which the failure situation will be able to be unfrozen and re-experienced, with the individual in a regressed state, in an environment that is making adequate adaptation.'
>
> (Winnicott 1958:281)

Mrs B. unconsciously found her own way back to the moment of trauma, by degrees which were in proportion to her fragile but growing trust in my capacity to hold her through these experiences. Earlier in the analysis she had only been able to enumerate the details as they had been told to her. Later she could let herself dream about them.[3] She needed eventually to experience, in the transference, the 'unthinkable anxieties' of her childhood and in particular the 'fear of falling' (Winnicott 1965b:58, 1970).

The analysis gradually moved towards a situation which, in important respects, replicated the earlier experience of failure. Gradually, too, she helped me to represent 'an environment that is making adequate adaptation' Only then could she combine in her analysis a representation of the original failure with an unconscious hope that (this time) she could go through the experience in the presence of someone able to stay with her through it, with herself and the other person both able to survive that intensity of feeling.

Here again, as in example 4.6, 'the patient uses the analyst's failures, often quite small ones, perhaps manoeuvred by the patient'. The patient was then able to use me to represent the mother who had previously failed her. The 'failure situation' had become unfrozen, and she could now attack me with the feelings she had first experienced towards her mother, at the time of the accident (Winnicott 1965b:258). If these dynamics do apply here too, it is remarkable how precisely the details of the original failure were unwittingly repeated in this analysis.

I had to learn how to survive these attacks. What helped most in this was my being able to recognize the unconscious purpose in this sequence, and the cost to the patient if I were to collapse or retaliate.

Notes

1. The clinical sequence presented in this chapter is an extract from my paper 'The Reflective Potential of the Patient as Mirror to the Therapist'. In James O. Raney (ed) (1984) *Listening and Interpreting: The Challenge of the Work of Robert Langs.* New York: Jason Aronson.

2. I have noticed, with a number of patients, that the experience of *feeling better* is sometimes treated by the patient as a signal for further anxiety. Some analysts might treat this as a fear of losing the 'secondary gains from illness'. Others might regard it as 'negative therapeutic reaction'. However, I believe there are some occasions when a patient is indicating that an unconscious link has been formed between an earlier experience of trauma and the prior sense of safety, as if that 'safety' had been a warning signal for the pending disaster. Perhaps an unconscious set is formed in which feeling safe and subsequent catastrophe are seen as forever linked.

3. Winnicott says: 'That which has been dreamed and remembered and presented is within the capacity of the ego-strength and structure' (Winnicott 1965:254).